Lone Star Orthopaedic Institute

Patient Registration

Patient Information

Patient's Legal Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

I consent to receive the following (check all that apply): ☐ Voicemails ☐ Text Messages ☐ Emails

Gender**:** ◯ Female ◯ Male ◯ Other, not listed: _____

Are you Hispanic or Latino?
(Circle One)
☐ YES or ☐ NO

Race**:** ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American

☐ White ☐ Hispanic or Latino ☐ Choose not to disclose ☐ Other, not listed: _____

Preferred Language: ◯ English ◯ Spanish ◯ Other (Specify): _____

Pharmacy: _____ Phone: _____

Address: _____ City, State, Zip: _____

Primary Care Provider: _____ Phone: _____

Referring Physician: _____ Phone: _____

Responsible Party Information

Responsible Party: ☐ Self ☐ Guarantor

Responsible Party Name: _____ Date of Birth: _____

Gender: ◯ Female ◯ Male Social Security Number: _____ Phone: _____

Address: _____ City, State, Zip: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Do you have a living will? ☐ Yes ☐ No

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Consent for Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical exams, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist) and other health care providers or the designees care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Consent for Financial Communications

I acknowledge that as a courtesy, Lone Star Orthopaedic Institute may bill my insurance company for services provided to me. I agree to pay for services that are not covered, or covered charges not paid in full, including, but not limited to and co-payment, co-insurance, and/or deductible, any charges not covered by insurance. I understand there is a fee for returned checks.

I acknowledge Lone Star Orthopaedic Institute may use the services of a third party business associate, or affiliated entity as an extended business office (EBO Servicer) for medical account billing and servicing.

I hereby assign Lone Star Orthopaedic Institute any insurance or third party benefits available for health care services provided to me. I understand Lone Orthopaedic Institute has the right to refuse or accept such benefits. If these benefits are not assigned to Lone Star Orthopaedic Institute, I agree to forward all health insurance or third party payments that I receive for services rendered to me immediately upon receipt.

I certify that any information I provide, if any, in applying for payment under Title XVII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Lone Star Orthopaedic Institute by the Medicare or Medicaid program.

I agree that, in order for Lone Star Orthopaedic Institute or Extended Business Office (EBO) servicers and collection agents, to service my account or to collect any amounts I may owe. I expressly agree and consent that Lone Star Orthopaedic Institute or EBO servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Lone Star Orthopaedic Institute or EBO servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

A photocopy of this consent shall be considered as valid as the original.

Signature of Patient or Representative: _____ Date: _____

Printed Patient Name: _____ Relationship to Patient: _____

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Patient HIPAA Acknowledgement and Consent Form

I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the providers business associates. To the extent permitted by law, I consent to the use of my information for the purposes described in the Notice of Privacy Practice.
I hereby permit Lone Star Orthopaedic Institute and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.
Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.
If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, lab reports, operative reports, physician progress notes, nurse notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions, and/or infectious diseases, including but not limited to, blood borne diseases, such as HIV and AIDS.

I authorize the following friends or family members to access my Protected Health information for the purposes of communicating results, findings and care decisions.

Please ✓ whether or not this individual is authorized to also pick up prescriptions on your behalf.

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

Name: _____ Relationship: _____ ☐ Yes ☐ No

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Signature of Patient or Representative: _____ Date: _____

