All-Star Orthopaedics And Sports Medicine

New Patient Information

Legal Name _____ _____
Last First Middle Preferred Name

Home Address _____ _____ ____ _____
Street Apt # City ST Zip

Phone(s) Home _____ Work _____ Cell _____

Email address _____ Date of Birth _____ Age _____

Gender _____ Marital Status _____ Social Security No _____ Driver's License # _____

How did you hear about our practice? _____

Family Doctor/PCP _____ Your Doctor's Phone Number _____

Insurance Information – Insured Person – Primary Policy Holder *Relationship to Patient _____

Name _____ Social Security No. _____
Last First Middle

Home Address _____ _____ ____ _____
Street Apt # City ST Zip

Phone(s) Home _____ Work _____ Cell _____

Email address _____ Date of Birth _____ Driver's License # _____

Insurance Company _____ ID # _____ Group # _____

Insurance Phone No. _____ Your Employer _____

Insurance Co Claims Address _____
Complete address (Usually on the back of the card)

Secondary or Student Insurance Information *Relationship to Patient _____

Name _____ Social Security No. _____
Last First Middle

Insurance Company _____ ID # _____ Group # _____

Insurance Phone No. _____ Your Employer _____

Insurance Co Claims Address _____
Complete address (Usually on the back of the card)

Emergency Contact / Legal Guardian

Name _____ Phone _____ Relationship to Patient _____

Reason for Visit Area for treatment: *Right or Left, Finger, Hand, Wrist, Arm, Shoulder, Elbow, Back/Neck, Hip Leg, Knee Foot Ankle Toe* _____
Please complete this portion

If an accident was it at Work / Auto / Home / Sports / other _____ Date of Injury _____
Please complete

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS I authorize Las Colinas Orthopedic Surgery and Sports Medicine to release to my insurance company any information acquired in the course of my care and to permit payment directly to Las Colinas Orthopedic Surgery and Sports Medicine dba All-Star Orthopaedics and Sports Medicine for responsibility for any balance remaining after the payment of correct benefits.

_____ _____
Patient / Guardian Signature Date

Financial Agreement Form

I agree to pay for services rendered. If applicable, I agree to pay for my co-payment at the time of service and I understand that I will be fully responsible for any services deemed as non-covered or denied by insurance company. I also understand that there may be a patient responsibility balance even after my insurance company has made a payment.

I agree to comply quickly with any request by my insurance company or All-Star Orthopaedics and Sports Medicine to assist in quick and efficient payment of my medical claim.

I accept that it is my responsibility to understand and verify that the physicians of All-Star Orthopaedics and Sports Medicine are in-network with my insurance plan including any facilities that I may be referred to for surgery, physical therapy, further testing and/or other types of ancillary services etc.

If my insurance company requires a referral to see a specialist, I agree to be ultimately responsible in obtaining my referral along with the assistance of a representative from the specialist's office.

Payment can be made in the form of cash, verifiable check, and/or credit card. There will be a $25.00 per check charge for all returned checks as having non-sufficient funds.

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below. Further, I assign insurance benefits for all services rendered by Mark S. Greenberg, M.D. and/or Thomas M. Schott, M.D. and/or Bing S. Tsay, M.D. and/or Stephen J. Timon, M.D. and/or Michael K. Hahn, M.D. and/or Kevin M. Honig, M.D. and/or W Grear Hurt, M.D. and/or Brian E. Straus, M.D. and/or any other licensed healthcare service provider employed by the company. Additionally, I agree to release all such medical information as may be necessary to assist in payment of medical claims.

Printed Name of Patient: _____

Signature of Patient and/or Legal Guardian: _____

Date: _____ Social Security Number: _____

All-Star Orthopaedics And Sports Medicine

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

All-Star Orthopaedics and Sports Medicine may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate to collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, managed care organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician or health service entity that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, have copied, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. This office charges **$25.00** for a copy of your medical records, along with a signed medical records release form.

