Texas Orthopaedic Associates FW, LLP **NEW PATIENT FORM** **Date**

Name Last ________________________ First ________________ Middle ______________ Preferred Name _____________
DOB _______/_______/___________ **Age** _________ **SSN** _______/_________/_________________
Sex ☐Male ☐Female ☐___________________ Cell Phone # (________)_________-_____________
Marital Status ☐Single ☐Married ☐Other Home Phone # (________)_________-_____________
Spouse's / Partner's Name _______________________________ Work Phone # (________)_________-_____________
Home Address ____ Apt. No. __________
City ________________________________ State _____________ Zip _____________
Employed ☐Yes ☐No **Employer(s)** ____
Occupation(s) ____
Address ____ City/State/Zip ___________________________________

Student ☐Yes ☐No **School** ______________________________________ City/State __________________________
List all sports played ____ Date of Injury _______________________
Coach Name ____ Cell Phone # (________)_________-____________
Athletic Trainer Name ___________________________________ Cell Phone # (________)_________-____________
Athletic Trainer email _______________________________________

Who referred you to this office? ☐Physician ☐Coach ☐Trainer ☐Friend Name _________________________________
Primary Care Physician ___________________________________ Office Phone # (________)_________-_____________
Preferred Pharmacy ______________________________________ Bus Phone # (________)_________-_____________
Preferred Pharmacy Address ____ City/State __________________________

Emergency Contact Information
Name ____ Cell Phone # (________)_________-_____________
Relationship ____________________ DOB ____/______/_______ Home Phone # (________)_________-_____________
Email ____ Work Phone # (________)_________-_____________
If a minor, please provide parent/guardian information
Primary Contact ☐**Same as Emergency Contact**
Name _______________________________ Relation ____________ Cell Phone # (________)_________-____________
Secondary Contact
Name _______________________________ Relation ____________ Cell Phone # (________)_________-____________
Name _______________________________ Relation ____________ Cell Phone # (________)_________-____________

Release of Medical Information to School or Organization Medical and Operational Personnel:
I ______________________________________ (Parent / Legal Guardian if above named patient is a minor):
AUTHORIZE _____ (Initials) **the release of all medical records** from **TEXAS ORTHOPAEDIC ASSOCIATES, LLP (An Ortho Lone Star Affiliate)** to the above-mentioned school / organization and or school / organization representatives as it relates to my medical care (or to my child's medical care). This includes, but is not limited to: appointments, records, office dictations, treatment plans, test results, therapy reports and insurance information. And **I AUTHORIZE** the office personnel and medical providers at **TEXAS ORTHOPAEDIC ASSOCIATES, LLP (An Ortho Lone Star Affiliate)** to personally discuss or disclose relevant information to the above-mentioned school / organization and or school / organization representatives as it relates to my (or my child's) appointments, treatment, medical care, test results, progress, prognosis, and insurance. This Authorization will remain in effect until I provide written Notification to **TEXAS ORTHOPAEDIC ASSOCIATES, LLP (An Ortho Lone Star Affiliate)** of changes or updates to this authorization.

DECLINE _____ (Initials) all communication and release of medical information to the above-mentioned school or organization and its representatives as it relates to my (or to my child's) medical care.

________________________________ ____________________
Signature (Self or Parent / Legal Guardian) Date

Texas Orthopaedic Associates FW, LLP **NEW PATIENT FORM** **Date**

☐ **I authorize release** of my medical information to **TEXAS ORTHOPAEDIC ASSOCIATES, LLP (An Ortho Lone Star Affiliate)**

Acknowledgement: I, the undersigned, certify that I have read and fully understand the information in this Health Information Authorization form. I understand that if I need to change my information I have provided on this form, I will notify a staff member promptly.

