

SOUTH TEXAS BONE & JOINT

NEW PATIENT INFORMATION (Please print)

Date:

Patient's Name			TDL#	Date of Birth	Age:	M or F	Social Security No.
Mailing Address Permanent Temporary			City, State and Zip Code		(Area Code) Cell Phone No.		(Area Code) Home Phone No.
Patient's Employer			Occupation (indicate if a student)		How Long Employed		(Area Code) Business Phone
Employer's Street Address			City and State		Zip code		No. of Children and Ages
Spouse's Name			Spouse's Social Security No.			Spouse's Date of Birth	
Spouse's Employer			Occupation (Indicate if a Student)		How Long Employed		(Area Code) Business Phone
Employer's Street Address			City and State				Zip code
Relative or Friend (Circle)			City and State		Zip code		(Area Code) Home Phone No.
Email address			Preferred Pharmacy Name & Location				

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of Insurance Company			Name of Insurance Company			
Accident ☐	Was An Automobile Involved? ☐ Yes ☐ No	Date of Accident	Attorney Case? ☐ Yes ☐ No	Name of Attorney		
Were X-Rays Taken of This Injury or problem? ☐ Yes ☐ No		If yes, Where Were X-Rays Taken? (Hospital, ETC)			Date X-Rays Taken	
Have You or Any Member of Your Immediate Family Been Treated By Our Physician(s) Before?					When	
Referred By		Street Address, City, State and Zip Code			(Area Code) Phone No.	

PLEASE READ: ---

It is customary to pay for professional services when rendered unless other arrangements have been made in advance. The patient is responsible for all fees, regardless of insurance coverage. Copies of your fee slip will be provided to you. This, with your monthly statement, may be submitted to your insurance company for reimbursement.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please Read and Sign)

I Hereby Authorize _____ M.D. To Furnish Information to Insurance Carriers Concerning My Illness And Treatments and I Hereby Assign To The Physician(s) All Payments For Medical Services Rendered To Me Or My Dependents. I understand that I am Responsible For Any Amount Not Covered By Insurance.

Signature _____

MEDICAL HISTORY

Name and Phone number of your regular physician: _____

Approximate date of last visit with your regular physician: _____

Please list all conditions for which you are now under treatment, or treat yourself: _____

Do you smoke cigarettes: Yes / No If so, how much: _____

Do you consume alcohol: Yes / No Beer, wine, whiskey, other (how much): _____

FAMILY MEDICAL HISTORY

NAME: _____

DATE: _____

Medical Conditions	MOM	DAD	SISTER	BROTHER	MOM'S MOM	MOM'S DAD	DAD'S MOM	DAD'S DAD
ASTHMA								
CANCER								
DIABETES: TYPE 1								
DIABETES: TYPE 2 (NIDDM)								
EPILEPSY								
HEART DISEASE								
HYPERCHOLESTEROLEMIA								
HYPERLIPIDEMIA								
HYPERTENSION								
MRSA								
NO CURRENT PROBLEMS OR DISABILITY								
OBESITY								
OSTEOARTHRITIS								
RHEUM. ARTHRITIS								
SLEEP APNEA								
SINUSITIS								
STROKE								
THYROID DISEASE								
UNKNOWN HISTORY								
LIVING or DECEASED								

MEDICAL HISTORY (continued)

List Medications – including nutritional supplements, and diet pills. (If more than ten, use medication list)

Medication Name	Dosage	Prescriber	Reason for Medication

Medication Allergies – Please list allergies (include penicillin, or kidney dye)

Other Allergies

If needed, will you accept a blood transfusion? _____ Blood Products? _____

Are you now or have you in the past six months received any treatment from an alternative care provider (chiropractor, acupuncture, etc.) If so, please list:

Previous surgeries:

Previous hospitalizations, non-surgical – Please list the reason for the hospitalization and the year:

Diagnosis:

\	Do you have the problem?		Do you receive treatment for it?		Does it limit your activities?	
	Yes	No	Yes	No	Yes	No
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Asthma or pulmonary disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Ulcer or stomach disease	☐	☐	☐	☐	☐	☐
Bowel disease	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐
Anemia or other blood disease	☐	☐	☐	☐	☐	☐
Overweight	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Osteoarthritis, degenerative Arthritis	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐
Back pain	☐	☐	☐	☐	☐	☐
Lyme disease	☐	☐	☐	☐	☐	☐

Other medical problem _____

Circle yes or no:

Do you have sleep apnea: Yes No
 Are you treated for it? Yes No
 Do you use CPAP? Yes No
 Do you wake gasping for air? Yes No

How much school have you completed?

