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								

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

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

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PHYSICIAN ASSISTANT CONSENT

Sports Medicine

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

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

Lauren A. Vesely, P.A.-C

Adult Spinal Surgery

John P. Masciale, M.D.

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 Recio, P.A.-C

Joint Reconstruction
Joint Replacement
Arthritis Surgery

Justin Klimisch, M.D.

Christian P. Ehrhard, 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 P.A. 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)

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

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 right 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 and 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 and 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 any revised notice to the address I've provided (whether by 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 _____.