

PLEASE PRINT

# PATIENT REGISTRATION

Acct # \_\_\_\_\_

REFERRED BY \_\_\_\_\_

OTHER FAMILY MEMBERS SEEN IN OUR OFFICE \_\_\_\_\_

Drug Allergies (Please include your REACTION): \_\_\_\_\_

PATIENT LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ / DATE OF BIRTH \_\_\_\_\_ / AGE \_\_\_\_\_ / DRIVER'S LICENSE NO. & ST \_\_\_\_\_

ADDRESS (PERMANENT) \_\_\_\_\_ STREET APT# \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ NO. OF DEPENDENTS \_\_\_\_\_

EMPLOYED BY \_\_\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_ BUS PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYED BY \_\_\_\_\_ EMPLOYER'S ADDRESS \_\_\_\_\_ BUS PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PATIENT'S TEMPORARY ADDRESS \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_

NEAREST FRIEND OR RELATIVE FOR EMERGENCIES \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_ PHONE \_\_\_\_\_

SIGNATURE OF PATIENT OR LEGAL GUARDIAN \_\_\_\_\_

<b>RESPONSIBLE/INSURED PARTY</b> IF PATIENT NOT RESPONSIBLE FOR THE BILL. PLEASE INDICATE WHO IS RESPONSIBLE FOR THE BILL					
NAME	ADDRESS	CITY	STATE	ZIP CODE	
HOME PHONE	RELATIONSHIP TO PATIENT		INSURED PARTY DATE OF BIRTH		
EMPLOYER	EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE	BUS PHONE
Insurance Name: _____					
Insurance Claims Mailing Address: _____					
INSURED PARTY'S SOCIAL SECURITY NO.			INSURED PARTY'S DRIVER'S LICENSE NO.		

PLEASE INDICATE METHOD OF PAYMENT FOR TODAY'S VISIT \_\_\_ CHECK \_\_\_ CASH OTHER \_\_\_\_\_

REQUEST FOR PAYMENT OF, MEDICAL SERVICES AND LABORATORY TESTS AT OUR OFFICE WILL BE MADE AT THE TIME OF YOUR VISIT. BY ASKING YOU TO DO THIS WE CAN DOWN THE COST OF BILLING, BOOKKEEPING; AND HOPEFULLY, KEEP YOUR MEDICAL FEES DOWN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED ON BEHALF OF MYSELF AND MY FAMILY REGARDLESS OF INSURANCE BENEFITS.

DATE \_\_\_\_\_

RESPONSIBLE PARTY SIGNATURE \_\_\_\_\_

**NO PATIENT CAN BE SEEN UNTIL THIS FORM IS COMPLETED IN ITS ENTIRETY**

PLEASE COMPLETE REVERSE SIDE OF THIS REGISTRATION FORM

NAME & LOCATION OF PHARMACY: \_\_\_\_\_

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Doctor or Clinic: \_\_\_\_\_

Were you referred to this office?  Yes  No By whom? \_\_\_\_\_

If no referral, how did you hear about us? \_\_\_\_\_

Estimated Date of Injury: \_\_\_\_\_ is this work related?  Yes  No

Preferred Pharmacy: \_\_\_\_\_  
Street Address City Telephone

**Past Medical History**

Are you allergic to any medications?  Yes  No

Please list medication **AND** reaction: \_\_\_\_\_

Do you have any food allergies?  Yes  No

Please list food with reaction: \_\_\_\_\_

Are allergic to any metals?  Yes  No

Please list metal with reaction: \_\_\_\_\_

Are you allergic/sensitive to latex?  Yes  No

Please list latex with reaction: \_\_\_\_\_

Any other allergies?

Please list with reaction: \_\_\_\_\_

**Current Medications include MG and Dosages:** \_\_\_\_\_

**Past Surgical History**

Have you ever had surgery?  Yes  No

Please List: \_\_\_\_\_

**Social History**

Do you smoke or have you ever smoked? Do you use any tobacco products?  Yes  No

When did you quit? \_\_\_\_\_

How much do you smoke? \_\_\_\_\_

Do you drink alcohol?  Yes  No

Have you ever been treated for alcoholism, drug or substance abuse?  Yes  No

Do you work?  Yes  No

What type of work do you do? \_\_\_\_\_

Are you  Married  Single  Divorced  Widowed?