☐ Less than high school ☐ Graduated from high school ☐ Some college
☐ Graduated from college ☐ Postgraduate school or degree

Do you smoke cigarettes?

1. Activity level

☐ Yes
☐ No, I quit more than six months ago.
☐ No, I have never smoked.

☐ Are you a high competitive sports person?
☐ Are you well-trained and frequently sporting?
☐ Sporting sometimes
☐ Non-sporting

Your height _____ feet _____ inches.
 Your weight: _____

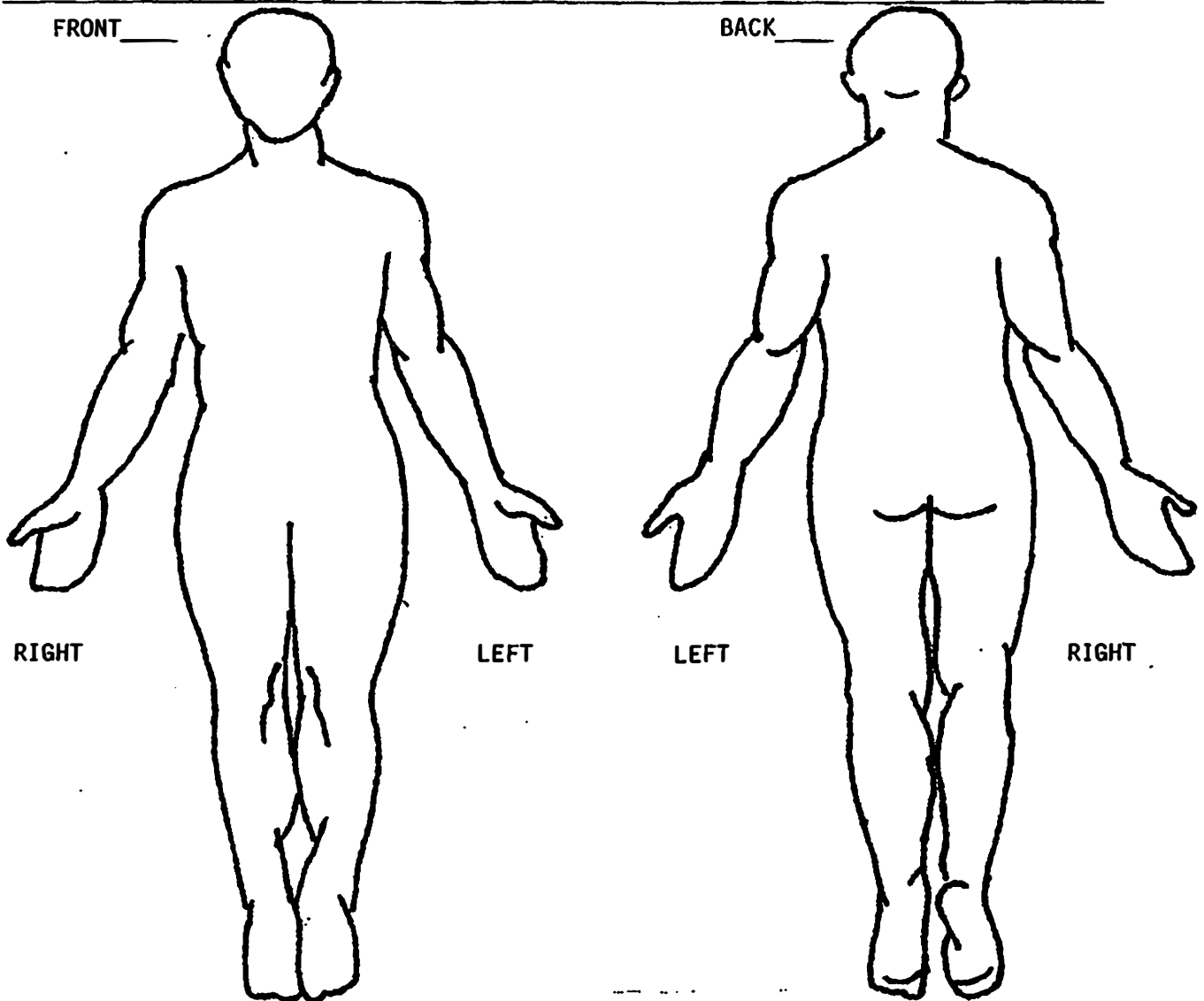
South Texas Bone & Joint

DATE: _____ NAME: _____

DALLAS PAIN ASSESSMENT DRAWING

DRAW THE LOCATION OF YOUR PAIN ON THE BODY OUTLINE

ACHE	BURNING	NUMBNESS	PINS AND NEEDLES	STABBING	OTHER
AAAA	====	0000		/////	XXX
AAAA	====	0000		/////	XXX



IF YOU HAVE BACK AND LEG PAIN, CIRCLE THE NUMBER THAT BEST DESCRIBES HOW YOU FEEL MOST OF THE TIME.

1. ALL BACK PAIN AND NO LEG PAIN.
2. MOSTLY BACK PAIN & A LITTLE LEG PAIN.
3. HALF BACK PAIN & HALF LEG PAIN.
4. A LITTLE BACK PAIN & MOSTLY LEG PAIN.
5. NO BACK PAIN, ALL LEG PAIN.

**New Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, SOUTH TEXAS BONE & JOINT originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that SOUTH TEXAS BONE & JOINT is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that