Southwest Joint Replacement & Sports Medicine Center

PATIENT REGISTRATION FORM

*REQUIRED FIELDS ARE IN RED

PATIENT INFORMATION (Please print)

Patient Name (Last)* _____ (First)* _____ (MI) _____

Preferred Full Name (if different from above) _____

Address* _____

City, State, ZIP* _____

Home Phone (Landline) _____ Cell _____ Work _____

Date of Birth* _____ E-Mail Address _____

Social Security Number _____

Gender Identity:* ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race:* ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White ☐ Hispanic ☐ Other ☐ Declined

Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Preferred Language:* ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Swahili ☐ Mandarin
☐ Indian: Hindi, Tamil, Gujarati ☐ Vietnamese ☐ Other _____

Marital Status:* ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Emergency Contact Name _____ Relationship to Patient _____ ☐ Guardian

Address, City, State, ZIP _____

Emergency Contact Home No. _____ Emergency Contact Work No. _____ Ext. _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party:* ☐ Another Patient ☐ Guarantor ☐ Self ☐ **Check here if information is same as patient**

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Home Phone _____ Work #: _____ Date of Birth _____

Social Security Number _____ Sex:* ☐ Female ☐ Male E-Mail Address _____

Address, City, State, ZIP _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Name _____ Subscriber ID: _____ Group #: _____

Name of Insured _____ Insured's Date of Birth _____ Relationship to Insured _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Name _____ Subscriber ID: _____ Group #: _____

Name of Insured _____ Insured's Date of Birth _____ Relationship to Insured _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

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 in your care, 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 examinations, 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 recommend 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 as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek 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).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative: _____ Date: _____

Printed name of patient or personal representative: _____ Relationship to patient: _____

Patient HIPAA Acknowledgment and Consent Form 1

Southwest Joint Replacement & Sports Medicine Center		
Patient Name*	Date of Birth (MM/DD/YYYY)*	Today's Date (MM/DD/YYYY)*

Notice of Privacy Practice/Clinics

_____ (**Patient/Representative initials)** 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 Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Prescription Refill Policy

Our office requires 48-hour notice for prescription refills. All medication refills must be phoned, faxed or electronically submitted to the office Monday - Thursday 9:00 AM - 4:00 PM and Friday 9:00 AM - 3:00 PM. It is the patient's responsibility to verify with their pharmacy and our office that it has been received prior to the above deadline. There will be absolutely no refills given on the weekends.

Patient HIPAA Acknowledgment and Consent Form 2

Southwest Joint Replacement & Sports Medicine Center		
Patient Name*	Date of Birth (MM/DD/YYYY) *	Today's Date (MM/DD/YYYY)*

Release of Information

I hereby permit Southwest Joint Replacement & Sports Medicine Center 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, laboratory reports, operative reports, physician progress notes, nurse's 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.

Prescription Order Pick-up

There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.*

- ☐ ***I do want*** to designate the following individual to pick up a prescription order on my behalf:

Name	Relationship to Patient

- ☐ ***I do not want*** to designate anyone to pick-up my prescription order.

Financial Agreement

- I acknowledge that, **Southwest Joint Replacement & Sports Medicine Center** does not treat work injuries nor accept workers compensation insurance.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, charges not covered by insurance, or charges denied for no referral.
- I understand it is my responsibility to verify that my primary care physician has authorized my visits and that my primary care physician has submitted a referral to my insurance, if required by my insurance plan. The referral must be on file in our office prior to your appointment date and time.

Form Completion

I understand there will be a $25 charge per occurrence for the completion of the following forms:

- Disability Forms
- FMLA
- Aflac
- Supplemental Insurance
- Medical Hardships

*Payment is due when the forms are presented and will not be processed without payment. Please allow 5 to 7 business days for completion of forms.

