

Welcome to Orthopedic & Sports Medicine Associates. We are dedicated to providing you the best possible orthopedic care.
Our office hours are Mon.-Thurs. 8:30-5:00, Fri. 8:30-12:00.

Medication Policy

We do not renew prescriptions after office hours or on weekends. Please contact your pharmacy for all medication refills. Refill requests received after 4:30 p.m. Mon – Thurs. and 11:30 a.m. on Friday will not be refilled until the next business day.

What Pharmacy do you use? _____

Pharmacy location? _____

By signing below you are giving us your permission to download prescription drug history.

Patient Name

Signature of patient or legal guardian

Print Name

Date

Cancellation Policy

If you need to cancel an appointment we ask that you give us at least 24 hours notice. If you no show your appointment you will be charged a \$25.00 fee.

If you have an emergency after hours dial 911 or go to the emergency room.

I have read and understand our cancellation and prescription renewal policy.

Patient Name

Signature of patient or legal guardian

Print Name

Date

Stephen D. Sandoval M.D.
Shannon D. Cain PA-C

PATIENT'S INFORMATION:

Last Name _____ First _____ Middle _____

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone #(____) _____ Work Phone #(____) _____ Ext. _____ Pager/Cell # (____) _____

Date of Birth ____/____/____ Social Security # ____-____-____ Driver's License # _____

Marital Status: Married _____ Single _____ Widow(er) _____ Divorced _____ Separated _____

Full Time Student: _____ Yes _____ No School Name: _____

Employer _____ Employer's Phone # (____) _____

Employer's Address: _____ City _____ State _____ Zip _____

Name of Spouse (If Applicable) _____ Date of Birth ____/____/____

Spouse's Employer _____ Employer's Phone # (____) _____

Employer's Address: _____ City _____ State _____ Zip _____

Nearest Relative/Friend (Not Living With You) _____ Phone # (____) _____

IF PATIENT IS A MINOR (Age 17 & under) Please complete the following & the above employment and spouse info.

Guarantor's Name _____ Relationship to patient _____

Date of Birth ____/____/____ Social Security # ____-____-____ Driver's License # _____ State _____

Whom May We Thank For Your Referral? _____**INSURANCE INFORMATION: (Copies of your insurance cards are required)**

Name of Primary Policy Holder _____ Date of Birth ____/____/____

Name of Secondary Policy Holder _____ Date of Birth ____/____/____

AUTHORIZATIONS

I understand that as part of my healthcare, this practice originates and maintains health records & radiology films describing my health history, symptoms, examination and test results, diagnosis, treatment and plans for future care of treatment. The health records & radiology films will be retained by Orthopedic & Sports Medicine Associates L.L.P. , even if my healthcare provider leaves the practice.

Signature of Patient/Legal Guardian: _____ Date: _____

By signing below, you consent to the use and disclosure of your protected health information by Orthopedic & Sports Medicine Associates, our staff, and our business associates for treatment, payment and health care operations. For a detailed description of uses and disclosures for these purposes, please review our Notice of Information Privacy Practices (Notice). You have the right to review our Notice prior to signing this consent. The terms of the Notice may change, if the terms do change, a revised Notice will be posted at our office located at 321 N Highland Ave. Ste 120 Sherman, TX 75092. You have the right to request that we restrict our uses of disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. You have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on the agreement.

Signature of Patient/Legal Guardian: _____ Date: _____

As the party responsible for medical decision making for the minor child represented in this medical record, I give my consent to O.S.M.A. to render both emergency and non-emergency healthcare services both in and out of physical presence.

Signature of Patient/Legal Guardian: _____ Date: _____

PATIENT HISTORY FORM

Date: _____

NAME: _____ AGE: _____ Sex: M _____ F _____

How were you referred to our office? Physician _____ Magazine _____ Internet _____ Newspaper _____ TV _____ Other _____

Name of Referring Physician: _____

Your Primary Care Physician: _____ Cardiologist: _____

CHIEF COMPLAINT

REASON FOR TODAY'S VISIT: _____

WHEN DID YOUR INJURY OR PROBLEM BEGIN? _____

DO YOU CONSIDER THIS WORK RELATED: _____ Yes _____ No When was it reported to your employer? _____

PATIENT MEDICAL HISTORY

LIST ANY MEDICAL PROBLEMS YOU HAVE: _____

LIST ALL MEDICATION YOU ARE TAKING

NAME OF MEDICATION	DOSE	HOW OFTEN	REASON

DO YOU HAVE ANY ALLERGIES? _____ Yes _____ NO

ASPIRIN _____ SULFA _____ PENICILLIN _____ ANESTHETIC _____ LATEX _____ OTHER _____

PAST SURGERIES: _____

Any Anesthesia problems _____

FAMILY HISTORY

What illnesses run in your family? _____

SOCIAL HISTORY

Are you : Right _____ or Left _____ handed?

