DALLAS ORTHOPEDIC & SHOULDER INSTITUTE

JEFF ZHAO, D.O.
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Patient Information

Name:_____

Date of Birth ___/___/____ Sex: M F SS# _____

DL# _____ Issue State _____

Address:_____

City _____ State:_____ Zip: _____

Cell Phone: _____Home Phone: _____ Work Phone: _____

Email _____@_____

Name of Primary Care Physician: _____

Office Phone: _____

How did you hear about us? (Examples: Your doctor, Internet search, hospital, insurance, family/friend, etc)_____

(Please Complete if Patient is a Minor)

Legal Guardian Name: _____ Relationship: _____

Address (if different from above):_____

City_____ State: _____ Zip: _____

Emergency Contact & Authorization to Disclose Information

Name:_____ Relationship: _____
Phone: _____ Authorized to disclose information (Y/N) Medical/Financial/Both

Name:_____ Relationship: _____
Phone: _____ Authorized to disclose information (Y/N) Medical/Financial/Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that:
1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized.

Pharmacy Information

Pharmacy Name: _____Phone: _____

Location: _____

Primary Insurance Information

Insurance Company:_____

Policy Holder Name:_____ ID/Policy #:_____

Group#:_____

Policy Holder Date of Birth: ____/____/_____ SS# _____

Secondary Insurance Information (If any)

Insurance Company:_____

Policy Holder Name:_____ ID/Policy #:_____

Group#:_____

Policy Holder Date of Birth: ____/____/____ SS# _____

Workers' Compensation (If any)

Are you being seen today for a WORK-RELATED injury? (Y/N) _____

Have you filed for a WORKERS' COMPENSATION claim? (Y/N) _____

If answer Y for one of the 2 questions above, please answer the followings:

When was the date of injury? (MM/DD/YYYY) _____

Employer: _____ Contact phone: _____

Insurance Company: _____

ID/Policy #:_____ Group#:_____

Claim Address: _____

Adjuster/Case manager name: _____

Adjuster/Case Manager Phone: _____

Patient Signature:_____ Date: _____/_____/_____

(Parent or Legal Guardian if Minor)

Patient Name: _____**Date:** _____

What is the reason for your visit? _____

_____

_____

Past Surgical History

Have you had any prior surgeries? ___ Yes ___ No

Please list all surgeries you have had with the surgeon name:_____

_____

_____

_____

Social History

What is your occupation? _____Retired/Disabled

Who lives at home with you? _____

Do you smoke? ___ Yes ___ No Do you use illicit drugs? ___ Yes ___ No

Do you drink Alcohol? ___ Yes ___ No If yes how Frequent?_____

Family History

Relation to Patient	Are they living?	If deceased what was the cause death?	If deceased at what age did they pass?
Mother			
Father			
Sibling			

Please list any DRUG ALLERGIES:_____

_____

Please list all your current medications.

Medication	Strength	Number of Times a Day
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	
	mg	

Do you have these medical conditions?

Recent chills/ fever	Yes	No	Abdominal Pain	Yes	No
Recent bruising	Yes	No	Kidney problems	Yes	No
Recent Skin Rash	Yes	No	Infections in urine	Yes	No
Arthritis	Yes	No	Blood in Urine	Yes	No
Visual disturbances	Yes	No	Connective tissue disorder	Yes	No
Neck pain	Yes	No	Back pain	Yes	No
Asthma	Yes	No	Joint pain	Yes	No
Bronchitis	Yes	No	Seizures	Yes	No
Emphysema	Yes	No	Stroke	Yes	No
Pneumonia	Yes	No	Dizziness	Yes	No
Shortness of Breath	Yes	No	Incontinence of Stool	Yes	No
Tuberculosis	Yes	No	Syncope	Yes	No
High Blood Pressure	Yes	No	Weakness in Extremities	Yes	No
Chest Pain	Yes	No	Psychiatric problems	Yes	No
Heart Attack	Yes	No	Anxiety	Yes	No
Circulatory problems	Yes	No	Depression	Yes	No
Palpitations	Yes	No	Diabetes	Yes	No
Swelling of Extremities	Yes	No	Thyroid problems	Yes	No
Gallbladder problems	Yes	No	Cancer	Yes	No
Peptic ulcer disease	Yes	No	Hepatitis	Yes	No
Blood in stools	Yes	No	Rheumatism	Yes	No
Persistent black stools	Yes	No	Sexual Dysfunction	Yes	No
Recent Constipation	Yes	No	Unusual Bleeding	Yes	No
Recent Diarrhea	Yes	No	Blood clots	Yes	No

Other medical conditions that are not listed above? _____

_____

_____

_____

_____

_____

Assignment of Benefits/Notice of Privacy Practices/Appointment of Authorized Representative

Please read and initial each paragraph

_____ Dallas Orthopedic and Shoulder Institute and associated physicians are committed to securing the privacy of your health information.

