

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)

- | | | | |
|---------------------------------------------|-----------------------------------------|--------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Referring Provider | <input type="checkbox"/> Google+ | <input type="checkbox"/> Other Social Media | <input type="checkbox"/> Care Now |
| <input type="checkbox"/> Family/Friend | <input type="checkbox"/> Online Profile | <input type="checkbox"/> Other Physician Profile | <input type="checkbox"/> Marketing Mailer |
| <input type="checkbox"/> Website | <input type="checkbox"/> Facebook | <input type="checkbox"/> Living Well Magazine | <input type="checkbox"/> Medical City Dallas Hospital/ER |
| <input type="checkbox"/> Search Engine | <input type="checkbox"/> D Magazine | <input type="checkbox"/> Health Grades or Vitals | <input type="checkbox"/> 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

YN Anemia or Bleeding Problems YN Cancer YN Heart Attack YN High Cholesterol YN Stroke

YN Blood Clots YN Chest Pain YN Heart Disease YN Hypertension YN Ulcer

YN Blood Transfusion YN Diabetes YN Hepatitis YN 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

YN Previous orthopedic fractures or surgeries: _____

YN Appendectomy-Date:_____ YN Gall Bladder-Date:_____ YN Hysterectomy-Date:_____

YN Back Surgery-Date:_____ YN Heart Surgery-Date:_____ YN Thyroid-Date:_____

YN CABG-Date:_____ YN Hemorrhoids-Date:_____ YN Tonsillectomy-Date:_____

YN Cancer Surgery-Date:_____ YN Hernia Repair-Date:_____

YN 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? <input type="checkbox"/> YES <input type="checkbox"/> 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

YN Arthritis _____

YN Ear, Nose, Throat Problems _____

YN Eye Problems _____

YN Heart Attack, Chest Pain, Irregular Heart Beat _____

YN Neurological Disorders _____

YN Psychiatric Treatment _____

YN Skin Disorders _____

YN Weight Loss _____

YN Ulcer or Digestive System Disorders _____

YN 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.