Do you have children?  Yes  No How many? \_\_\_\_\_

Do you live alone? \_\_\_\_\_

Do you exercise?  Yes  No How often? \_\_\_\_\_

Women: Is there any chance you might be pregnant?  Yes  No

**Family History**

Please select the family member with the following conditions.

**Arthritis**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Hypertension**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Cancer**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Diabetes**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Blood Clots/Bleeding**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Cardiac Disorders**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Mental Health Disorders**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Reactions to Anesthesia**  None  Mother  Father  Son  Daughter  Brother  Sister  Grandmother  Grandfather

**Past History: Have you had in the past or do you still have?**

- |                                    |  |  |  |
|------------------------------------|--|--|--|
| Diabetes                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cirrhosis                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Pain or Injury                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypothyroid                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hyperthyroid                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis / Chronic Cough         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hypertension/ High Blood pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Palpitations / Irregular heartbeat | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Syphilis                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sickle Cell Disorder                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gastrointestinal Reflux Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemophilia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ulcerative Colitis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Ulcers                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any other medical problems not listed: |  |
| Gastritis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                  |  |
| Hemorrhoids                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                  |  |
| Jaundice, Liver trouble            | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____                                  |  |

**Review of Systems: Do you currently have any of the following?**

- General:**  None of below listed symptoms  
 Cancer, where \_\_\_\_\_  Infection  Fever  Tingling  Warmth  
 Swelling  Redness  Numbness  Easy Bruising  Loss of Motion  Instability  Limping  
 Locking  Weight loss  Fatigue  Insomnia  Other \_\_\_\_\_

- Heart:**  None of below listed symptoms  
 Heart Attack  Chest Pain  Palpitations  High Blood Pressure  Other \_\_\_\_\_

- Respiratory:**  None of below listed symptoms  
 Asthma  COPD  Emphysema  Pneumonia  Other \_\_\_\_\_

- Stomach/Gastrointestinal:**  None of below listed symptoms  
 Reflux/GERD  Ulcer  Polyps  Ulcerative Colitis  Other \_\_\_\_\_

- Liver:**  None of below listed symptoms  
 Jaundice  Hepatitis  Cirrhosis  Cholecystitis/Gall Stones  Other \_\_\_\_\_

- Bladder/Kidneys:**  None of below listed symptoms  
 Incontinence  Stones  Dialysis  Renal Disease  Other \_\_\_\_\_

- Reproductive/Sexual:**  None of below listed symptoms  
 Pregnancy  HIV  Syphilis  Other  Other \_\_\_\_\_

- Musculoskeletal:**  None of below listed symptoms  
 Osteoarthritis  Neck Pain  Back Pain  Arthritis  Gout  Other \_\_\_\_\_

- Skin:**  None of below listed symptoms  
 Eczema  Rash  Impetigo  Psoriasis  Skin Cancer  Other \_\_\_\_\_

- Psychiatric:**  None of below listed symptoms  
 Bipolar  Depression  Schizophrenia  Other \_\_\_\_\_

- Diabetes:**  None of below listed symptoms  
 Insulin dependent  Non-insulin dependent  Other \_\_\_\_\_

- Hematologic:**  None of below listed symptoms  
 Abnormal Bleeding  Anemia  Other \_\_\_\_\_

**History of Present Illness**

Please mark the reason for your visit today.

- Neck       Arm       Shoulder     Elbow       Forearm     Wrist       Hand
- Finger     Back       Hip           Knee       Leg         Ankle       Foot

Which side?    Right       Left       Both

How would you describe your pain?

- Aching       Dull           Sharp       Throbbing    Worsening    Improving    Constant
- Intermittent  Locking     Other \_\_\_\_\_

When did your pain start?

- \_\_\_ hrs ago       \_\_\_ days ago       \_\_\_ weeks ago       \_\_\_ months ago       \_\_\_ years ago
- Other \_\_\_\_\_

When does your pain occur?

- In the morning     at night       Awakening from sleep     with weight bearing activity
- Other \_\_\_\_\_

How severe is your pain?    Mild       Moderate     Severe

How does this limit daily activities?