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

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date (MM/DD/YYYY)

PATIENT HISTORY FORM

Southwest Joint Replacement & Sports Medicine Center

Patient Name*	Date of Birth (MM/DD/YYYY)*	Today's Date (MM/DD/YYYY)*

Height _____ Weight _____

Primary Care Doctor Name, Address & Tel #*_____

Referring Provider Name, Address & Tel #_____

Pharmacy Name & Address:*_____ Pharmacy #:*_____

HISTORY OF PRESENT ILLNESS

What is the main reason for your visit today: _____

_____

Please indicate the pain level of your current problem (0 being the lowest & 10 being the highest) 0 1 2 3 4 5 6 7 8 9 10

When did this problem begin: _____ (Please specify date)

Is this problem due to an injury?* ☐ YES ☐ NO If yes, what is the date of injury? _____

DID THE INJURY OCCUR AT WORK?* ☐ **YES** ☐ **NO** **IF YES STOP AND NOTIFY THE FRONT DESK. OUR DOCTORS DO NOT TREAT WORK INJURIES.**

IS THIS INJURY DUE TO AN AUTO ACCIDENT?* ☐ YES ☐ NO **(THIS PRACTICE DOES NOT ACCEPT LETTERS OF PROTECTION)**

For this injury/problem have you recently had an: X-Ray?* ☐ YES ☐ NO MRI?* ☐ YES ☐ NO CT?* ☐ YES ☐ NO

If yes, when & where?_____ What treatment have you received?_____

Which hand is your dominant?* ☐ Right ☐ Left Are you pregnant?* ☐ YES ☐ NO If yes, when is your due date? _____

MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list the name, dosage and frequency of the Medication, Vitamin and/or Supplement

_____ _____ _____

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING: *ANSWER EACH WITH YES/NO AS APPLIES*

☐Y/☐N Anemia or Bleeding Problems* ☐Y/☐N Cancer* ☐Y/☐N Heart Attack* ☐Y/☐N High Cholesterol* ☐Y/☐N Stroke*

☐Y/☐N Blood Clots* ☐Y/☐N Chest Pain* ☐Y/☐N Heart Disease* ☐Y/☐N Hypertension* ☐Y/☐N Ulcer*

☐Y/☐N Blood Transfusion* ☐Y/☐N Diabetes* ☐Y/☐N Hepatitis* ☐Y/☐N Seizures*

☐ Other _____

If you have marked any of the above, when? _____

_____

ALLERGIES

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS, FOODS OR ENVIRONMENTAL ELEMENTS?* ☐ **YES** ☐ **NO**

If yes, please list all allergies and the reaction experienced.

_____ _____

_____ _____

PATIENT HISTORY FORM CONT'D

Southwest Joint Replacement & Sports Medicine Center

SURGERIES/HOSPITALIZATIONS

HAVE YOU EVER HAD ANY OF THE FOLLOWING: *ANSWER EACH WITH YES/NO AS APPLIES & DATE OF SURGERY*

☐Y/☐N Previous orthopedic fractures or surgeries:* _____

☐Y/☐N Appendectomy*-Date:_____ ☐Y/☐N Gall Bladder*Date:_____ ☐Y/☐N Hysterectomy*-Date:_____

☐Y/☐N Back Surgery*Date:_____ ☐Y/☐N Heart Surgery*-Date:_____ ☐Y/☐N Thyroid*-Date:_____

☐Y/☐N CABG*-Date:_____ ☐Y/☐N Hemorrhoids*-Date:_____ ☐Y/☐N Tonsillectomy*-Date:_____

☐Y/☐N Cancer Surgery*-Date:_____ ☐Y/☐N Hernia Repair*-Date:_____

☐Y/☐N Other Surgeries*& Date: _____

_____

Have you been hospitalized other than for the surgeries listed above* ☐Y ☐N

If yes please list when & why: _____

FAMILY HISTORY

☐ **I do not know the medical history of my biological parents or other family members.** (Go to next section, SOCIAL HISTORY)

