OrthoTexas
Orthopedics & Sports Medicine

Established Patient Forms

"I've been a patient at OrthoTexas for a long time, why am I asked to complete new forms?"
If it's been over one (1) year since your last visit, your Physician would like an update of your medical history, medications, and current problem that you are being seen for. We understand that completing these forms (again) is a lot of work, but we want the most current information to treat you. Also, obtaining new patient information (address, insurance, phone numbers, etc.) is key to make sure you haven't moved, changed insurance, and that we have correct information in order to contact you.

Please remember to:

- Bring your Driver's License/Government-issued ID and insurance card (if applicable) to your visit.
- Arrive 20 minutes prior to your scheduled appointment time.
- Complete the attached forms thoroughly—this will help us with your registration process and have reduce your wait time.
- Assist our Physician by bringing your Radiologist report in addition to any MRI, CT, or other scans you may have had.

You may receive a survey link via email three (3) days after your visit. Our goal is to be completely patient-focused and improve our service. We appreciate you taking the time to let us know your thoughts, suggestions, or areas we can improve.

Patient Portal: If you do not have access to your Patient Portal, please advise our staff and they will set up your account. This will assist you with timely access to a summary of your visit, secure messaging to email your Provider a question, and for you to update your address and contact information.

We thank you for choosing OrthoTexas!

Sincerely,

The OrthoTexas Team

OrthoTexas
Orthopedics & Sports Medicine

Name: _____ Date: _____ DOB: _____

Date of Injury: _____ Referred by: _____

Family Physician: _____ Phone: _____

Details of Injury: (How? Where? Any Treatment?) _____

_____

Body part being seen for: _____

Side of body: (circle) Right Left Both Dominant Hand (circle one): Left Right

Date symptoms began: _____/_____/_____ Current Symptoms: _____

If there is pain, where is it located?_____Pain Level (1-10; 10 being worst): _____

Medical History (High Blood Pressure, Diabetes, Emphysema, Gastric Reflux, etc.) _____

_____

_____

_____

Patient Medications:_____

_____

_____

_____ ☐ See Attached List

Pharmacy:_____Address:_____

HOSPITALIZATIONS/SURGERIES	YEAR	SURGEON/HOSPITAL

Patient Drug Allergies: _____

_____

_____ ☐ No Known Allergies

FAMILY HISTORY

Member	Alive/Deceased		Age	Health Status
Grandmother	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		

FAMILY HISTORY

Member	Alive/Deceased		Age	Health Status
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Review of systems (please check if you are currently or have had problems with these and describe)

Eyes_____ Diabetes_____ Arthritis _____

Ears, Nose, Throat_____ High Blood Pressure_____ Stroke_____

Lungs, Breathing_____ Bleeding Problems_____ Hepatitis _____

Chest Pain/Heart Problems_____ Balance Problem_____ Tuberculosis_____

Uclers_____ Numbness/Tingling_____ Seizures_____

Bowel Movement_____ Blackout/Fainting_____ Blood Clots_____

Bladder Problem_____ Depression_____ Cancer_____

Acid Reflux_____ Other:_____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Common Law Marriage

Work Status: ☐ Working Full-time ☐ Working Part-time ☐ Retired ☐ Student ☐ Disabled ☐ On Leave

Occupation:_____ Employer: _____

Do you drink alcohol? ☐ No alcohol consumption ☐ Yes, consumes alcohol ☐ Social Drinker ☐ Previous Alcoholism

Do you use tobacco? ☐ Never ☐ Currently (everyday) ☐ Currently (some days) ☐Formerly

Do you overuse/abuse? ☐ Never ☐ Currently ☐ In the past

Exercise regularly? ☐ Yes ☐ No Times per week and type:_____

Do you use an assistive device for ambulation (cane, walker, etc.)? ☐ Yes ☐ No Type:_____

Patient Signature:_____Date:_____

Per government requirements certain information is now required to update your medical record. Please complete the information below. (PLEASE PRINT ALL INFORMATION)

Primary Language (Check One)

☐ English ☐ Spanish ☐ Other: _____

☐ Decline to Answer

Ethnicity (Check One)

☐ Not Hispanic or Latino ☐ Hispanic or Latino

☐ Decline to Answer

Race (Check One)

☐ White ☐ Black / African American ☐ Asian ☐ Hispanic / Latino ☐ American Indian or Alaskan Native

☐ Native Hawaiian or other Pacific Islander ☐ Other: _____ ☐ Decline to Answer

Consent to Obtain RX History

☐ Yes ☐ No I consent for OrthoTexas to download my Prescription History if available. This consent is to help your physician make a better decision when prescribing any medication for you.

How Did You Hear About Us?

☐ Online Appointment Request
☐ Physician Referral
☐ Urgent - Acute Care
☐ Hospital ER
☐ Internal OrthoTexas Referral
☐ Internet Search
☐ Social Media
☐ High School Affiliation
☐ Professional - College Sports Affiliation
☐ Magazine - Newspaper - Print Ad
☐ Insurance Carrier Referral
☐ Workers Compensation
☐ Friends - Family - Word of Mouth
☐ Other: _____

Was there an injury? ☐ Yes ☐ No Work Related? ☐ Yes ☐ No Car Accident? ☐ Yes ☐ No

Sports Related? ☐ Yes ☐ No

Attorney Involved? ☐ Yes ☐ No

I understand and agree that I am responsible for all services rendered in the event this is work related and my claim is denied when filed to worker's compensation. I understand that OrthoTexas does not file any third-party insurance for motor vehicle or other accidents.

