

NEW PATIENT PACKET
Sports Medicine Center
Texas Orthopedic Specialists

FRIDAY NIGHT INJURY CLINIC
SPORTS CLINIC SCHOOL PHYSICAL



Howard W. Harris, M.D. Michael L. Nguyen, M.D. B. Todd Drury, M.D. Paul A. Tavakolian, M.D.



2425 Hwy 121 Bedford, TX 76021
817-540-4477
www.txortho.net

TEXAS ORTHOPEDIC SPECIALISTS, P.L.L.C.

SPORTS CLINIC DEMOGRAPHIC PAGE

(Office Use Only) Patient Id: _____

Preferred Provider: Dr. Taunton

Dr. Harris

Dr. Nguyen

Dr. Drury

Dr. Haile

Dr. House

Dr. Tavakolian

Dr. Suttle

VIP STATUS: THR Referral Baylor Referral Athlete(List School):

High school you attend: _____ Athletic trainer's name: _____

Patient Preferred Pharmacy: _____

Pharmacy City: _____ State: _____

Pharmacy Phone #: _____ Pharmacy Fax #: _____

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____ Maiden: _____ Prefix: _____ Suffix: _____

DOB: _____ Sex: F M SSN: _____ Marital Status: _____

Driver License: _____ Primary Language: _____

Race: American Indian/Alaska Native Asian Black/African American Nat Hawaiian/Pacific Islander

White Other Race Declined

Ethnicity: Hispanic Non-Hispanic

Religion: Buddhist Catholic Hindu Islam Jewish Protestant N/A Other Unknown

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Primary Work Phone: _____ Cell: _____

Fax: _____ Pager: _____

Email: _____

Primary Insurance (If X-ray or MRI needed): _____

Subscriber Id # _____

Group # _____

Claims Phone # _____

Claims Address: _____

Insured Name: _____ Relationship to patient: _____ DOB: _____

Emergency Contact: _____

Emergency Contact's Phone Number: _____

Primary Care Physician: _____



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Athlete / Patient Questionnaire

PATIENT NAME: _____ **DATE:** _____

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 ANSWER (Y) OR (N)

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 run in your family, please check: Bleeding____ Tuberculosis____ Diabetes____

Heart Disease____ Strokes____ Amputations____ High Blood Pressure____ Cancer____

SOCIAL HISTORY

Sports played/position: _____

Do you smoke? Y or N Approximate amount daily? _____ Have you ever smoked? _____

Do you drink alcoholic beverages? _____ Approximate amount _____ Daily Weekly or Monthly

Recreational Drugs? _____ 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

Pregnancy Status Information and Release for X-ray and Fluoroscopy Procedure

In the interest of protecting an unborn child/developing fetus from unnecessary exposure to radiation, Texas Orthopedic Specialists requests that all women of childbearing age (approximately ages 10 to 55) complete this form. If you have any reason to believe that you may be pregnant, we need to know before any test involving the use of radiation is performed. This information will be confidential, and we will retain this document for our records.

Name: _____ Date of Birth: _____

Are you pregnant? If you are unsure, select "maybe".

_____ YES _____ NO _____ MAYBE

If you selected "yes" or "maybe" to the above question, the Radiologic technologist will discuss this information with your doctor. Your doctor will recommend proceeding with the test if he believes the benefits of exposure far outweigh the risks. Although the risk of any negative effects to the fetus is deemed to be minimal, there is a possibility that the exposure could have negative effects. You have the right to decline the procedure even if your doctor recommends that you proceed with the procedure.

By signing below, I give my consent to continue with the X-ray exam.

Patient/Guardian Signature

Date

Texas Orthopedic Specialists, P.L.L.C. Witness



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Sports Injury Clinic

General Consent for Treatment

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 any Texas Orthopedic Specialists physician, physician assistant or their designee as is necessary in their 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 by any Texas Orthopedic Specialists physician.

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.

I give my consent to treatment to Texas Orthopedic Specialists to perform any and all examinations, tests, treatment, physical and occupational therapy, athletic training, blood and urine specimen procurement, and any other reasonable measure it's providers deem necessary to diagnose and to treat my condition.

I acknowledge that my plan of care may include admission to Texas Health Harris Methodist Hospital Southlake or Bear Creek Surgical Center, in which Dr. Taunton, Dr. Harris, Dr. Nguyen, Dr. Drury and Dr. Suttle have financial interest.

Patient Signature: _____ Date: _____

Print Name: _____

Personal Representative: _____ Date: _____
(if under 18 yrs. of age)

Relationship to patient: _____



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Sports Injury Clinic

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: _____ Date: _____

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 Code: _____

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.

Medical Records
2425 Hwy 121, 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 HIPAA privacy regulations.

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

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority:

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME

DATE

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Texas Orthopedic Specialists, P.L.L.C. may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Texas Orthopedic Specialists, P.A. has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '**Notice**' before signing this agreement. If I ask, Texas Orthopedic Specialists, P.L.L.C. will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Texas Orthopedic Specialists, P.L.L.C. to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Texas Orthopedic Specialists, P.L.L.C. has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative)

DATE

Relationship to Patient if signed by another party

DATE

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '**Notice**' at any time by contacting: Texas Orthopedic Specialists, P.L.L.C.

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Bedford, TX 76021.

Texas Orthopedic Specialists, P.L.L.C.
Sports Medicine Center
Friday Night Injury 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.L.L.C., 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: _____

Personal Representative: _____ Date: _____
(if under 18 yrs of age)

Relationship to patient: _____

Texas Orthopedic Specialists, P.L.L.C. representative: _____



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