MINOR PATIENTS UNDER AGE 18

SOUTH TEXAS BONE & JOINT

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

NAME OF INSURANCE COMPANY		
ADDRESS TO MAIL CLAIMS		
CITY AND STATE	ZIP CODE	(AREA CODE) BUSINESS PH#
NAME OF INSURED		SOCIAL SECURITY #
GROUP #		
POLICY #		
MEDICARE (PLEASE GIVE NUMBER) ☐		
MEDICAID ☐	CASE #	

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 #

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY		
ADDRESS TO MAIL CLAIMS		
CITY AND STATE	ZIP CODE	(AREA CODE) BUSINESS PH#
NAME OF INSURED		SOCIAL SECURITY #
GROUP #		
POLICY #		
RAILROAD RETIREMENT (PLEASE GIVE NUMBER) ☐		
EFFECTIVE DATE		

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								

South Texas Bone and Joint

PATIENT/SOCIAL/FAMILY HISTORY

PLEASE CHECK THE APPROPRIATE SPACE THAT APPLIES:

OTHER FAMILY MEMBER	CHILD	ADULT (SELF)	COMMENTS
			BLEEDING TENDENCIES
			GOUT
			INFECTIONS OF THE BRAIN
			LUNG DISEASE
			KIDNEY DISEASE
			DIABETES
			EPILEPSY/CONVULSIONS
			ULCERS (STOMACH OR OTHER)
			SCARLET FEVER
			RHEUMATIC FEVER
			PANCREATITIS
			PNEUMONIA
			MEASLES
			GERMAN MEASLES
			ULCERATIVE COLITIS
			ASTHMA
			HEART ATTACK
			YELLOW JAUNDICE/HEPATITIS
			BLOOD CLOTS IN LEGS OR PHLEBITIS
			GONORRHEA OR SYPHILIS
			HIGH BLOOD PRESSURE
			GALLBLADDER DISEASE
			MONONUCLEOSIS
			TUBERCULOSIS
			ARTHRITIS
			POLIO
			MIGRAINES
			CANCER
			NORMAL CHILDHOOD DISEASES

OTHERS NOT LISTED:

_____

_____

IF YOU SMOKE NOW OR HAVE SMOKED IN THE PAST, PLEASE COMPLETE:

HOW MUCH SMOKED PER DAY? ____CIGARETTES ____CIGARS ____PIPEFULS
HOW LONG AGO DID YOU QUIT? _____ HOW LONG DID YOU SMOKE BEFORE YOU QUIT? _____

HOW MUCH DO YOU DRINK PER DAY? _____ PER WEEK? _____
PLEASE LIST ANY MEDICATIONS YOU TAKE DAILY AT HOME:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

South Texas Bone and Joint

NAME:_____ DOB: _____

LAST MENSTRUAL
PERIOD:_____

IS THERE ANY POSSIBILITY THAT YOU MAY BE PREGNANT? _____YES _____NO

LAST TETANUS BOOSTER:_____

OTHER IMMUNIZATIONS:_____

ALLERGIES:
HAVE YOU EVER BEEN ALLERGIC TO OR HAD A REACTION TO A MEDICINE OR SHOT? IF SO, PLEASE CHECK FROM THE FOLLOWING LIST:

DEMEROL_____ LOCAL ANESTHETIC_____ SPECIFY OTHER:
CODEINE_____ TETANUS ANTITOXIN_____
PENICILLIN_____ TRANQUILIZERS_____
SULFA DRUGS_____ BARBITURATES_____

ANTIBIOTICS_____ ASPIRIN_____

FOOD ALLERGIES:

IODINE_____ SEAFOOD/SHRIMP_____ STRAWBERRIES_____
BEEF/PORK_____ OTHER:_____

OPERATIONS:

HAVE YOU EVER HAD AN OPERATION OR MEDICAL ADMISSION TO A HOSPITAL? IF SO, PLEASE COMPLETE THE FOLLOWING:

OPERATION	HOSPITAL	PHYSICIAN	DATE

MEDICAL ADMISSIONS	HOSPITAL	PHYSICIAN	DATE

ORTHOPAEDIC SCREEN: PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD OR NOW HAVE:

RHEUMATISM
RECURRENT JOINT SWELLING OR PAIN
DISLOCATED JOINTS
TORN CARTILAGE OR LIGAMENTS
SEVERELY INJURED OR SPRAINED JOINTS
KNOWN ARTHRITIC CONDITION
JOINT INFECTION OR GOUT
JOINT LAXITY
LOSS OF JOINT MOTION
OTHER ABNORMALITY INVOLVING JOINTS
BURSITIS
PAINFUL BONE SPURS
FRACTURES

NECK OR BACK PAIN
RUPTURED DISC
SCIATICA
OTHER SPINE ABNORMALITY
OTHER DEFORMITY
BRITTLE OR SOFT BONES
OSTEOPOROSIS
KNOWN BONE CYST/OR TUMORS
BONE INFECTION
AMPUTATION
TENDINITIS
TORN MUSCLES OR TENDONS