All-Star Orthopaedics and Sports Medicine is legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of our findings. No retaliation will be made against you by All-Star Orthopaedics and Sports Medicine because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Privacy Officer to obtain additional information regarding any questions you may have concerning this notice or to receive a copy of this notice. **This Notice of Privacy Practices is effective as of April 13, 2003.**

I have read and understand the contents of this notice and I request the following restrictions:

_____

I further request payment of medical benefits to either myself or to the party who accepts assignment. Regulations pertaining to medical assignments of benefits apply.

Signed_____ Date: _____

Patient Name:_____ **Patient SS#** _____

All-Star Orthopaedics And Sports Medicine

Patient Preference Regarding Communication of Health Information

1. Who to Contact

I hereby give permission to All-Star Orthopedics & Sports Medicine to disclose and discuss any information related to my medical conditions to/with the following members (relatives or close personal friends):

Name	Relationship
Name	Relationship
Name	Relationship

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions.

2. How to Contact

I wish to be contacted in the following manner:

Home Telephone:
☐ OK to leave message with detailed information
☐ Leave message with call back number only

Work Telephone:
☐ OK to leave message/voicemail with detailed information
☐ Leave message/voicemail with call back number only

Written Communication:
☐ OK to mail to my home address: _____

_____

☐ OK to mail to my work/office address: _____

_____

☐ OK to fax to this number: _____

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that the request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. ***THIS IS NOT A REQUEST TO RELEASE MEDICAL RECORDS.***

Signature of Patient or Legal Representative	Date

Prescription Refill Policy

Please sign below to indicate that you have read and that understand our policy on obtaining prescription refills.

Prescriptions will only be written and refilled from Monday through Friday during the hours of 8:30 am to 4:00 pm. No prescriptions will be written or called in after these hours or on holidays and weekends. Therefore, it is your responsibility to closely monitor your supply of medications. We recommend that you make your prescription requests at least 48 hours prior to running out of you prescriptions.

NAME **DATE**

FINANCIAL DISCLOSURE NOTICE TO BENEFICIARY

This is a notice informing you that some or all physicians of All-Star Orthopedics and Sports Medicine have an ownership interest in the entities listed below. As owners, we may, indirectly, receive compensation for services you receive at these entities.

• Irving Coppell Surgical Hospital	IRVING, TEXAS
• Baylor Surgicare at Grapevine	GRAPEVINE, TEXAS
• Preferred Imaging of Grapevine	GRAPEVINE, TEXAS
• Southlake Regional Medical Center	SOUTHLAKE, TEXAS
• Pine Creek Medical Center	DALLAS, TEXAS
• Select Pain Center of Grapevine	GRAPEVINE, TEXAS
• Presbyterian Hospital of Flower Mound	FLOWER MOUND, TEXAS
• Reliant Rehab Hospital of HEB	BEDFORD, TEXAS
• Park Cities Surgery Center	DALLAS, TEXAS
• Harris Methodist Southlake Center for Diagnostics & Surgery	SOUTHLAKE, TEXAS
• Texas Health Center for Diagnostics & Surgery Plano	PLANO, TEXAS

By signing below, you are acknowledging that you have received a notice of the information provided above.

_____ _____

Signature of Patient or Authorized Representative Date

GENERAL CONSENT FOR TREATMENT

I, knowing that I have a condition requiring diagnostic, medical, surgical and or non surgical treatment do hereby voluntarily consent to such procedures and care and to such medical, surgical and or non surgical or other services under the general and specific instruction of **Mark S. Greenberg, M.D.** and/or **Thomas M. Schott, M.D.** and/or **Bing S. Tsay, M.D.** and/or **Stephen J. Timon, M.D.** and/or **Michael K. Hahn, M.D.** and/or **Kevin M. Honig, M.D.** and/or **W Grear Hurt, M.D.** and/or **Brian E. Straus, M.D.** and/or any other **License Healthcare provider**, his/her assistants and/or his/her designee as is necessary in his/her judgment and employed by All-Star Orthopaedics And Sports Medicine.

I also acknowledge that no guarantees have been made to me as to the results of the treatments or examination and that this possible risks, benefits and complications of the said procedure have been discussed with me by the service provider.

