

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 _____
Last First Middle Social Security No. _____
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 _____
Last First Middle Social Security No. _____
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 Gear 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 Coppel 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

All-Star Orthopaedics And Sports Medicine

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: _____

FEES FOR FORM COMPLETION

Due to the dramatic increase in requests and demands by third parties for form completion, All-Star Orthopaedics and Sports Medicine will begin assessing a fee for such completion. This fee is intended to compensate the physician for the time and expertise required to review and complete the necessary forms.

Effective immediately the fee schedule below will apply to form completion requests. All usual methods of payment will be accepted. Payment must be made before the completed form is released.

Once payment is made we commit to completing your form within 72 hours. Please plan accordingly when submitting your form.

• School Forms	\$15.00
• Sports Participation Forms	\$15.00
• Paperwork for Patient Assistance	\$25.00
• Return to Work	\$25.00
• Disability Forms	\$25.00
• FMLA Forms	\$25.00
• Insurance Forms	\$25.00

Patient/Legal Representative

Date

BACK & NECK QUESTIONNAIRE

Please answer all questions completely.

It is in your best interest and will assist your doctor with your care.

Be sure to bring this form with you to your appointment.

Patient Name:

Date:

DOB:

MRN:

AGE:

Height: _____ **FT**

_____ **IN**

Weight:

1. Referring doctors name and address:

2. Internist/family doctor name and address:

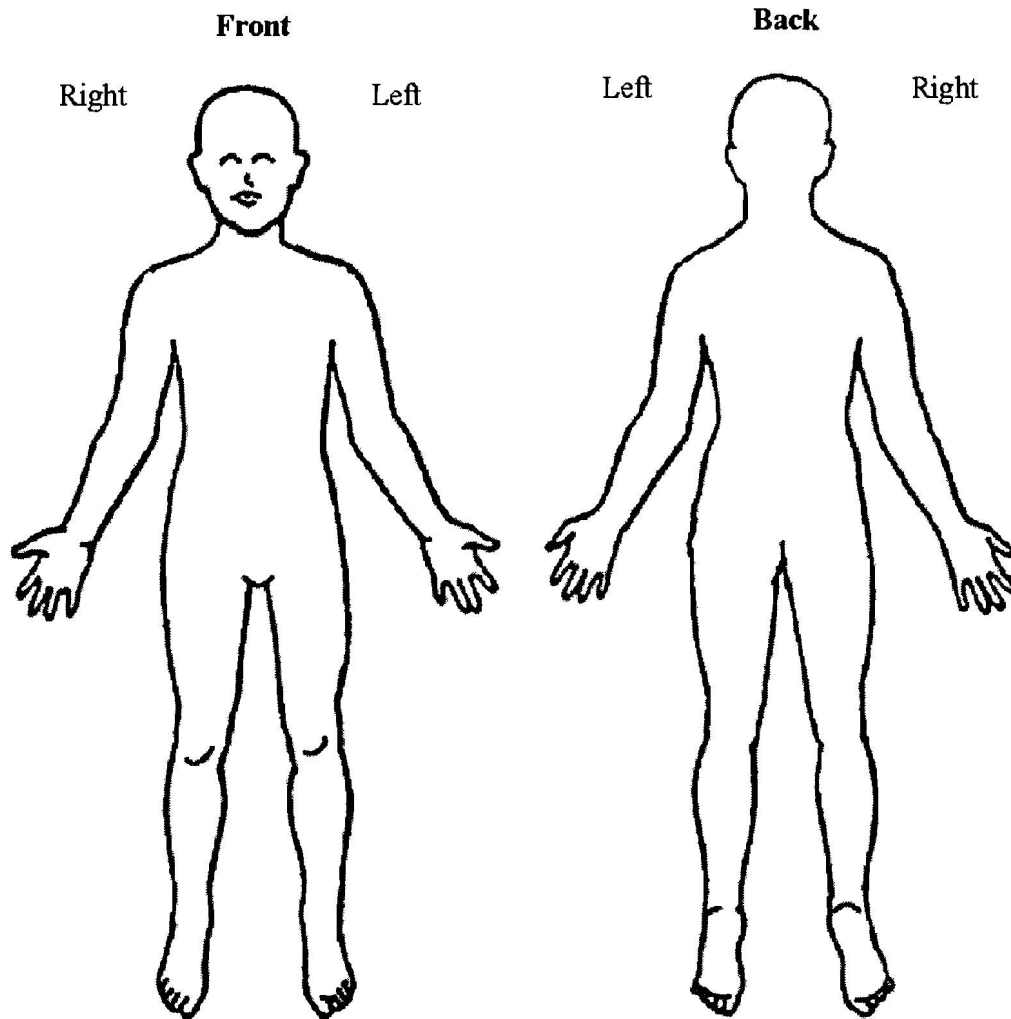
Mark in the areas of your body that you now feel your typical pain. Include all affected areas.
Use the appropriate symbols indicated below:

Pain XXXXX

Numbness OOOOO

Pins and Needles =====

Stabbing /////



Please mark on line: How bad is your pain right now on a scale from 0-10?

0-----5-----10

A. Chief Complaint:

1. For the problem that caused you to visit us, please check with an [X].

☐ Neck Pain (Complete Section B)

☐ Arm Pain or Numbness (Complete Section B)

☐ Back Pain (Complete Section C)

☐ Leg Pain or Numbness (Complete Section C)

☐ Other: _____

2. How long have you had your main problem(s)? _____

3. Has this problem recently gotten worse? ☐ YES ☐ NO If so, when?

4. What started the problem? _____

CONTINUE TO SECTION B IF YOU HAVE NECK PAIN/ARM PAIN OR NUMBNESS

CONTINUE TO SECTION C IF YOU HAVE BACK PAIN/LEG PAIN OR NUMBNESS

B. Complete this section for neck problems

If you are seeing the doctor for leg or back pain, skip this section and go to Section C.

1. What portion of your pain is in your neck and how much in your arm(s)?

Check only one:

☐ all NECK pain, no arm pain

☐ mostly NECK pain, only some arm pain

☐ neck pain and arm pain are about equal (50/50)

☐ only some neck pain, mostly ARM

☐ no neck pain, all ARM pain

2. There is:

☐ No arm pain

☐ RIGHT arm pain (no left arm pain)

☐ mostly RIGHT arm pain, some left arm pain

☐ right and left arm pain are about equal (50/50)

☐ mostly LEFT arm pain, some right arm pain

☐ LEFT arm pain (no right arm pain)

3. Do you have any numbness in the arms or hands? ☐ YES ☐ NO

If YES, where?

Left Side of Body

- ☐ arm
- ☐ forearm
- ☐ thumb
- ☐ index finger
- ☐ long finger
- ☐ ring finger
- ☐ small finger

Right Side of Body

- ☐ arm
- ☐ forearm
- ☐ thumb
- ☐ index finger
- ☐ long finger
- ☐ ring finger
- ☐ small finger

4. Do you have any weakness in the arms of hands? ☐ YES ☐ NO

If YES, where?

Left Side of Body

- ☐ shoulder
- ☐ arm
- ☐ forearm
- ☐ hand/fingers

Right Side of Body

- ☐ shoulder
- ☐ arm
- ☐ forearm
- ☐ hand/fingers

5. Please indicate which, if any, of these problems you are experiencing:

- ☐ difficulty picking up small objects or buttoning shirts
- ☐ problems with balance or frequent tripping
- ☐ headaches in the back of the head
- ☐ walking is difficult/impossible due to imbalance
- ☐ dropping objects because of weak or clumsy hands

CONTINUE TO SECTION D.

C. Complete this section for back problems

If you do not have lower back or leg problems, skip this section. Go to Section D.