- does not limit activities     moderately limit activities    severely limits activities
- Other \_\_\_\_\_

What do you think caused your current problem?

- Trauma       Work Related       Repetitive Movements       Other \_\_\_\_\_

What makes it better?

- Rest       Ice     Immobilization       Heat       Medications       Physical Therapy
- Other \_\_\_\_\_

What makes it worse?

- Movement    Rest    Pushing/Pulling    Lying down    Standing    Lifting    Other \_\_\_\_\_

Have you been treated for this problem before?    Yes    No

Please list Doctor or Care Giver's that you have previously seen for this problem:

\_\_\_\_\_

Have you had tests for this problem?       Yes    NO

- X-Ray       MRI       CT    EMG       CT / Myelogram     Bone Scan     Discography
- Other \_\_\_\_\_

Have you had treatments for this problem?    Yes    No

- Physical Therapy/Occupational Therapy    Injections     Acupuncture       Chiropractic Care
- Other \_\_\_\_\_

Medications:

- Muscle Relaxants     Pain Medications     Anti-inflammatory       Over the counter Medications  
(Aspirin, Tylenol, Advil, Aleve, etc)

Patient's Full Name: \_\_\_\_\_

Account # \_\_\_\_\_ Chart # \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION

I authorize *Oak Cliff Orthopaedic Associates* DBA Texas Orthopaedic Surgical Associates to furnish requested information from the patient's medical and other records to 1) any insurance company or third party payer for the purpose of obtaining payment on the account of *Oak Cliff Orthopaedic Associates*, 2) any other person(s) or entities financially responsible for the patient's care or treatment, and 3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's records for the purpose of conducting any medical audit, utilization reviews, or quality assurance reviews. I authorize *Oak Cliff Orthopaedic Associates* DBA Texas Orthopaedic Surgical Associates to release information from or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which patient may be transferred.

Patient's Signature \_\_\_\_\_

Spouse/Guardian's Signature \_\_\_\_\_

Witness's Signature \_\_\_\_\_ Date \_\_\_\_\_

### ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign *Oak Cliff Orthopaedic Associates* DBA Texas Orthopaedic Surgical Associates all right, title, and interest in any payment due me for services described herein as provided in any policy or policies of insurance. I understand that I am responsible for providing to *Oak Cliff Orthopaedic Associates* DBA Texas Orthopaedic Surgical Associates all insurance information at the time of my admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Patient's Signature \_\_\_\_\_

Spouse/Guardian's Signature \_\_\_\_\_

Witness's Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent for Purposes of Treatment, Payment and Healthcare Operations

Please PRINT Patient Name: \_\_\_\_\_

Acct# \_\_\_\_\_

I consent to the use or disclosure of my protected health information by Texas Orthopaedic Surgical Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Texas Orthopaedic Surgical Associates. I understand that diagnosis or treatment of me by Dr. Berry, Dr. Arazoza, Dr. Hernandez, Dr. Aronowitz or Dr. Heck may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Texas Orthopaedic Surgical Associates is not required to agree to the restrictions that I may request. However, if Texas Orthopaedic Surgical Associates agrees to a restriction that I request, the restriction is binding on Texas Orthopaedic Surgical Associates and Dr. Berry, Dr. Arazoza, Dr. Hernandez, Dr. Aronowitz or Dr. Heck. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Berry, Dr. Arazoza, Dr. Hernandez, Dr. Aronowitz or Dr. Heck or Texas Orthopaedic Surgical Associates has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Texas Orthopaedic Surgical Associates 's Notice of Privacy Practices prior to signing this document. The Texas Orthopaedic Surgical Associates ' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Texas Orthopaedic Surgical Associates. The Notice of Privacy Practices for Texas Orthopaedic Surgical Associates is also provided at 810 N. Zang Blvd., Dallas, TX 75208 and on Texas Orthopaedic Surgical Associates website at [thebonedocs.com](http://thebonedocs.com). This Notice of Privacy Practices also describes my rights and the Texas Orthopaedic Surgical Associates 's duties with respect to my protected health information.

Texas Orthopaedic Surgical Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the Texas Orthopaedic Surgical Associates ' website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority