

PATIENT INFORMATION FORM

PATIENT DATA:

PATIENT NAME (LAST, FIRST, MIDDLE) SOCIAL SECURITY # _____ SEX _____

ADDRESS (_____) _____ - _____ (_____) _____ - _____
HOME PHONE NUMBER MOBILE PHONE NUMBER

CITY STATE ZIP CODE OCCUPATION

_____/_____/_____
DATE OF BIRTH (MM/DD/YYYY) MARITAL STATUS _____ REFERRED BY _____

EMPLOYER NAME & ADDRESS (_____) _____ - _____
WORK PHONE NUMBER

IN CASE OF EMERGENCY: NAME RELATIONSHIP (_____) _____ - _____
EMERGENCY PHONE NUMBER

GUARANTOR INFORMATION:

POLICY HOLDER NAME GUARANTOR SOCIAL SECURITY # _____ DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS CITY STATE ZIP CODE

EMPLOYER NAME & ADDRESS (_____) _____ - _____
BUSINESS PHONE NUMBER

IS THIS VISIT DUE TO A: PERSONAL INJURY AUTOMOBILE ACCIDENT WORK RELATED INJURY

PRIMARY INSURANCE INFORMATION:

NAME OF PRIMARY INSURANCE (_____) _____ - _____
VERIFICATION PHONE #

CLAIMS ADDRESS CITY STATE ZIP CODE

MEMBER ID/SUBSCRIBER ID GROUP NUMBER/POLICY NUMBER

SECONDARY INSURANCE INFORMATION:

NAME OF SECONDARY INSURANCE (_____) _____ - _____
VERIFICATION PHONE #

CLAIMS ADDRESS CITY STATE ZIP CODE

MEMBER ID/SUBSCRIBER ID GROUP NUMBER/POLICY NUMBER

***PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.
THANK YOU!***

CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics and Sports Medicine, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and Sports Medicine and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics and Sports Medicine. I understand that this consent may be revoked in writing at any time.

PATIENT NAME (PRINT NAME)

PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT or GUARANTOR, if minor

DATE SIGNED

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics and Sports Medicine, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics and Sports Medicine, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

PATIENT NAME (PRINT NAME)

SIGNATURE OF PATIENT or GUARANTOR, if minor

DATE SIGNED

TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT**

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call TMH Physician Organization's Business Practices Officer at 713.383.5125.

Patient Name: _____

Signature of Patient or
Patient's Qualified Personal Representative: _____ Date _____

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained: _____

Processed by: _____

**PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION
TO INDIVIDUALS INVOLVED IN MY HEALTH CARE**

I GIVE PERMISSION for **The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Name: _____

Name: _____

Relationship: _____

Relationship: _____

I DO NOT GIVE PERMISSION for **The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

I GIVE PERMISSION for any **surgery centers or hospitals associated with The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Name: _____

Name: _____

Relationship: _____

Relationship: _____

I DO NOT GIVE PERMISSION for any **surgery centers or hospitals associated with The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

* Patient's Signature: _____

Date: _____

Patient's Printed Name: _____

Signature of Witness: _____

Date: _____

* Patient is a minor (___ years of age) *OR is unable to give permission because: _____

Signature of Individual Signing on Behalf of Patient: _____ Date: _____

Legal authority to act on the patient's behalf: _____

ALLERGIES to medications/medical equipment,
Please list the medications you are allergic to:

Medication	Type of reaction

Do you have an allergy to any of the following:	Yes	No	Type of reaction
Latex			
Adhesives or tape			
Anesthetics			
Iodine or IV contrast			

Immunizations: Are your immunizations up to date? Yes No

Tetanus (Year)?		Flu Shot (Year)?		Pneumonia Vaccine (Year)?	
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Family History

Do any of the following diseases run in your family

Disease	Mother	Father	Siblings	Children
Heart disease / heart attack				
High blood pressure				
Cancer (type)				
Stroke				
Bleeding disorders				
Seizures				
Mental illness				
Diabetes				

Social history / Habits

Do you smoke cigarettes?	Yes	No	How many packs per day?		For how many years?		Year quit?	
Do you use other tobacco products?	Yes	No	Type and amount		For how many years?		Year quit?	
Do you drink alcohol?	Yes	No	How many drinks per week?					
Do you use recreational or street drugs	Yes	No	Type					
How would you describe your overall health	Excellent		Good		Fair		Poor	

What type of exercise or sport do you participate in?

Sport	Daily	Weekly	Monthly	Rarely

Reviewed by: _____ Date: _____

Today's Date: _____ Patient Name: _____
Last First Middle

Main problem for your visit today: _____

When and how did your problem begin? _____

Was this the result of an accident? Yes Date: _____ Is there litigation pending? Yes

What makes your symptoms worse? _____

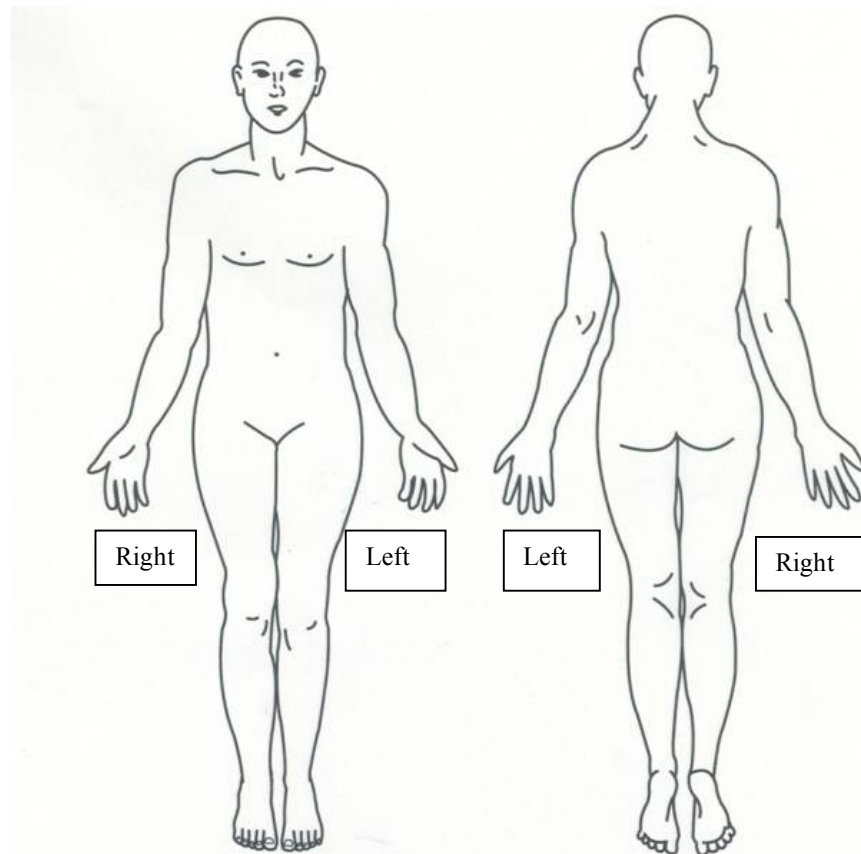
What makes your symptoms better? _____

What treatments have you tried? Over-the-counter pain medication Narcotic medication

Physical Therapy Chiropractic Treatment Spinal Injection (How many? _____)

How does this affect you? It interferes with work activities It wakes me up at night

It interferes with recreational activities



Please mark with the following symbols the areas where you are having MOST of your:

Aching or Pain:
XXXXXX

Numbness or Tingling:
OOOOO

Draw arrows where pain goes or shoots:
->>>>>

How long have you had your symptoms?

_____ Years
_____ Months
_____ Weeks

Please circle the number below that best represents the intensity of your pain:

No Pain 1 ---- 2 ---- 3 ---- 4 ---- 5 ---- 6 ---- 7 ---- 8 ---- 9 ---- 10 Worst Pain Ever Felt

Patient/Guardian signature: _____ Date: _____