SOUTH TEXAS BONE & JOINT reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should SOUTH TEXAS BONE & JOINT change their notice, they will send a copy of my revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient's Signature

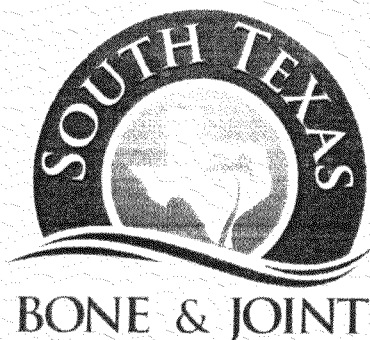
Date

FOR OFFICE USE ONLY

[] Consent received by _____ on _____.

[] Consent refused by patient, and treatment refused as permitted.

[] Consent added to the patient's medical record on _____.



601 TEXAN TRAIL, SUITE 300, CORPUS CHRISTI, TEXAS 78411

TELEPHONE: (361)854-0811 FAX: (361)806-5040

www.SouthTexasBoneandJoint.com

PHYSICIAN ASSISTANT CONSENT

Sports Medicine

Bernard M. Seger, M.D.
Arthroscopy & Knee Surgery

Charles W. Breckenridge, M.D.
Arthroscopy & Shoulder Surgery

Jackie Coates, P.A.-C

Adult Spinal Surgery

John P. Masciale, M.D.

Ramiro Benitez, FNP-C

John M. Borkowski, M.D.

Stephen Springer, P.A.-C

Foot and Ankle Surgery

Dawn M. Grosser, M.D.

Surgery of the Hand

Ryan B. Thomas, M.D.

Jose R. Recio, P.A.-C

Joint Reconstruction Joint Replacement Arthritis Surgery

Justin Klimisch, M.D.

Kaylee Sims, P.A.-C

General Orthopaedics

Frank A. Luckay, M.D.

Primary Care Sports Medicine

Michael W. Montgomery, M.D.

