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.

Texas Orthopedic SPECIALISTS

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 Dr. McCabe

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): _____
Subsriber 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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Office Use Only: Patient ID # _____ Date: _____/_____/_____

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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Texas Orthopedic Specialists, P.L.L.C.
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, treat-ment, 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 insuranc 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:

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

2425 Hwy 121
Bedford, TX 76021

817-540-4477
817-540-5633

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.

2425 Hwy 121
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 Speciliasts, 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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