Occupation: _____ Employed by: _____

Married _____ Widowed _____ Divorced _____ Separated _____ Single _____ How many children? _____

How much do you Smoke? _____ How much Alcohol do you Drink? _____

Have you ever used street drugs? Yes _____ No _____ If so when was the last time? _____

Do you exercise? Yes _____ No _____

Recent weight gain? Yes _____ No _____ Recent Weight Loss? Yes _____ No _____ Intentional ? Yes _____ No _____

Do you use a: Wheelchair _____ Walker _____ Cane _____ Who do you live with? _____

PHYSICAL EXAM

Pulse _____ RR _____ Temp _____ Pain _____ Height _____ Weight _____

Authorization for Use and Disclosure of Protected Health Information (PHI)

I, _____, hereby authorize **Orthopedic & Sports Medicine Assoc.** to use and/or disclose my protected health information (PHI) to the following:

[Name of persons(s) or organization(s) authorized to **receive/release** my health information]

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

How to Contact:

I wish to be contacted in the following manner:

☐ Home Phone ☐ Cell Phone ☐ Work Phone

☐ OK to leave detailed medical information

☐ Leave message with call back number only

- I understand that signing this Authorization is voluntary and that if I refuse to sign this form it will not prevent receipt of health care or eligibility for benefits under a health plan.
- I understand that I am entitled to receive a copy of this form upon signing it.
- I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I have a right to revoke this Authorization, but I must send a written revocation to **Orthopedic & Sports Medicine Assoc., 321 N. Highland Ave Ste 120, Sherman, TX 75092**. I also understand that the revocation date applies to uses and disclosures made after the revocation is made.

This authorization will remain in effect until: _____/_____/_____
(Date of Expiration)

Signature of Patient or Representative Printed Name of Patient or Representative

Date signed: _____/_____/_____

COLLECTION/PAYMENT POLICY

We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. If a patient has insurance that we do not participate in, our office is happy to file the claim upon request: **however, payment in full is expected at the time of service.**
- It is the patient's responsibility to pay any deductible, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
- **Payment for professional services can be made with cash, checks, MasterCard, Visa, or Care Credit.**
- If a patient feels that he or she may require financial assistance, they should ask to speak to the patient accounts manager. Patients that do not have insurance are expected to pay for professional services at time of service unless prior arrangements have been made.
- I understand that **I will be legally responsible for all collection costs** involved with the collection of this account including court cost, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice **before the visit**. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our staff will be happy to answer questions relating to how a claim was filed, or regarding additional information requested from the insurance carrier. However, specific coverage issues will need to be addressed by the insurance company's member services department at the number on your insurance card.

Responsible Party for Minors (under 18 years of age)

- **We assign all financial responsibility to the parent/guardian that completes and signs the patient registration form. Any amount due at the time of service is expected from the parent/guardian accompanying the minor at the visit. In the event that a divorce decree assigns distinct financial responsibility for medical bills to another individual, we still hold the registering parent/guardian responsible.**

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you. **Please sign and date that you have read and agree with the Financial Policy of Orthopedic & Sports Medicine Assoc. L.L.P.**

Signature of Patient/Responsible Party

Date

Physician Assistant Consent

This practice utilizes a Physician Assistant to assist in the delivery of orthopedic care.

A Physician Assistant is a graduate of a certified training program and is licensed by a state board. Under the supervision of a physician, a Physician Assistant can diagnose, treat, and monitor common, acute and chronic orthopedic problems and disease provide health maintenance. "Supervision" does not require the constant physical presence of the supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

The relationships of physician/physician assistant are based on mutual respect and trust which allows the ability to provide the highest quality of care possible for their patients.

A Physician Assistant provides medical services that are within his/her education, training and experience. These services may include:

- ❖ Obtaining histories and performing physical exams
- ❖ Ordering and/or performing lab test, imaging studies, etc.
- ❖ Developing and implementing a treatment plan
- ❖ Monitoring the effectiveness of therapeutic interventions
- ❖ Assisting at surgery
- ❖ Suturing, splinting, and casting
- ❖ Offering counseling and education
- ❖ Supplying sample medications and writing prescriptions
- ❖ Making appropriate referrals

I understand that at any time I can refuse to see the Physician Assistant and request to see a physician.

Physician Assistants' services maybe billed separately from the physician. Insurances vary on covering the services of the Physician Assistant. If you have a concern, please speak to the front desk.

I have read the above, and ____hereby CONSENT ____DO NOT CONSENT to the services of a Physician Assistant for my health care needs.