Printed Patient Name: _____ Relationship to Patient: _____

Lone Star Orthopaedic Institute

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Date: _____

Patient Name:_____ DOB: _____

Preferred Language: _____ Race/Ethnicity: _____

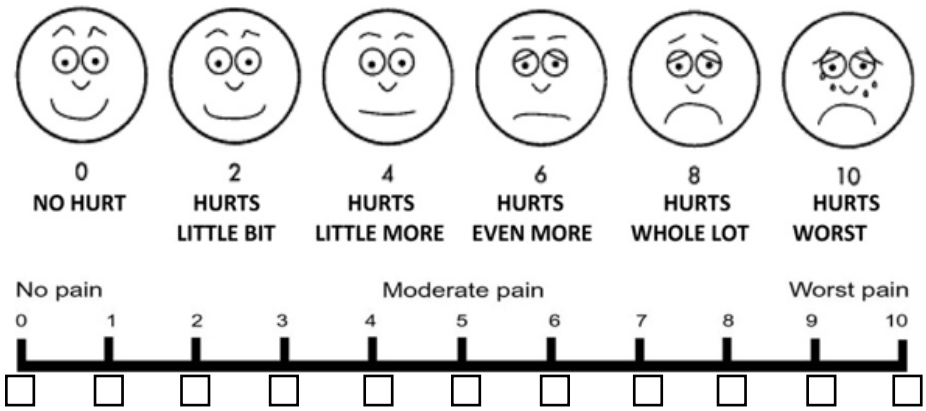
How were you referred to us? _____

Referring Physician Name: _____

Reason for Visit: _____

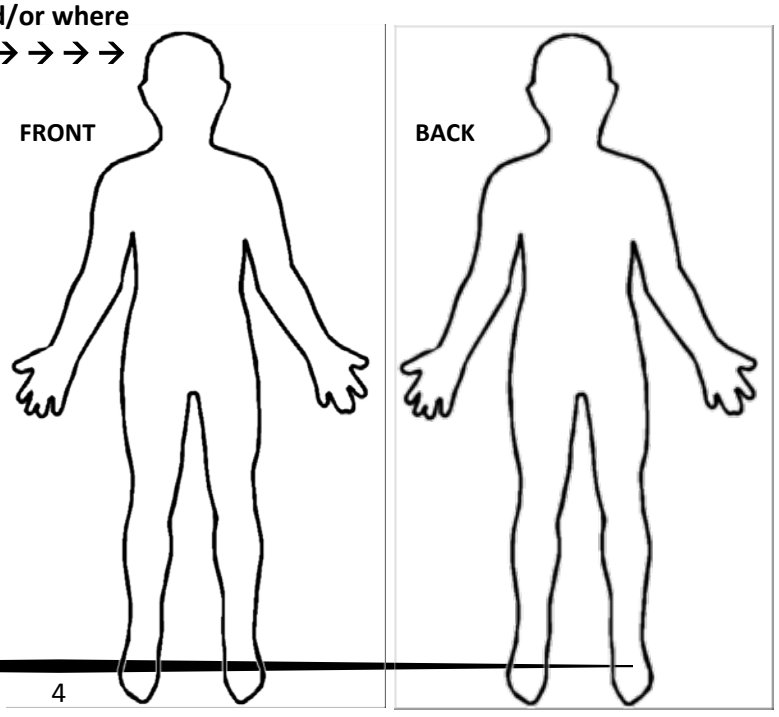
Are you symptoms related to an injury: ___Y ___N Date of injury: _____

What is the degree of pain from the scale of 1-10 that you are currently experiencing? (please Circle)



Please indicate on the chart where you are injured and/or where your site of pain is located → → → → → → → → → → → → → →

Nimbness & Tingling XXXXXXXXX
Needles 0000000000
Burning ----------
Stabbing //////////



Aggravating Factors: ___Lifting ___Coughing ___Sneezing ___Standing ___Walking ___Sitting

___Climbing Stairs Other (describe) _____

Describe your pain: ___Constant ___Intermittent ___Unchanged ___Worse ___Better

___Burning ___Sharp-shooting ___Tingling ___Numbness ___Pinprick

___Stabbing ___Deep-Presure ___Tightness ___Spasms

Other(describe)_____

What makes pain worse? _____

What makes pain better? _____

How does the pain limit? _____

Is there any Bowel or Bladder problems? _____

How far are you able to walk without your symptoms causing you to stop and rest? _____

_____

Do you use a: ___Walker ___Cane ___Wheelchair ___Motorized Scooter

Treatment & Eval: ___MRI ___X-Rays ___CT ___EMG ___Bone Scan ___Labs ___Epidurals

Check treatment tried for pain, write how long this treatment was tried if specified.

___Physical Therapy How Long? _____ ___TENS ___Heating Pad ___Ice

___Inversion Table ___Steroid Injection How many injections? _____

___Surgery, What kind? _____ ____Chiropractor, How long? _____

___Exercise, What kind? _____ ____Medication, Which? _____

___Brace, Which? _____ ____Other(describe)_____

Please answer the following questions to the best of your ability.

1. **Have you noticed that you are dropping things or that your hands feel clumsy?** ___Y ___N
2. **Do you feel off-balance or unsteady on your feet?** ___Y ___N
3. **Do you feel weakness in one or both your arms or hands?** ___Y ___N
4. **Do you feel numbness or tingling in one or both of your arms or hands?** ___Y ___N

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Name (First, Last)		Today's Date	
DOB:	□ Male □ Female	Height:	Weight:
Primary Care Provider/Clinic Name:		Who referred you to this clinic?	
Reason for todays visit:			

PERSONAL HEALTH HISTORY

When was your last flu vaccine?	When was your last pneumonia vaccine?

Past Medical History: (Diabetes, Hypertension, etc…)

Year	Description

Past Surgical History:

Year	Reason (example: appendectomy)	Did you stay in the hospital after procedure?

Other Hospitalizations:

Year	Reason	Location

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MEDICATIONS

Please include over the counter medications, vitamins, and supplements, or attach your medication list.