LIST OF MEDICATIONS FOR PATIENT:____

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

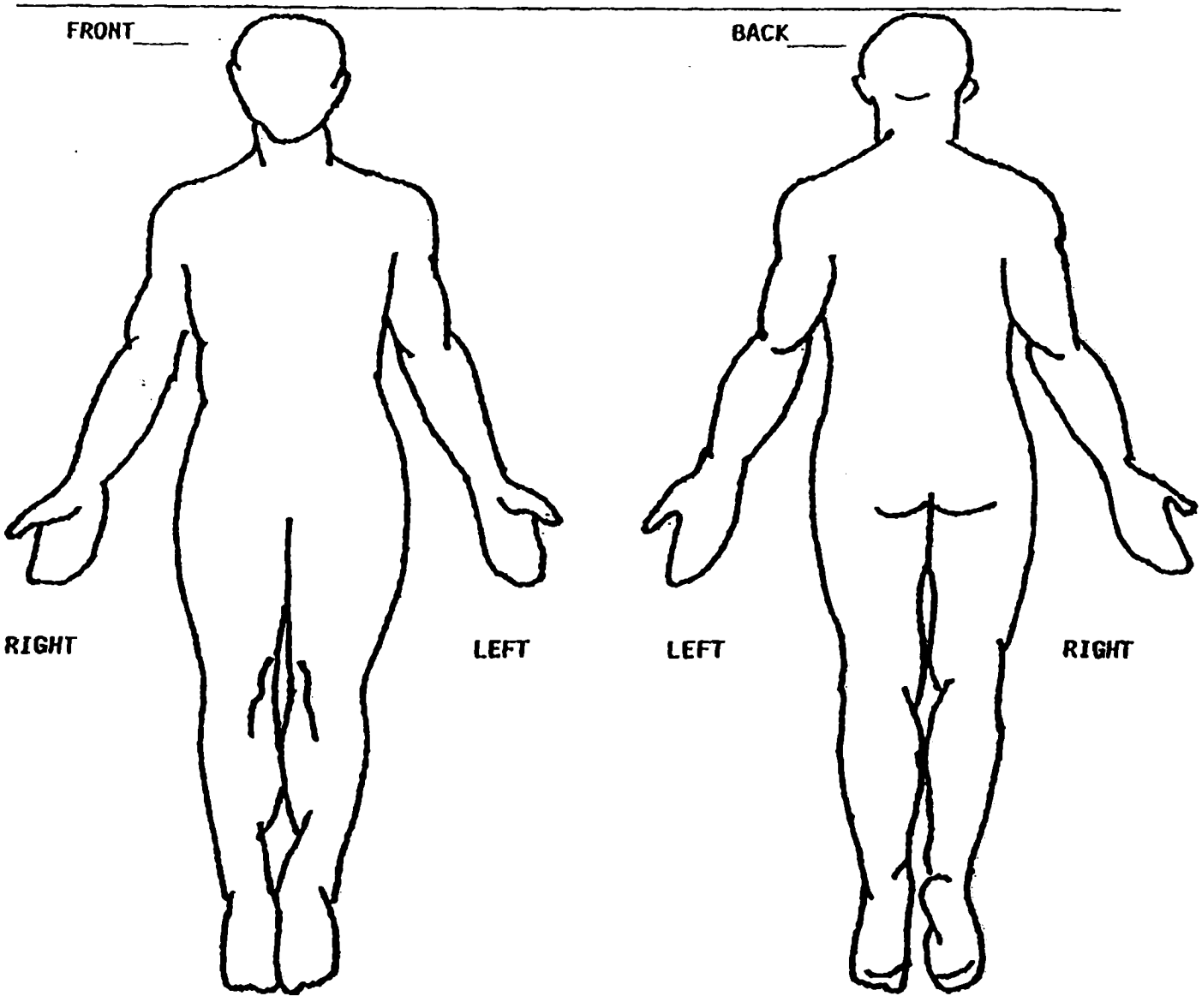
MEDICATION NAME	DOSAGE	FREQ.	DOCTOR	DATE PRESCRIBED	ROUTE	INDICATION

DATE:_____ NAME:_____

DALLAS PAIN ASSESSMENT DRAWING
DRAW HTE LOCATION OF YOUR PAIN ON THE BODY OUTLINE

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

FRONT____ BACK____



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.

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) _____

SOUTH TEXAS BONE & JOINT

601 TEXAN TRAIL, SUITE 300, CORPUS CHRISTI, TEXAS 78411
TELEPHONE: (361)854-0811 FAX: (361)806-5040
www.SouthTexasBoneandJoint.com

ACCIDENT/SYMPTOM INFORMATION

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

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 _____.

DATE _____

PATIENT'S NAME _____ 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
____ Diabetes
____Lactose intolerance
____Osteoporosis
____Osteopenia
____Thyroid Disease
(Hyperparathyroidism, Hyperthyroidism, or 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
____ Hip Fracture
____ Any other fracture or broken bone related to an injury or fall
____Family history of bone disease
____Recent or unexplained weight loss

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
____Antiseizure medication such as Dilantan, Depakote, etc.
____Bisphosphonates such as Boniva, Fosamax, Zometa, 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

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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.

NURSE PRACTITIONER CONSENT

This facility has Nurse Practitioners to assist in the delivery of orthopaedic care. A nurse practitioner (N.P.) is **not** a doctor. A Nurse Practitioner is a graduate of a Master's Program of Nursing and they are certified by National Licensing Agencies, and licensed by the State Board of Nursing. Additionally, a Nurse Practitioner may be certified in Family Medicine (FNPc). 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 nurse practitioner 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 Nurse Practitioner for my health care needs.

I understand that at any time I can refuse to see the N.P. or FNPc 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)