Orthopedic & Sports Medicine Assoc. L.L.P. **Date: _____**

PATIENT'S INFORMATION: Gender _____M_____F Do you have an advanced directive? Yes ____ No ____

Last Name_____ First _____ Middle_____

Physical Address_____ City_____ State_____ Zip_____

Mailing Address_____ City_____ State_____ Zip_____

Email Address: _____

Home Phone # (____) _____ Work Phone # (____) _____ Cell # (_____) _____

Date of Birth_____/_____/_____ Social Security # _____-_____-_____ Driver's License #_____State_____

Marital Status: Married_____Single_____Widowed_____Divorced_____

Preferred Language_____Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____ Race_____
(Ex. Black, White, Asian, Other)

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_____ Spouse's Phone # (_____) _____

Employer's Address: _____ City_____ State_____ Zip_____

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

IF PATIENT IS A MINOR (Age 17 & under)

Guarantor's Name _____ Relationship to patient _____

Date of Birth_____/_____/_____ Social Security #_____-_____-_____ Driver's License #_____ State_____

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_____/_____/_____

I understand that as part of my healthcare, this practice originates and maintains health records & x-rays, that includes my health history, symptoms, examination, test results, diagnosis, treatment, and future treatment. The health records & x-rays 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 Privacy Practices, located on our website or may be requested at our office.
By signing below, you also consent to the request, and use, of your prescription medication history from other healthcare providers, pharmacies, and benefit payers for treatment purposes.
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: _____

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? _____

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 $35.00 fee.

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

By signing below, you are giving us permission to download your prescription drug history, and agreeing that you have read and understand our cancellation and prescription renewal policy

_____ _____ _____
Signature of patient or legal guardian **Print Name** **Date**

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, Discover, 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

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: _____

Pain Management Physician: _____

Height: _____ Weight: _____

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? _____
IS THIS RELATED TO A CAR ACCIDENT: _____ Yes _____ No

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: _____

Problem with Anesthesia: _____

FAMILY HISTORY
What illnesses run in your family? _____

SOCIAL HISTORY
Dominant Hand: Right_____ Left _____

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? _____What drug?_____

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? _____

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 ____ CONSENT ____DO NOT CONSENT to the services of a Physician Assistant for my health care needs.

_____ _____

Name Date

_____ _____

Signature Date

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: _____/_____/_____

Orthopedic and Sports Medicine Assoc. LLP
321 N Highland Ave Ste 120
Sherman, TX 75092

PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. narcotics, tranquilizers and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. Because my physician may prescribe controlled substance medications to help manage my pain, I agree to the following conditions:

1. **I am responsible for the controlled substance medications prescribed to me.** If my prescription is lost, misplaced or stolen or if I "run out early," **I understand that it will not be replaced**.
2. **Refills** of controlled substance medications:
   a. **Will be made only during regular office hours** Monday through Friday, 8:30 - 4:30 or by 11:30 on Friday. Refills will not be made at night, on weekends, or during holidays. **Call your pharmacy for refills.**
   b. **Will not be made** if I "run out early," or "lose a prescription," or "spill or misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
   c. **Will not be made** as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least twenty-four (24) hours ahead if I need assistance with a refill.
   d. **If medication is stolen a police report must be on file.**
3. It may be deemed necessary by my doctor that I see a pain-management specialist at any time while I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction); my medications will no longer be refilled.
4. I agree to comply with random urine, blood, or breath testing, documenting the proper use of my medications as well as confirming compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
5. I understand that **if I violate any of the above conditions,** my prescription for controlled substance medications may be terminated **immediately**. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of nonprescribed illicit (illegal) drugs, I may also be reported to all my physicians, medical facilities and appropriate authorities.
6. I understand that the **long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined** and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me of any advances in this field and will make treatment changes as needed.
7. I understand it is not our policy to prescribe narcotics for undiagnosed pain.
8. If medication is needed beyond the normal post-operative period, or if pain persists after completion of non-surgical treatment, you will be referred to a pain management program so that a team of specialists can help you with your persistent pain. At this point, I understand that I will be given all pain medications from the pain specialists, and not from your office. The pain specialist will keep your office notified of my progress.
9. I agree to have all prescriptions for controlled substances filled at the same pharmacy. Should the need arise to change pharmacies, the practice will be notified. The pharmacy I have selected is:

   Pharmacy Name: _____Phone: _____

I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve the desired effect and there is a risk of becoming physically dependent on the medication. I know that it may be necessary to stop taking the medication. If so, I must do this under medical supervision, and I may have withdrawal symptoms.

Patient Printed Name_____

Patient Signature_____Date _____

Place a check by any of the conditions that apply to you. If there have not been any changes since your last visit check here: _____

Patient Name: _____ **Date: _____**

Constitutional

____Night Sweats
____Anorexia
____Chills
____Diaphoresis
____Recent Illness
____Fatigue
____Fever
____Insomnia
____Malaise
____Weight Gain/Obesity
____Weight Loss

Eyes

____Blindness
____Vision Change
____Visual Disturbance
____Amblyopia
____Cataract
____Diabetic Retinopathy
____Glaucoma
____Macular Degeneration

Ears/Nose/Throat/Neck

____Cancer of Head and Neck
____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

____Hemorrhoids
____Hepatitis
____Abdominal Pain
____Anorexia
____Constipation
____Diarrhea
____Dysphagia

Gastrointestinal (continued)

____Gastroesophageal Reflux
____Jaundice
____Melena
____Vomiting

Musculoskeletal

____Stiffness
____Swelling
____Arthralgia(s)
____Back Pain
____Bone Fracture
____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 or Tremor
____Gait Abnormality
____Headache
____Back Pain
____Facial Pain
____Generalized Pain
____Limb Pain
____Neck Pain
____Paresis
____Paresthesia
____Seizure
____Spasms/Spasticity
____Syncope
____Vertigo

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

Psychiatric (continued)

____Psychosis
____Suicidality

Endocrine

____Diabetes Mellitus Type 1
____Diabetes Mellitus Type 2
____Adrenal Excess
____Adrenal Insufficiency
____Hypercalcemia
____Hyperglycemia
____Hyperlipidemia
____Hyperthyroidism
____Hypocalcemia
____Hypothyroid
____Obesity
____Pheochromocytoma
____Secondary amenorrhea
____Oligomenorrhea
____Chills

Hematologic/Lymphatic

____Abnormal Ecchymoses
____Petechiae
____Abnormal Bleeding
____Bruising
____Anemia
____Arterial Thrombosis
____Leukocytosis
____Leukopenia
____Lymph Node Enlargement/Mass
____Neutropenia
____Prolonged Bleeding Time
____Prolonged PT (INR)
____Pulmonary Embolus
____Thrombocytopenia
____Thrombocytosis
____Venous Thrombosis

Allergy/Immunology

____Anaphylactoid Reaction
____Angioedema
____Food Allergy (What Kind?)
____Rhinitis
____Urticaria

Medications

Are you taking any new medications? Yes or No
Please List _____

Have you discontinued any medications? Yes or No
Please List

_____

Have you changed any medications? Yes or NO
Please List

_____