Name	Dose/Strength	Frequency	Prescribing Physician

ALLERGIES

Have you ever had a problem/reaction with anesthesia? □ Yes □ No

If yes, please explain:

Are you allergic to any medications? □ Yes □No If yes please list allergy and reaction below

Allergy/Medication	**Reaction**

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SOCIAL HISTORY

Marital Status: □ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Children: □ Yes □ No If yes, how many?_____ Ages?_____

Occupation: □ Retired □ Disabled □ Working, Current Occupation_____

FAMILY HEALTH HISTORY

	Age	Health Problems	Age at Death		Age	Health Problems	Age at Death
Father				Paternal Grandfather			
Mother				Paternal Grandmother			
Sibling(s)				Maternal Grandfather			
Children				Maternal Grandmother			

HEALTH HABITS

Alcohol	Do you drink alcohol? □ Yes □ No If yes, how many glasses a week? What type of alcohol?
Tobacco/Drug Use	Do you use tobacco? □ Yes □ Never □ No, quit Year_____ If yes, check all that apply: □ Cigarettes, per day ____ □ Chew, per day ____ □ Pipe, per day ____ □ Cigars, per day ____ Do you use illicit/recreational drugs? □ Yes □ No If yes, what kind? _____
Exercise	Do you exercise? □ No □ Yes; 1-3 times/week □ Yes; 4 or more times/week □ Yes; active but no formal exercise If yes, what type? _____

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PERSONAL SAFETY

Do you live alone? □ Yes □ No If no, who do you live with?_____

Do you use a cane? □ Yes □ No

Do you have frequent falls? □ Yes □ No Do you use a wheelchair? □ Yes □ No

Do you have an Advanced Directive or Living Will? □ Yes □ No

If no, if you would like one to prepare, please notify the staff.

PLEASE CIRCLE ALL THAT APPLY TO YOU HEALTH CARE PAST OR PRESENT

CONSTITUTIONAL
- Fever/Chills ☐
- Unexpected Weight Loss ☐
- Nausea/Vomiting ☐
- Fatigue ☐

RESPIRATORY
- Shortness of Breath ☐
- Cough ☐
- Asthma/Bronchitis ☐
- Wheezing ☐
- Hurts to Breathe ☐

PSYCHAITRIC
- Hallucinations ☐
- Nervousness ☐
- Depression ☐
- Anxiety ☐

EYES
- Blurred Vision ☐
- Color Blindness ☐
- Redness ☐

GASTROINTESTINAL
- Heart Burn ☐
- Constipation ☐
- Black/Tarry Stools ☐
- Diarrhea ☐

ENDOCRINE
- Abnormal Growth ☐
- Goiter ☐
- Heat/Cold Intolerance ☐
- Increased Thirst/Urination ☐

EAR, NOSE, THROAT, MOUTH
- Deafness ☐
- Nose Bleeds ☐
- Hoarseness ☐
- Ear Ringing ☐
- Post Nasal Drip ☐

MUSCULOSKELETAL
- Stiffness ☐
- Joint Swelling ☐
- Numbness/Tingling ☐
- Joint Pain ☐
- Unsteady Gait ☐

ALLERGIC/IMMUNOLOGIC
- Immunosuppressed ☐
- Hay Fever ☐
- Food/Environmental Allergy ☐
- Sensitivity to Pollen ☐

CARDIO AND VASCULAR
- Palpitations ☐
- Chest Pain ☐
- Fainting ☐
- Leg Cramps ☐
- Heart Murmur ☐

INTEGUMENTARY/BREAST
- Skin Rash ☐
- Itching ☐
- Scarring/keloids ☐
- Nail Ridging/Pitting ☐

HEMATOLOGIC/LYMPHATIC
- Enlargement ☐
- Pain ☐

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MODIFIED ZUNG DEPRESSION INDEX

Patient Name _____

Please indicate for each of these questions which answer best describes how you have been feeling recently.

		Rarely or none of the time (less than one day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1	I feel downhearted and sad				
2	Morning is when I feel the best				
3	I have crying spells or feel like it				
4	I have trouble getting to sleep at night				
5	I feel that nobody cares				
6	I eat as much as I used to				
7	I still enjoy sex				
8	I notice I am losing weight				
9	I have trouble with constipation				
10	My heart beats faster than usual				
11	I get tired for no reason				
12	My mind is as clear as it used to be				
13	I tend to wake up too early				
14	I find it easy to do things I used to				
15	I am restless and can't keep still				
16	I feel hopeful about the future				
17	I am more irritable than usual				
18	I find it easy to make a decision				
19	I feel quite guilty				
20	I feel that I am useful and needed				
21	My life is pretty full				
22	I feel that others would be better off if I were dead				
23	I am still able to enjoy the things I used to				