

## 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)  
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### **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

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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

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**All-Star Orthopaedics And Sports Medicine**

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**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.

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Printed Name of Patient:

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Signature of Patient and/or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

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## All-Star Orthopaedics And Sports Medicine

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### 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.**

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

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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

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### 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.

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**NAME**

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**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

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### 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? \_\_\_\_\_

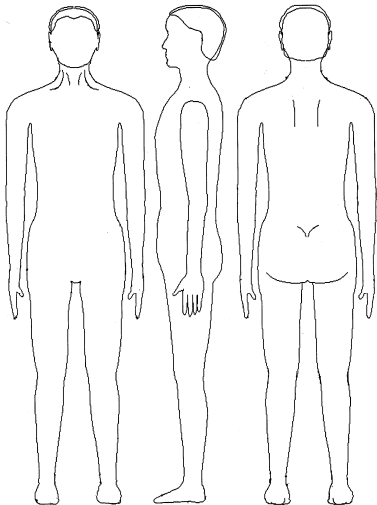
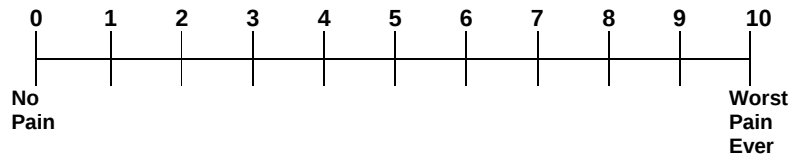
Describe the injury or problem: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_

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

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: \_\_\_\_\_

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### CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

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

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### 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?

- |                                   |                                                                     |
|-----------------------------------|---------------------------------------------------------------------|
| <input type="checkbox"/> Inactive | - just daily activity                                               |
| <input type="checkbox"/> Light    | - some walking, gardening, occasional weekend recreational activity |
| <input type="checkbox"/> Moderate | - regular (3x week) moderate exercise and occasional weekend sports |
| <input type="checkbox"/> Vigorous | - regular (3-5x week) vigorous exercise and/or sports activity      |
| <input type="checkbox"/> 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.***

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Patient's signature

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Date

## Foot & Ankle Questionnaire

**Date:** \_\_\_\_\_  
**Patient Name:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_

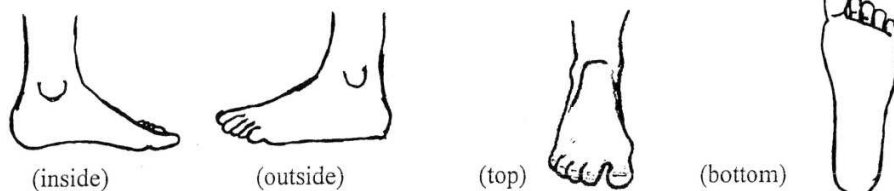
**Chief complaint:** \_\_\_\_\_  
\_\_\_\_\_

### **History of Present Illness:**

- How long have you had the problem? \_\_\_\_\_
- Was there a traumatic event? If so, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

- Describe your pain (circle all that apply)  
☐ Sharp   ☐ Aching   ☐ Shooting   ☐ Burning   ☐ Dull   ☐ Throbbing  
☐ Electrical

Please mark the following diagram (XXXXXXX) to show where your pain is located.



- What makes your pain better? \_\_\_\_\_  
\_\_\_\_\_
- What makes your pain worse? \_\_\_\_\_  
\_\_\_\_\_
- When do you notice your problem the most? \_\_\_\_\_  
\_\_\_\_\_
- Has there been any previous history to problems in the affected area? \_\_\_\_\_  
\_\_\_\_\_
- Have you had any treatment so far? If so, what type? \_\_\_\_\_  
\_\_\_\_\_