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple health care providers who may be involved in that treatment directly or indirectly;
- Obtain payment from third party payers;
- Conduct normal health care operations such as quality assessments and physician certifications;
- Conduct research.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that **TEXAS ORTHOPAEDIC ASSOCIATES, LLP (An Ortho Lone Star Affiliate)** has the right to change its Notice of Privacy Practices from time to time and that I may contact their Compliance Officer at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

Do we have your permission to:

1. Leave a message on your answering machine regarding your appointment(s)? ☐ Yes ☐ No
2. Leave a message on your answering machine asking you to call our office? ☐ Yes ☐ No
3. Contact you at your place of employment? ☐ Yes ☐ No
4. Discuss and or coordinate your treatment plan with other care providers including, but not limited to Physicians, Therapists, Athletic Trainers, etc. ☐ Yes ☐ No

Names of People with whom we can discuss your medical condition, including appointment information:

Name ______________________ Relationship/Phone ______________________

Name ______________________ Relationship/Phone ______________________

Name ______________________ Relationship/Phone ______________________

Name ______________________ Relationship/Phone ______________________

May we provide your athletic trainer, coach, team doctor and their associates with your health information? Yes No

______________________ ______________________ ______________________

Print Patient's Name Date of Birth Address

______________________ ______________________ ______________________

Signature / Patient or Authorized Representative Relationship Date

______________________ ______________________ ______________________

Witness Title Date

Date_______________

For Nurse	
Pulse ______________	
BP________/________	

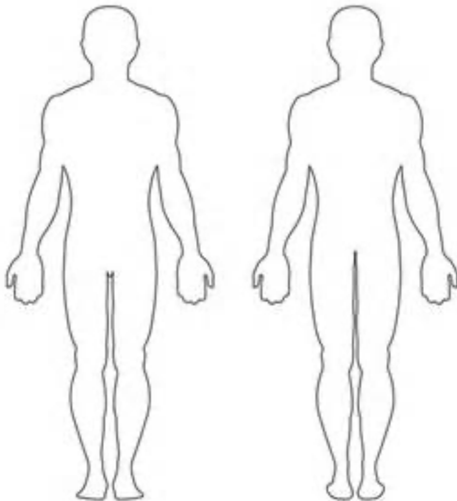
Texas Orthopaedic Associates, LLP
Fort Worth – An Ortho Lone Star Affiliate
General Medical Information

For Nurse	Temp ________
Temp Other ______________	

Patient Name______________________**Nickname** __________**DOB**______________**Doctor**____________

Age ________ **Height** _________ **Weight** _______ **I am:** ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Mark where you are experiencing pain.



Check the boxes next to where you have **pain or problems**

☐ Neck			☐ Mid Back	
☐ Upper Back	Right Left		☐ Lower Back	
☐ Shoulder Blade	Right Left		☐ Pelvis	Right Left
☐ Shoulder	Right Left		☐ Hip	Right Left
☐ Arm	Right Left		☐ Thigh	Right Left
☐ Elbow	Right Left		☐ Knee	Right Left
☐ Forearm	Right Left		☐ Leg	Right Left
☐ Wrist	Right Left		☐ Ankle	Right Left
☐ Hand	Right Left		☐ Foot	Right Left

When did your symptoms **FIRST** begin? (Date if known)____________________________**Pain Level** (0-10)__________

Describe how the problem or condition **FIRST** began____

Mark an **X** in the box next to **all other orthopedic problems** for which you have had treatment, **and explain:**

If NONE mark here ☐

	Circle	Year	Explain: *Diagnosis, tests, treatment, surgery, physician, etc.*
☐ Neck			
☐ Mid Back			
☐ Low Back			
☐ Chest Wall			
☐ Abdominal Wall			
☐ Scapula	Right Left		
☐ Shoulder	Right Left		
☐ Elbow	Right Left		
☐ Wrist/Hand	Right Left		
☐ Pelvis	Right Left		
☐ Hip	Right Left		
☐ Thigh	Right Left		
☐ Knee	Right Left		
☐ Ankle/Foot	Right Left		
☐ Other	Right Left		