Name

Date

Signature

Date

Please put a check by the following that apply to you:
Check Here if there are no changes since your last visit _____

Patient Name: _____

Date: _____

Constitutional

- ___ Night Sweats
- ___ Anorexia
- ___ Chills
- ___ Diaphoresis
- ___ Recent Illness
- ___ Fatigue
- ___ Fever
- ___ Insomnia
- ___ Malaise
- ___ Weight Gain/Obesity
- ___ Weight Loss

Eyes

- ___ Blindness
- ___ Vision Change
- ___ Macular Degeneration
- ___ Visual Disturbance
- ___ Amblyopia
- ___ Cataract
- ___ Diabetic Retinopathy
- ___ Glaucoma

Ears/Nose/Throat/Neck

- ___ Cancer
- ___ Dental Pain
- ___ Gastroesophageal Reflux
- ___ Nasal Allergies
- ___ Sleep Apnea-Obstruction
- ___ Sleep Disordered Breathing
- ___ Snoring

Cardiovascular

- ___ Arrhythmia
- ___ Chest Pain/Pressure
- ___ Claudication
- ___ Dyspnea
- ___ Edema
- ___ Exercise Intolerance
- ___ Fatigue
- ___ Hypertension
- ___ Near-Syncope/Dizziness
- ___ Palpitations
- ___ Syncope

Respiratory

- ___ Asthma
- ___ Productive Sputum
- ___ Apneic Events
- ___ Chest Congestion
- ___ Chest Tightness
- ___ Cigarette Smoking
- ___ Cough
- ___ Dyspnea on exertion
- ___ Dyspnea
- ___ Foul Smelling Sputum
- ___ Hemoptysis
- ___ Occupational Exposure
- ___ Passive Smoking

Gastrointestinal

- ___ Vomiting
- ___ Hemorrhoids
- ___ Hepatitis
- ___ Abdominal Pain
- ___ Anorexia
- ___ Constipation
- ___ Diarrhea
- ___ Dysphagia
- ___ Jaundice
- ___ Gastroesophageal Reflux
- ___ Melena

Musculoskeletal

- ___ Stiffness
- ___ Swelling
- ___ Arthralgia(s)
- ___ Back Pain
- ___ Bone Fracture
- ___ Bone Pain
- ___ Carpal Tunnel Syndrome
- ___ Joint Complaint
- ___ Muscle Weakness
- ___ Myalgias
- ___ Neck Pain
- ___ Osteoporosis
- ___ Sciatica
- ___ Shoulder Pain

Dermatologic

- ___ Rash
- ___ Sores
- ___ Acne Vulgaris
- ___ Arthropod Bite
- ___ Callus
- ___ Cellulitis
- ___ Ecchymosis
- ___ Herpes Simplex
- ___ Keloid
- ___ Lupus Erythematosus
- ___ Melanoma
- ___ Neoplasm
- ___ Pyogenic Granuloma
- ___ Skin Cancer

Neurologic

- ___ Dizziness
- ___ Dyskinesia
- ___ Tremor
- ___ Gait Abnormality
- ___ Headache Pain
- ___ Back Pain
- ___ Facial Pain
- ___ Generalized Pain
- ___ Limb Pain
- ___ Vertigo
- ___ Neck Pain
- ___ Paresis
- ___ Paresthesia
- ___ Seizure
- ___ Spasms/Spasticity
- ___ Syncope

Psychiatric

☐ Alcohol Abuse
☐ Anxiety
☐ Conversion/Dissociative Phenom
☐ Depression
☐ Disturbances of Consciousness
☐ Disturbances of Emotion
☐ Disturbances of Memory
☐ Disturbances of Thinking
☐ Drug Abuse
☐ Eating Disorder
☐ Hallucination
☐ Mania
☐ Psychosis
☐ Suicide

Endocrine

☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Adrenal Excess
☐ Adrenal Insufficiency
☐ Hypercalcemia
☐ Hyperglycemia
☐ Hyperlipidemia
☐ Hyperthyroidism
☐ Hypocalcemia
☐ Hypothyroid
☐ Obesity
☐ Pheochromocytoma
☐ Primary Amenorrhea
☐ Secondary Amenorrhea
☐ Oligomenorrhea
☐ Chills

Hematologic/Lymphatic

☐ Abnormal Ecchymoses
☐ Petechiae
☐ Abnormal Bleeding
☐ Bruising
☐ Anemia
☐ Arterial Thrombosis
☐ Leukocytosis
☐ Leukopenia
☐ Lymph Node Enlargement/Mass
☐ Neutropenia

Hematologic/Lymphatic (Continued)

☐ Prolonged Bleeding time
☐ Prolonged PT (INR)
☐ Pulmonary Embolus
☐ Thrombocytopenia
☐ Thrombocytosis
☐ Venous Thrombosis

Allergy/Immunology

☐ Anaphylactoid Reaction
☐ Angioedema
☐ Food Allergy(What kind?) _____
☐ Rhinitis
☐ Urticaria