

SOUTH TEXAS BONE & JOINT

**MINOR
PATIENTS
UNDER
AGE 18**

NEW PATIENT INFORMATION (PLEASE PRINT)

DATE:

PATIENT'S NAME		EMAIL	DATE OF BIRTH	AGE	M/ F	SOCIAL SECURITY #
MAILING ADDRESS		PERMANENT OR TEMPORARY	CITY, STATE, ZIP CODE	(AREA CODE) CELL PHONE#		(AREA CODE) HOME PHONE #
FATHER'S NAME		FATHER'S EMPLOYER				(AREA CODE) CELL PHONE#
EMPLOYER'S STREET ADDRESS		OCCUPATION	HOW LONG EMPLOYED		(AREA CODE) BUSINESS PH#	
MOTHER'S NAME		MOTHER'S EMPLOYER				(AREA CODE) CELL PHONE#
EMPLOYER'S STREET ADDRESS		OCCUPATION	HOW LONG EMPLOYED		(AREA CODE) BUSINESS PH#	
PARENT'S MAILING ADDRESS IF DIFFERENT		CITY, STATE, ZIP CODE				(AREA CODE) HOME PHONE #
RELATIVE OR FRIEND (CIRCLE)		CITY, STATE, ZIP CODE				(AREA CODE) HOME PHONE #
RELATIVE OR FRIEND (CIRCLE)		CITY, STATE, ZIP CODE				(AREA CODE) HOME PHONE #
PREFERRED PHARMACY NAME & LOCATION						

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.

PRIMARY INSURANCE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY				NAME OF INSURANCE COMPANY			
ADDRESS TO MAIL CLAIMS				ADDRESS TO MAIL CLAIMS			
CITY AND STATE	ZIP CODE	(AREA CODE) BUSINESS PH#		CITY AND STATE	ZIP CODE	(AREA CODE) BUSINESS PH#	
NAME OF INSURED		SOCIAL SECURITY #		NAME OF INSURED		SOCIAL SECURITY #	
GROUP #				GROUP #			
POLICY #				POLICY #			
MEDICARE (PLEASE GIVE NUMBER) ☐				RAILROAD RETIREMENT (PLEASE GIVE NUMBER) ☐			
MEDICAID ☐	CASE #			EFFECTIVE DATE			
INDUSTRIAL ☐	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO		DATE OF INJURY	INDUSTRIAL CLAIM NUMBER			
ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	ATTORNEY CASE? ☐ YES ☐ NO	NAME OF ATTORNEY			
WERE X-RAYS TAKEN OF THIS 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? ☐ YES ☐ NO						WHEN?	
REFERRED BY			STREET ADDRESS, CITY, STATE AND ZIP CODE			(AREA CODE) PHONE #	

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 MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE _____

MEDICAL HISTORY

Name and address of your regular physician _____ .

_____ .

Approximate date of last visit with your regular physician _____ .

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

Medications you are presently taking including herbs, nutritional supplements and/or diet pills:

Do you smoke cigarettes or consume alcohol? If so, how much: _____

Allergies - Please list Medicine Allergies

Other Allergies

Penicillin? _____

Kidney Dye? _____

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 hospitalization and year.

Diagnosis: _____

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								

LIST OF MEDICATIONS FOR PATIENT:

****List All medications: Also any Herbal, Vitamins or Over the Counter Meds.**

[illegible]

REVIEW OF SYSTEMS

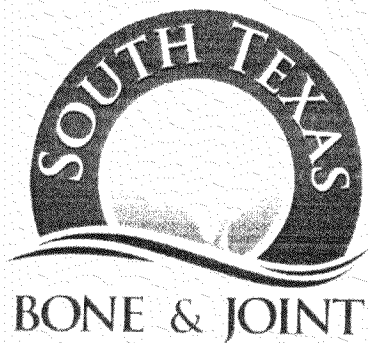
Your name _____

Date _____

For each of the items listed below, please place a check mark in the **YES** column if you are experiencing the symptom or place a check mark in the **NO** column if you have not experienced the symptom. We appreciate your help in giving this information.

	YES	NO
EYES/VISION		
Loss or change of vision		
Double or blurred vision		
EARS/HEARING		
Loss of hearing		
Buzzing or noise in ear		
NOSE AND THROAT		
Hoarseness		
Nose bleeds		
Difficulty swallowing		
BREATHING/RESPIRATORY		
Shortness of breath		
Excessive cough		
Night sweats		
Fevers		
NEUROLOGICAL		
Frequent headaches		
Dizziness or fainting spells		
Seizures or convulsions		
Memory loss		
HEART/CARDIOVASCULAR		
Chest pain		
Abnormal heartbeat		
STOMACH AND INTESTINES		
Frequent nausea or vomiting		
Recent weight loss		
Stomach, abdominal, bowel pain		
Frequent or severe constipation		
URINARY		
Bloody urine		
Painful or difficulty in urination		
Frequent urination		
MUSCLES AND SKELETAL		
Joint swelling		
Joint pain		
Loss of motion in joints		
Swelling of extremities		
SKIN		
Rashes		
Expanding moles		

Name of cardiologist (if you visit one) _____



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www.SouthTexasBoneandJoint.com

ACCIDENT/SYMPTOM INFORMATION

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.

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

*Any past history of spine pain?_____

*Spinal surgeries?_____

*Any incontinence of Bladder or Bowel?_____

*Allergies:_____

Past Medical History:	Social:	Medication:
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHYSICAL EXAM

NEURO:	SENSORY:	EXTREMITY:
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**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 _____.



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 Dilantin, 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