



Sports Injury Clinic New Patient Packet



Howard W. Harris, M.D.

2425 Highway 121 ♦ Bedford, TX 76051 ♦ 817-540-4477



Sports Injury Clinic - Patient Demographics

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

Patient Date of Birth: _____/_____/_____

Insurance Company: _____

(If x-ray or MRI needed)

Insurance Phone Number: _____

Primary Subscribers Name: _____

DOB: _____ ID #: _____ Group: _____

Parent(s) Name: _____

Contact Number: _____

Emergency Contact: _____

Emergency Contact's Phone Number: _____

Primary Care Physician: _____



Athlete/Patient Questionnaire

Name: _____

Organization/School _____ Your Age _____

Chief Complaint _____

Date of injury or onset of symptoms ____/____/____

Describe the manner in which you were injured: _____

How often do you have the pain/discomfort (constant, daily, weekly) _____

Describe the character of the pain (sharp, dull, radiating, etc.) _____

Since you first noticed the pain is it getting better, worse or unchanged? _____

What makes the pain worse? (activities, etc) _____

What makes the pain better? (ice, ibuprofen, etc) _____

List current treatments you have tried for this complaint (medications, injections, physical therapy, surgery): _____

Indicate whether they have helped or not. _____

What activity limitations have resulted from this problem? _____

PAST ILLNESS: *Please check all that apply.*

Diabetes HIV Stroke Blood Clot Heart Disease
Hypertension Thyroid Cancer Hepatitis Lung Disease
Kidney Disease Gastrointestinal Disease
Other Explain: _____

ALL PAST SURGERIES (List with approximate age, including all minor surgeries)

If any of the following have run in your family. *Please check all that apply.*

Bleeding Tuberculosis Diabetes Heart Disease Strokes
Amputations High Blood Pressure Cancer

SOCIAL HISTORY

Sports played/position _____

Do you smoke? yes no Approximate amount daily? _____

Have you ever smoked? yes no

Do you drink alcoholic beverages? yes no

Approximate amount Daily Weekly Monthly

Recreational drugs? yes no

Type/approximate amount daily _____

ALLERGIES

None Iodine IV Contrast Tape X Ray dye Latex

Allergies to medication (please list) _____

MEDICATIONS

List all medications you are presently taking and the doctor prescribing:

(Attach list if necessary) _____



Authorization Form –For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below. In spaces provided below, please list only family member or friends that you are allowing access to your information.

Patient Name: _____

The health information you may release subject to this authorization is as follows:

Release my protected health information to the following person(s)/entity:

Name _____

Street _____

City: _____ State: _____ Zip: _____

Athletic Trainer: _____ School: _____

The reasons or purposes for this release of information are as follows:

This authorization shall be in force and effective until the following event and/or date:

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

Practice Administrator
2425 Highway 121, Suite 100
Bedford, TX 76021
Phone: 817-540-4477
Fax: 817-540-5633

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIP AA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative (if under 18 yrs. of age) Date

Name of Patient or Personal Representative



General Consent for Treatment

Howard W. Harris, M.D.
Sports Injury Clinic

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of Howard W. Harris, M.D., and the physicians of Texas Orthopedic Specialists, P.A., his assistants or his designee as is necessary in his judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination. I also acknowledge that the athletic trainer may accompany the patient named below to his/her clinic visit in place of guardian or personal representative.

Patient/Guardian Signature (if under 18 yrs. of age): _____

Print Name: _____

Relationship to patient: _____

Name of Patient: _____

Date: ____/____/____



**Sports Injury Clinic
Friday Night Clinic Financial Statement**

I understand and agree that the physician consultation, treatment and x-ray received at a Friday night injury clinic, at Texas Orthopedic Specialists, P.A., is free of charge to me and will not be billed to my insurance.

I further understand and agree that any and all follow-up consultation, treatment, x-ray, surgeries and rehabilitation with the physician and his staff will be billed to my insurance and I will incur any co-pay and/or deductible payment that is associated with that care.

Patient Signature: _____ Date: _____

Print Name: _____ Date: _____

Personal Representative: _____ Date: _____

(if under 18 yrs of age)

Relationship to patient: _____

Texas Orthopedic Specialists, P. A. representative; _____



Directions to Our Office:

2425 Highway 121
Bedford, TX 76021

Directions from Airport Freeway/183 area, take 121 North towards Grapevine
Exit Harwood Road
Turn LEFT on Harwood Road.
Turn LEFT on South bound access road
Stay on access road and go down about a quarter of a mile
The building will be on the right hand side in a two story building

Directions from Hwy 114 area, take 121 South towards Fort Worth
Exit Harwood Road.
Do not turn on Harwood Road.
Stay straight on access road and go down about a quarter of a mile
The building will be on the right hand side in a two story building.