Date__________________

List All Medication Allergies ☐ None ____________________

List All Other Allergies ☐ None ____________________

List All Medications (dosage & frequency) ☐ None ____________________

____

____

List all Nutritional Supplements ☐ None ____________________

____

Pharmacy Name / Number ____________________

Mark an **X** in the box next to **all** of the following conditions that **you** have had **and describe:**

If NONE mark here ☐

☐ Diabetes (Type)	☐ Skin Disease
	☐ Muscle Disease
☐ Heart Murmur or Heart Valve Disease	☐ Bone Disease
☐ Heart Disease, Vascular Disease	☐ Ankylosing Spondylitis
☐ Heart Attack	☐ Fracture
☐ Abnormal Heart Rhythm	☐ Dislocation
☐ High Cholesterol	☐ Ligament Injury
☐ High Blood Pressure	☐ Tendon Injury
☐ Low Blood Pressure	
☐ Anemia	☐ Congenital Dysplasia, Disorder or Condition
	☐ Connective Tissue Disorder (i.e. Marfans, Ehlers Danlos)
☐ Blood Clots (Lung or Limb)	☐ Inflammatory Arthritis (i.e. Rheumatoid, Gout)
	☐ Autoimmune Disease
☐ Asthma	☐ Metabolic Disease
☐ Lung Disease	
☐ Sleep Apnea	☐ Fibromyalgia
	☐ Complex Regional Pain Syndrome
☐ Skin Infection (ie. MRSA)	
☐ Any Infectious Disease	☐ Cancer (Type)
☐ Hepatitis (ie. A, B, C, Other)	☐ Tumor
☐ HIV AIDS	
	☐ Concussion / head injury
☐ Kidney disease	☐ Severe / frequent headaches (Migraines)
☐ Stomach Ulcer / GERD	☐ Stroke
☐ Ulcerative Colitis	☐ Seizure disorder
☐ Crohns Disease (IBF)	Last Seizure Date
☐ Thyroid disease	☐ Drug or Narcotic Dependency
☐ Liver Disease	☐ Alcohol Dependency

List <u>All Other</u> Medical Problems: ____________________

____

Date__________________

List <u>All Other</u> Previous Surgeries: ____

____

Do you have or have you had **any other injuries or sport related problems** not mentioned above? ☐ No ☐ Yes

Explain____

____

Have you ever had a blood transfusion? ☐ No ☐ Yes When______________________

Do you have a diagnosed blood clotting disorder? ☐ No ☐ Yes Describe______________________
Do you bruise easily? ☐ No ☐ Yes Describe______________________
Do you bleed for a prolonged time period when cut? ☐ No ☐ Yes Describe______________________

Are you missing a paired organ (ie kidneys, testicles, etc.) ☐ No ☐ Yes Describe______________________

Have **<u>you</u>** or anyone in **<u>your family</u>** ever had any **complications or problems from anesthesia?** ☐ No ☐ Yes

Explain any anesthesia complications____

Mark an **X** in the box next to **<u>all</u>** of the following conditions that a **<u>Family Member</u>** has had and **<u>explain</u>**:

If NONE mark here ☐

Condition	**Explain**
Diabetes	
Lung Disease / Asthma	
Heart Disease / Attack	
Stroke	
High Blood Pressure	
Blood Clots	
Bleeding Disorder / Anemia	
Muscle Disease	
Bone Disease	
Osteoarthritis	
Inflammatory Arthritis	
Autoimmune Disease	

Do you drink beer or alcohol? ☐ No ☐ Yes How often ______________________

Do you smoke? ☐ No ☐ Yes Packs per week__________________ Years?______________
Do you use smokeless tobacco? ☐ No ☐ Yes Cans/bags per week________If you use tobacco, please STOP
Have you been advised to quit? ☐ No ☐ Yes Quit date______________________

My signature below indicates that the above information is true and correct to the best of my knowledge.

Signed ____**Date**______________________
(Parent / Guardian for Minor)