Southwest Joint Replacement & Sports Medicine Center
PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please print)

Patient's 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 _____ Employer Name _____

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 etc ☐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) _____

Telephone _____ Date of Birth _____ Social Security Number _____ Sex: ☐Female ☐Male

E-Mail Address _____

Address, City, State, ZIP _____

Employer Name _____ Employer Phone Number _____

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

Insurance Name _____ Insurance Telephone No. _____

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

Subscriber ID (Policy Number) _____ Group ID _____

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

Insurance Name _____ Insurance Telephone No. _____

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

Subscriber ID (Policy Number) _____ Group ID _____

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

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

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____

Southwest Joint Replacement & Sports Medicine Center

PATIENT HISTORY FORM

Patient Name _____ Date of Birth _____ Today's Date _____

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 circle 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

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? _____

_____

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: _____

_____

MEDICATIONS, VITAMINS & SUPPLEMENTS

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

Southwest Joint Replacement & Sports Medicine Center
CONT'D PATIENT HISTORY FORM

ALLERGIES

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

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

_____ _____

_____ _____

FAMILY HISTORY

Adopted? ☐ YES ☐ NO	Mother	Father	Sibling	Grandparents
Alive				
Deceased				
Heart disease				
Hypertension				
Diabetes				
Arthritis				
Cancer				

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N If yes, # of packs per day _____ How many years _____ When did you quit? _____

Do you drink alcohol? ☐ Y ☐ N If yes, drinks per day _____ ☐ Social Drinker

Narcotic use? ☐ Y ☐ N Is it MD prescribed? ☐ Y ☐ N If yes, by whom? _____

Are you pregnant? ☐ Y ☐ N If yes, due date _____

Your occupation? _____ Are you currently working? ☐ Y ☐ N If yes, ☐ Full-Duty ☐ Light-Duty

What are your restrictions? _____

REVIEW OF SYSTEMS

*DO YOU **CURRENTLY** HAVE ANY OF THE FOLLOWING: CHECK ALL THAT APPLY AND PLEASE INCLUDE DETAILS AND DATES OF ONSET*

☐Y☐N Arthritis_____

☐Y☐N Ear, Nose, Throat Problems_____

☐Y☐N Eye Problems_____

☐Y☐N Heart Attack, Chest Pain, Irregular Heart Beat_____

☐Y☐N Neurological Disorders_____

☐Y☐N Psychiatric Treatment_____

☐Y☐N Skin Disorders_____

☐Y☐N Weight Loss_____

☐Y☐N Ulcer or Digestive System Disorders_____

☐Y☐N Urinary, Bladder, Kidney Problems_____

☐ Other_____

Patient/Responsible Party Signature _____ Date _____

I have read and reviewed this patient history form.

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

Southwest Joint Replacement & Sports Medicine Center

Patient Name _____ Date of Birth _____ Today's Date _____

1. **_____(Initial) Financial Agreement.**

- I acknowledge, that as a courtesy, **Southwest Joint Replacement & Sports Medicine Center** may bill my medical insurance company for services provided to me.
- 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 that there is a fee for returned checks of $25.
- 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.

2. **_____(Initial) Third Party Collection**.

I acknowledge that **Southwest Joint Replacement & Sports Medicine Center** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. **_____(Initial) Assignment of Benefits.**

I hereby assign to **Southwest Joint Replacement & Sports Medicine Center** any insurance or other third-party benefits available for health care services provided to me. I understand **Southwest Joint Replacement & Sports Medicine Center** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Southwest Joint Replacement & Sports Medicine Center**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. **_____(Initial) Medicare Patient Certification and Assignment of Benefit.**

I certify that any information I provide, if any, in applying for payment under Title XVIII ("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 **Southwest Joint Replacement & Sports Medicine Center** by the Medicare or Medicaid program.

5. **_____(Initial) Consent to Telephone Calls for Financial Communications.**

I agree that, in order for **Southwest Joint Replacement & Sports Medicine Center**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Southwest Joint Replacement & Sports Medicine Center** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **Southwest Joint Replacement & Sports Medicine Center** 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.

6. **_____(Initial) General Consent to Treat.**

I, the undersigned, hereby consent to the following: Administration and performance of general treatments use of prescribed medications, performance of diagnostic procedures/test and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.

7. **_____ (Initial) 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.