MOTHER:* ☐ Alive-Age: _____ ☐ Deceased at age: _____ Due to: _____

FATHER:* ☐ Alive-Age: _____ ☐ Deceased at age: _____ Due to: _____

ARE THERE ANY ILLNESSES THAT RUN IN THE FAMILY?			(PLEASE SELECT ALL THAT APPLY)
Diabetes*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Hypertension (HTN)*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Breast Cancer*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Heart Disease (CAD)*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Lung Cancer*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Colon Cancer*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Heart Attack*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
High Cholesterol*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Asthma*	☐YES	☐NO	Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER
Other: _____			Relation:* ☐DAD ☐MOM ☐SISTER ☐BROTHER

SOCIAL HISTORY

ALCOHOL USE*
- ☐Does not use alcohol
- ☐Uses alcohol

Frequency of drinking:*
- ☐never
- ☐rarely
- ☐socially
- ☐daily

Amt: _____drinks / week

TOBACCO STATUS *
- ☐non tobacco user
- ☐never a smoker
- ☐current every day smoker
- ☐current some day smoker
- ☐former smoker
  - -Quit date: _____
- ☐smokeless tobacco user

# of yrs smoked: _____
Amt: _____ per day

MARITAL STATUS*
- ☐Married
- ☐Divorced
- ☐Single
- ☐Widow/Widower
- ☐Partner
- ☐Domestic Partner

OCCUPATION/WORK*
- ☐employed full time
- ☐employed part time
- ☐homemaker
- ☐student
- ☐not employed
- ☐retired
- ☐disabled

Occupation: _____

PATIENT HISTORY FORM CONT'D

Southwest Joint Replacement & Sports Medicine Center

REVIEW OF SYSTEMS

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ _____

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Heart attack
- ☐ Irregular heart rate
- ☐ Palpitations
- ☐ Fainting
- ☐ _____

GENITOURINARY
- ☐ Incontinence
- ☐ UTI
- ☐ _____

ENDOCRINE
- ☐ Heat/Cold intolerance
- ☐ Thyroid problems
- ☐ Unusual weight gain
- ☐ _____

SKIN/BREAST
- ☐ Breast lump or mass
- ☐ Bruising
- ☐ Rash/Redness
- ☐ _____

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ _____

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Swollen joints
- ☐ Arthritis
- ☐ _____

LYMPHATICS
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Enlarged lymph nodes
- ☐ _____

EYES
- ☐ Blurred vision
- ☐ Difficulty seeing
- ☐ Double vision
- ☐ _____

GASTROINTESTINAL
- ☐ Abdominal pain or swelling
- ☐ Acid reflux
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcers
- ☐ Vomiting
- ☐ _____

NEUROLOGIC
- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness
- ☐ _____

ALLERGIC/IMMUNOLOGIC
- ☐ Hives
- ☐ Metal or Nickel sensitivity
- ☐ _____

EARS/NOSE/THROAT
- ☐ Deafness
- ☐ Hearing changes
- ☐ Nasal congestion
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ _____

PSYCHIATRIC
- ☐ Anxious
- ☐ Confusion
- ☐ Depressed
- ☐ _____

HEMATOLOGY
- ☐ Bleeding
- ☐ Blood clots
- ☐ _____

Patient/Responsible Party Signature _____ **Date** _____

I have read and reviewed this patient history form.

*Physician Signature:*_____ *Date:*_____ *Time:*_____

HOW DID YOU LEARN ABOUT US? (Check all that apply)

- ☐ Referring Provider
- ☐ Family/Friend
- ☐ Website
- ☐ Search Engine
- ☐ Google+
- ☐ Online Profile
- ☐ Facebook
- ☐ D Magazine
- ☐ Other Social Media
- ☐ Other Physician Profile
- ☐ Living Well Magazine
- ☐ Health Grades or Vitals
- ☐ Care Now
- ☐ Marketing Mailer
- ☐ Medical City Dallas Hospital/ER
- ☐ Other (please specify) _____