1. What portion of your pain is in your back and how much is in your leg(s)?

Check only one:

- ☐ All BACK pain, no leg pain
- ☐ Mostly BACK pain, only some leg pain
- ☐ Back pain and leg pain are about equal (50/50)
- ☐ Only some back pain, mostly LEG pain
- ☐ No back pain, all LEG pain

2. There is:

- ☐ No leg pain
- ☐ RIGHT LEG pain, no left leg pain
- ☐ Mostly RIGHT LEG pain, some left leg pain
- ☐ Right and Left leg pain are equal (50/50)
- ☐ Mostly LEFT LEG pain, some right leg pain
- ☐ LEFT LEG pain, no right leg pain

3. The pain is mostly in what part of your leg(s)? Please check the areas with an [X].

Left Side of Body

- ☐ buttocks

Right Side of Body

- ☐ buttocks

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> groin | <input type="checkbox"/> groin |
| <input type="checkbox"/> thigh back | <input type="checkbox"/> thigh back |
| <input type="checkbox"/> thigh front | <input type="checkbox"/> thigh front |
| <input type="checkbox"/> calf | <input type="checkbox"/> calf |
| <input type="checkbox"/> foot | <input type="checkbox"/> foot |

4. How far can you walk before LEG PAIN makes you stop and rest?

- ☐ Across the room
- ☐ 1 or 2 blocks
- ☐ Across a parking lot
- ☐ 1 or 2 miles
- ☐ I can walk as far as I want without leg pain

5. Do you have any of the following?

- ☐ Worse pain with sitting
- ☐ Worse pain with standing/walking
- ☐ Another medical problem (ie. Shortness of breath, chest pain, back pain)
that limits walking
- ☐ Weakness in legs

CONTINUE TO SECTION D.

D. Treatment History – All patients should complete this section

1. Do you have a loss of bowel or bladder control? ☐ YES ☐ NO

If YES, what is the cause? _____

2. What treatments have you had and what was the effect?

- | | Better | Worse | No Change |
|---|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Injections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Pain Medication | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Traction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Have other doctors previously seen you regarding this problem?

- ☐ YES ☐ NO If YES, please provide contact information for any doctors seen previously.

Doctor Name	Specialty	City	Treatments

4. Have you had an MRI, CT, X-RAY, or EMG to evaluate your spine problems?

☐ YES ☐ NO If YES, please fill in the following table.

Test	Body Part	Date	Location

E. Medical History – All patients should complete this section

In general, your health is (mark one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Terrible. Have you ever had:

- | | |
|--|---|
| <input type="checkbox"/> Asthma/Breathing problems | <input type="checkbox"/> Phlebitis or blood clots |
| <input type="checkbox"/> Diabetes (years_____) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer (Type_____) | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> AIDS or HIV testing | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Reaction to anesthetics |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid disease |

☐ Anemia ☐ Anemia
☐ Pacemaker ☐ Other: _____
 How much do you smoke? _____
 How much do you drink? _____
 Any other recreational drugs? ☐ YES ☐ NO if YES, what? _____

1. Surgical History. Please provide the Surgery, Surgeon, and Date for any surgeries.

Surgery	Surgeon	Date
a) _____		
b) _____		

2. Family History. Has anyone in your family have any of the following problems? Check all that apply.

		Explain
Bleeding Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Anesthesia Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Heart Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Spine Problems	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

F. Medications – All patients should complete this section

1. Are you allergic to any medications? ☐ YES ☐ NO If YES, please complete the following:

Medication Name	Rash	Wheezing/Swelling	Shock	Upset Stomach other

3. Are you currently taking any medications (prescriptions or non-prescription)?
☐ YES ☐ NO If YES, complete the following:

- A) _____
B) _____
C) _____
D) _____

G. Review of Systems: Check all that apply:

During the past year have you had?

- | | |
|--|---|
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Unplanned weight loss |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Unusual stress in home life | <input type="checkbox"/> Unexplained fevers |
| <input type="checkbox"/> Unusual stress in work life | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Lumps in neck, groin, armpits |
| <input type="checkbox"/> Persistent unusual cough | <input type="checkbox"/> Trouble breathing w/exercise |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Persistent diarrhea |
| <input type="checkbox"/> Excessive constipation | <input type="checkbox"/> Dark black stools |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Pain or burning with urinating |
| <input type="checkbox"/> Difficulty urinating (starting, stopping) | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Generalized morning stiffness | <input type="checkbox"/> Dry eyes or mouth |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Joint pain or swelling |

Patient Signature: _____

Date: _____

Reviewed: _____