DATE: _____

PATIENT / GUARDIAN SIGNATURE: _____

GUARDIAN RELATIONSHIP TO PATIENT: _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

Patient Name: _____ DOB: _____ MRN: _____ Date of Visit: _____

Occupation: _____ PCP: _____ Referred by: _____

CHIEF COMPLAINT

Date of injury or onset of symptoms: _____ Is it a work related injury?_____

Describe the injury or problem: _____

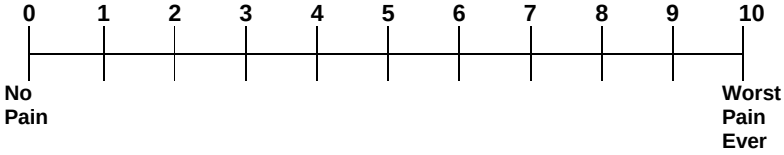
_____

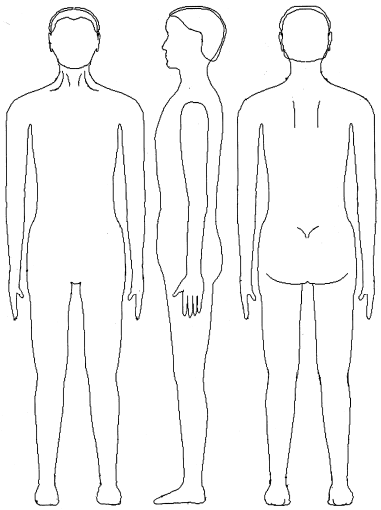
_____

_____

Pain: (check all that apply) ☐ dull ☐ sharp ☐ stabbing ☐ burning ☐ achy ☐ throbbing ☐ shooting ☐ squeezing ☐ pressure ☐ crampy

Using the following scale, please rate how bad your pain is today:





Where is your pain? Mark the drawing.

What makes it better? _____

What makes it worse? _____

Pain at Best: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Pain at Worst: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

MEDICAL & SURGICAL HISTORY

Please detail any operations you have had. Please check here if none:_____

Operation	Year	Surgeon	Hospital/City/State
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Please indicate all major health conditions: (i.e. high blood pressure, diabetes, hypertension, history of blood clots):

Please check if none:_____

☐ AIDS/HIV
☐ ALCOHOLISM
☐ ANEMIA
☐ ANXIETY
☐ ASTHMA
☐ BLEEDING
☐ BLOOD CLOTS
☐ CANCER
_____
☐ DEPRESSION
☐ DIABETES
☐ EPILEPSY/SEIZURES
☐ GLAUCOMA
☐ GOUT
☐ HEART DISEASE
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ INFECTIOUS MONO
☐ INFECTIONS
_____
☐ JAUNDICE
☐ KIDNEY DISEASE
_____
☐ LIVER DISEASE
_____
☐ LUNG DISEASE
_____
☐ MITRAL VALVE PROLAPSE
☐ OSTEOPOROSIS
☐ PHLEBITIS
☐ PNEUMONIA
☐ POLIO
☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS
☐ SLEEP APNEA
Use C-PAP? Y / N
☐ STROKE
☐ THYROID DISEASE
_____
☐ TUBERCULOSIS
☐ ULCER
☐ VARICOSE VEINS
☐ VENEREAL DISEASE
_____
☐OTHER (please list)
_____
_____

Please list all the drugs and medications you have taken over the past 4 weeks. (Include aspirin, birth control pills, supplements, (i.e. vitamins) and any drug or medication with or without a prescription):

Name of Drug	Dose/Frequency	Name of Drug	Dose/Frequency
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Have you ever taken cortisone? ☐ N ☐ Y If 'yes': For what condition_____ Dosage_____ Frequency_____

Please list any ***Allergies to medications***:_____

Please list any other ***Allergies***:

FAMILY HISTORY

The following questions concern your family medical history:

	IF LIVING		**IF DECEASED**	
	Age(s)	Major Medical Conditions	Age(s) at Death	Cause(s) of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

Please list any illnesses that run in the family _____

Does anyone in your family have any of the following problems?
☐Arthritis ☐Heart disease ☐High blood pressure ☐Anesthesia complications ☐Cancer ☐Stroke

☐ Nerve problems ☐Blood problems (blood clots, anemia, abnormal bleeding) ☐ Diabetes
☐ Other: _____

CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

- ☐ Recent weight change_____
- ☐ Fatigue/weakness
- ☐ Fever, chills
- ☐ Skin rash/disease
- ☐ Vision problem/eye disease
- ☐ Nose/throat problem
- ☐ Hearing problems/ear disease
- ☐ Frequent Headaches
- ☐ Fainting spells
- ☐ Seizures
- ☐ Problems with coordination
- ☐ Depression
- ☐ Thyroid Problems
- ☐ Joint stiffness, pain or swelling
- ☐ Muscle weakness
- ☐ Difficulty in moving an arm or leg
- ☐ Irregular heart beat
- ☐ Heart Disease
- ☐ Swollen legs or feet
- ☐ Stomach pain/heartburn
- ☐ Ulcers
- ☐ Hepatitis or gallbladder disease
- ☐ Change in bowel habits (also blood in stools)
- ☐ Blood disorder or blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Kidney disease or kidney stones
- ☐ Sexually transmitted disease
- ☐ Change in appetite or thirst
- ☐ Shortness of breath or wheezing
- ☐ Frequent cough
- ☐ Change in urinary habits (including pain, blood in urine, trouble stopping/starting your urine)
- ☐ Heart Murmur
- ☐ Chest pain

HEALTH HABITS

Height _____ feet/inches Weight _____lbs

Do you smoke cigarettes? ☐ Yes ☐ No Packs/day_____ For how long? _____yrs

Do you drink alcohol? ☐ Yes ☐ No Drinks/wk_____ Do you use marijuana/drugs ☐ Yes ☐ No

How would you describe your level of physical activity over the past six months?

- ☐ Inactive - just daily activity
- ☐ Light - some walking, gardening, occasional weekend recreational activity
- ☐ Moderate - regular (3x week) moderate exercise and occasional weekend sports
- ☐ Vigorous - regular (3-5x week) vigorous exercise and/or sports activity
- ☐ Intense - competitive vigorous sports training

Do you consider your current weight ideal? ☐ Yes ☐ No
If no, list your ideal weight _____

The following question concerns your health now and in the past. Please provide the best answer you can.

In general, would you say your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Does your health now limit you in the following activities? ☐ No ☐ Yes If so, how much?

a. Moderate activities, such as moving a table, pushing a vacuum, bowling or playing golf:

☐ Very Limited ☐ Somewhat Limited ☐ Not Limited

b. Climbing several flights of stairs:

☐ Very Limited ☐ Somewhat Limited ☐ Not Limited

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and daily household activities)?

☐ Extremely Limited ☐ Mostly Limited ☐ Somewhat Limited ☐ Slightly Limited ☐ Not Limited

I attest that the above information is accurate and complete to the best of my knowledge.

_____ _____

Patient's signature Date

HAND QUESTIONNAIRE

Patient Name: _____

Date: _____

DOB: _____

Referred by: _____

Dominant Hand: **[ ]** RIGHT **[ ]** LEFT

Occupation: _____

Hobbies/Sports/Musical Instruments: _____

_____

Side involved: **[ ]** RIGHT **[ ]** LEFT **[ ]** BOTH

Location: **[ ]** ELBOW **[ ]** WRIST **[ ]** THUMB **[ ]** INDEX **[ ]** MIDDLE
[ ] RING **[ ]** SMALL

Onset of symptoms: _____

If Specific event, date: _____

Description of injury: _____

_____

Initial symptoms: _____

_____

Symptoms now: _____

_____

Time of symptoms: **[ ]** CONSTANTLY **[ ]** INTERMITTENTLY **[ ]** MORNING
[ ] EVENING **[ ]** NIGHT
[ ] W/ACTIVITY/TYPE OF ACTIVITY: _____
____ _____

Work status since injury: **Currently working:** **[ ]** YES **[ ]** NO
If YES: **[ ]** REGULAR DUTY **[ ]** LIGHT DUTY

Treatment to date:	**How long/When?**	**Treatment by:**	**Effect:**
[ ] None			
[ ] Splinting			
[ ] Cast			
[ ] NSAIDS			
[ ] Therapy			
[ ] Injections			
[ ] Surgery			

Previous tests: **[ ]** X-rays **[ ]** Nerve studies/EMGs **[ ]** MRI **[ ]** CT