By signing below, I am verifying that the information provided is complete and accurate.

_____ _____

Signature of Patient / Responsible Party Date

_____

Printed Name

Orthopedics & Sports Medicine

Authorization for Disclosure of Medical Information

With my signature below, I authorize OrthoTexas to disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to OrthoTexas' notice of privacy practices for a more complete description of such uses and disclosures. I have the right to review the notice of privacy practices at any time.

_____ (Initials) I acknowledge receipt of Notice of Privacy Practices. I understand I will receive communication from OrthoTexas via text, call, or email regarding appointment reminders or to obtain feedback on my experience with the healthcare team. If at any time I wish to revoke the consent to receive that communication, I understand I have the right to notify the OrthoTexas office of that request.

I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations. I understand and have been provided with a notice of patient privacy handout that provides a more complete description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the office and I must agree on the use and disclosure of my protected health information. A photocopy or fax of this consent is as valid as this original. I understand that I may revoke this consent, in writing, except where disclosures have already been made in reliance.

Signature of Patient	**Date**
Printed Name	**Date of Birth**

Who may we speak to regarding your treatment?

I give permission to OrthoTexas to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc: ☐ **Only disclose to me**

Individual authorized to receive your health information	Relationship/Telephone Number
Individual authorized to receive your health information	Relationship/Telephone Number

OrthoTexas
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NOTICE TO PATIENTS

DISCLOSURE OF PHYSICIAN OWNERSHIP

To better serve you, many of the physicians at OrthoTexas Physicians and Surgeons, PLLC ("OrthoTexas") have ownership interests in various healthcare facilities in North Texas. These facilities and our physicians are committed to providing clinical services to our patients in a safe, high quality environment. Their ownership interest in these facilities often provides them a voice in administration and in clinical and operational policies. This involvement helps ensure the highest level of patient care and customer service.

The following is a current list of facilities (individually a "Facility") with whom one or more OrthoTexas physicians have an ownership financial interest:

- Baylor Surgicare at Plano Parkway
- Direct Orthopedic Care
- Frisco Medical Center, LLP d/b/a Baylor Medical Center at Frisco
- Metrocrest Surgery Center, LP d/b/a Baylor Surgicare at Carrollton
- Physicians Medical Center, L.L.C. d/b/a Texas Health Center for Diagnostics & Surgery - Plano
- Surgery Center of Plano

Patients of OrthoTexas always have the option of utilizing an alternate health care facility. OrthoTexas physicians welcome any questions regarding this aspect of their patient's care.

As nationally recognized leaders in orthopedic care, OrthoTexas physicians are at the forefront of advancements designed for patients with orthopedic problems. OrthoTexas physicians are frequently sought out by medical device manufacturers and other healthcare companies and organizations (individually, a "Company") to participate in research, development, education and other healthcare initiatives. These organizations realize that physicians are important contributors to the ongoing advancements in healthcare. As such, these companies sometimes offer ownership interests to physicians which is common industry practice. Some of these healthcare companies or organizations may be used in your medical treatment. However, a physician's decision as to which product, device or provider, if any, to be used in your care and treatment is made upon the physician's clinical judgment and what is in your best medical interest.

The following is a current list of companies with whom one or more OrthoTexas physicians have ownership relationships. Please feel free to ask your OrthoTexas physician any specific questions or concerns you may have about a company, product or your physician's ownership with OrthoTexas.

4Web	Flexion Therapeutics	Micro-Imaging Solutions
Axiom Regenerative Therapies	Gramercy Extremity Orthopedics	PIN
Bio2 Technologies	In2Bones	RevelationMD
Breg	Iroko Pharmaceuticals	Trice Medical
Cymedica	Kiowa Neuromonitoring	TX CIN

We hope this helps clarify the nature of our ownerships with other healthcare companies and organizations in orthopedic care. We are very proud to be leaders in technological innovation that we believe ultimately results in better patient care.

Please review carefully the information contained in this Notice.

1. During the course of our physician/patient relationship, I may refer you to a Facility or one or more other physicians who provide specialized medical services or refer the use of a Company product, device or provider.

2. I want to inform you that I am aware of the services, devices and/or products provided at a Facility or a Company when I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services, that physician also may have an ownership or financial interest in a Facility or a Company.

3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than a Facility (as previously defined) or physicians or a product, device or provider other than from a Company (as previously defined) to whom I might refer you from time to time to.

4. I will not be treating you differently if you choose to obtain health care at a facility other than a Facility and, if you desire, I will be happy to provide you information about alternative health care facilities.

If you have any questions, please do not hesitate to ask. We welcome you as a patient and we value our relationship with you.

By signing below you acknowledge that you have read and understand this notice, and that you are aware of an ownership interest in a Facility or a Company. Should you be referred to a Facility, Company or to another physician who holds an ownership interest in a Facility or a Company, you acknowledge your decision to decline the option to have your health care provided at another health care facility. You further acknowledge that you signed this notice prior to any referral of you to a Facility, a Company or another physician.

Signature of Patient	Signature of Parent or Guardian, (if applicable)
Printed Name	Date of Birth