This facility has Physician Assistants to assist in the delivery of orthopaedic care. A Physician Assistant (P.A.) is **not** a doctor. A Physician Assistant is a graduate of a certified training program, and is licensed by the state board. Under the supervision of a physician, they can diagnose, treat, and monitor common acute and chronic diseases, as well as provide maintenance care. "Supervision" does not require the constant physical presence of the supervising physician but rather overseeing the activities of and accepting responsibility for the medical services provided.

A Physician Assistant may provide such medical services that are within his/her education, training, and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment
- Monitoring the effectiveness of therapeutic interventions
- Assisting/performing surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above and hereby consent to the services of a Physician Assistant for my health care needs.

I understand that at any time I can refuse to see the P.A. and request to see a physician.

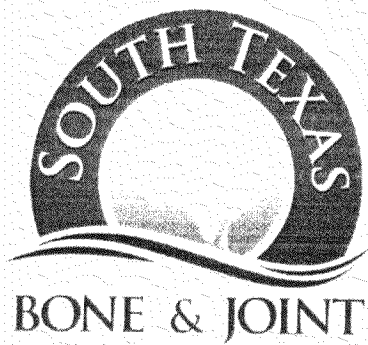
I understand that should I need surgery at a hospital or outpatient surgical center, it will be performed by an Orthopaedic Surgeon.

Name

Date

Signature

Witness (optional)



601 TEXAN TRAIL, SUITE 300, CORPUS CHRISTI, TEXAS 78411

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ACCIDENT/SYMPTOM INFORMATION

Sports Medicine

Bernard M. Seger, M.D.
Arthroscopy & Knee Surgery

Charles W. Breckenridge, M.D.
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PATIENT NAME _____

(Please print)

IF YOUR OFFICE VISIT TODAY IS THE RESULT OF AN
ACCIDENT
PLEASE COMPLETE THE FOLLOWING INFORMATION

IS THIS WORK RELATED?
YES _____ **NO** _____

DESCRIBE HOW YOU WERE INJURED :

DATE OF INJURY: _____

WHERE THE ACCIDENT HAPPENED:

IF THIS WAS NOT AN ACCIDENT, PLEASE GIVE US
THE FIRST DATE OF YOUR SYMPTOMS APPEARED ON
THE SPACE BELOW.

DATE : _____

SIGNATURE
(parent if minor)

DATE



PATIENT'S NAME _____ DATE _____
DOB _____

Bone Health Questionnaire

1. Have you noticed **any** loss in height in the last 12 months or progressive spinal curvature? YES NO
2. Have you ever been diagnosed with any of the following? YES NO
(Please check **ALL** that apply.)
- | | |
|---|--|
| ☐ Rheumatoid Arthritis | ☐ Osteopenia |
| ☐ Diabetes | ☐ Thyroid Disease |
| ☐ Lactose intolerance | (Hyperparathyroidism, Hyperthyroidism, or |
| ☐ Osteoporosis | treatment with high doses of thyroid hormones) |
3. Do you or a family member have/have had any of the following as an adult? YES NO
(Please check **ALL** that apply.)
- | | |
|---|--|
| ☐ Spinal Fracture | ☐ Family history of bone disease |
| ☐ Hip Fracture | ☐ Recent or unexplained weight loss |
| ☐ Any other fracture or broken bone related to an injury or fall | |
4. Have you taken any of the following medications longer than **THREE** months at any time in your life? (Please check **ALL** that apply.) YES NO
- | | |
|--|---|
| ☐ Birth Control/Contraceptives or Hormonal Therapy | ☐ Bisphosphonates such as Boniva, Fosamax, Zometa, etc. |
| ☐ Antiseizure medication such as Dilantan, Depakote, etc. | ☐ Steroids such as Prednisone / Methylprednisolone, Glucosteroids, Glucocorticoids, etc. |
5. If you are a **FEMALE**, are you pre or post-menopausal? YES NO
6. Have you had a **bone density test (DXA)*** in the last TWO years? YES NO
***This test confirms the severity of bone loss and risk of fracture.**

PROVIDER USE ONLY:

SCHEDULE

REVIEWED-APPT NOT NEEDED