_____I request that payment of authorized Medicare and other insurance benefits be made on my behalf to Dallas Orthopedic and Shoulder Institute for any services furnished to me by any healthcare providers associated with that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or insurance company any information needed to determine these benefits or the benefits payable for related services.

_____I appoint Dallas Orthopedic and Shoulder Institute to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

_____Unless I request to the contrary in writing, I will accept appointment reminders on my listed telephone answering system and/or appointment reminder sent by texts and emails, whichever is the policy of this practice

Informed 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 the treatment after knowing the risks and hazards involved.

WEIGHING RISKS AND BENEFITS: Just as there may be risks in continuing my present condition without treatment, there are also risks and benefits related to the performance of the medical, surgical and/or diagnostic procedures. I (we) understand that common to any procedures is the potential for discomfort, such as pain, redness and/or swelling. Other potential risks also include but not limited to infection, blood clots, and allergic reactions

Please initial the followings:

_____ I (we) voluntarily request DR JEFF ZHAO as my physician, and such associates, assistants and other health care providers as they may deem necessary to treat my condition which will be explained to me during the process of my (our) medical care.

_____ I (we) understand that medical, surgical, and/or diagnostic procedure(s) will be recommended as deemed necessary.

_____ I (we) understand risks vs. benefits will be explained to me prior to any procedures being performed.

_____ I (we) understand that I (we) have the right to refuse any services recommended.

Patient Financial Responsibility Statement

In order to maintain our fees at the lowest possible level, it is important that we have a good understanding with our patients regarding financial responsibility. We hope that this summary will be helpful toward that end. We encourage you to discuss it with us and to ask questions.

We understand that your health coverage is provided through

- If you have out-of-network benefits, we will happily file claims on your behalf.
- You must pay any co-payment and applicable deductible amounts at the time of service unless other arrangements have been made with our office, Dallas Orthopedic and Shoulder Institute.
- The remainder of your bill will be sent to your health plan for direct payment to our office
- If your insurance carrier has not paid our claim within 45 days, we will expect payment from you.
- If, by mistake, your health plan remits payment to you, you agree to send it to us along with all paperwork sent to you at the time.
- You will remain responsible for amounts and any services that are not covered by your insurance plan.
- Your health plan may refuse payment of a claim for some of the following reasons:
    1) This is a pre-existing illness that is not covered by your plan
    2) You have not met your full calendar year deductible
    3) The type of medical service required is not covered by your plan
    4) The health plan was not in effect at the time of service
    5) You have other insurance which must be filed first

Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your medical insurance for you, we are not responsible for any limitations in coverage that may be excluded in your plan. If your health plan denies this claim for any of these or other reasons, our office cannot be responsible for this bill. It is your responsibility as the patient to pay the denied amounts in full.

As a part of convenience service to you, our office provides DMEs (durable medical equipment), such as arm slings, shoulder braces, and etc to those in need of them. Our specialized staff will fit appropriately for you for the correct DME. In cases of imperfect fit, we will be happy to refit you at no additional cost as long as you notify us ASAP when you start noticing problems. You may also return UNUSED item in its ORIGINAL package within **7** days of receipt to receive full refund.

Our primary mission is to provide you with quality, cost effective, medical care. Together we are trying to adapt to the changing way that health care is financed and delivered. However, we reserve the right to refuse service if you have an outstanding account balance that no payment has been arranged. Again, we value you as a patient and our first priority is to provide you with the best possible care. With this housekeeping chore complete, we are pleased to serve you.

I have completed this form with accurate information and have read and understand my obligations. I acknowledge that I am fully responsible for supplying correct insurance information, billing information, and payment of any services not covered or approved by my insurance carrier.

No Show Policy

A "no show" is someone who misses an appointment without canceling 24 hours (1 working day) in advance. No-Shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no show". An administrative fee of $40 may be billed to the patients account. The patient will be sent a letter alerting to the fact that they have failed to show up and did not cancel within the 24-hour time period in advance. A copy of the letter will be placed in the patient's file. Three "no-shows" may result in the temporary suspension of services. In order to reinstate services, the patient may be required to pay all fees associated with the no show policy.

Patient Name or Responsible Party/Guardian (Please Print): _____

Signature: _____

Date: _____