Patient Registration
Fondren Orthopedic Group

NEW PATIENT _____
DATE: _____ UPDATE: _____

PLEASE COMPLETE ENTIRE FORM **PATIENT INFORMATION**

NAME: _____
(Last Name) (First Name) (Middle Initial)

ADDRESS: _____
(City) (State) (Zip Code)

DOB: _____ AGE: _____ MALE / FEMALE MARITAL STATUS: _____ SOCIAL SECURITY #: _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE: _____

DRIVER'S LICENSE #: _____ EMPLOYER: _____

HOME NUMBER: _____ CELL PHONE _____ WORK PHONE: _____

EMAIL ADDRESS: _____ @ _____

PRESCRIPTIONS ARE NOW COMPLETED ELECTRONICALLY. PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW:

NAME: _____ PHONE: _____ ADDRESS(CROSS STREETS): _____

HOW WERE YOU REFERRED TO OUR OFFICE? CIRCLE ONE: **Dr. BENNETTS' WEBSITE** **FRIEND** **INSURANCE**

PHYSICIAN: _____ **MAGAZINE:** _____
(If by a physician please print physician's full name and phone number)

INSURANCE INFORMATION

***** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM *****

PRIMARY INSURANCE: _____ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? _____ DOB: _____ SS#: _____

EMPLOYER NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? _____ DOB: _____ SS#: _____

EMPLOYER NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

GUARANTOR INFORMATION (if different Patient)

SPOUSE PARENT GUARDIAN NAME: _____

EMPLOYER: _____ PHONE: _____

BUSINESS ADDRESS: _____ CELL: _____

MEDICAL HISTORY (Please answer Yes or No)

ON THE JOB INJURY: YES NO IF YES, DATE OF INJURY: _____ DATE LAST WORKED: _____

MOTOR VEHICLE ACCIDENT: YES NO IF YES DATE IF ACCIDENT: _____

IN CASE OF EMERGENCY

*****PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOU RESIDENCE*****

NAME : _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____

ASSISGNMENT AND RELEASE

This signature will authorize Fondren Orthopedic Group L.L.P. physicians to provide the indicated Medial/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Fondren Orthopedic Group L.L.P. all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medial information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: _____ Date: _____

Signature of Patient (or parent): _____ Date: _____

PATIENT HISTORY

IN ORDER TO COMPLY WITH ELECTRONIC MEDICAL RECORD GUIDELINES PLEASE COMPLETE ENTIRELY.

NAME: _____ **AGE:** _____ **Todays Date:**_____

Occupation: _____ **Height:**_____ **Weight:** _____

FEMALES: Are you pregnant? _____ **Last menstrual cycle** _____

PLEASE TELL US THE REASON FOR TODAYS VISIT INCLUDING BODY PART :

_____

_____

RIGHT OR LEFT SIDE: _____ **DATE SYMPTOMS BEGAN:** _____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM? NO YES

If YES, from whom: _____ Date : _____

Were x-rays taken: NO YES If YES , what body part: _____

LIST ALL ALLERGIES TO MEDICATIONS or CHECK ☐ NONE _____

LIST CURRENT MEDICATIONS (PLEASE INCLUDE ANY SUPPLEMENTS) OR CHECK ☐ NONE

_____

_____

Illnesses: ☐ None ☐ Diabetes ☐ Heart Trouble ☐ Hypertension ☐ Emphysema ☐ Asthma ☐ TB ☐ Ulcer ☐ Cancer ☐ Thyroid ☐ Hepatitis

☐ Other (explain) _____

Surgeries: ☐ None ☐ Tonsillectomy ☐ Appendectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Gallbladder

☐ Other (explain) _____

Transfusions: ☐ No ☐ Yes (explain) _____

Any problems with anesthesia ? ☐ No ☐ Yes (explain)_____

Hospitalizations Other than Surgery: ☐ No ☐ Yes (explain) _____

Habits: Tobacco: ☐ No ☐ Yes Type:_____How much per day?_____ ☐ Previous – Year Quit?_____

Drink Alcohol?: ☐ No ☐ Yes _____drinks per day **Use Drugs?:** ☐ No ☐ Yes

Family History	Age	Living/Deceased	Illnesses/Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			

Review of Systems: (Check all that apply)

General
____ Weight Loss
____Weight Gain
____Poor appetite
____Chills
____Fevers
____Night sweats

Cardiovascular
____Chest Pain(angina)
____Palpitations
____ Irregular heartbeat
____Rheumatic Fever
____Swollen ankles
____Shortness of breath on exertion
____Shortness of breath at night

Dermatology
____Rash
____Hives
____Lesions

Respiratory
____Shortness of breath
____Wheezing
____Coughing
____Coughing up blood

Neurological
____Loss of consciousness
____Headaches
____Dizziness
____Seizures
____Fainting spells

Infectious Disease
____Hepatitis
____HIV
____Other _____

Psychiatry
____Anxiety
____Depression
____Other _____

Gastrointestinal
____Indigestion
____Gas
____Nausea
____Vomiting
____Yellow skin
____Abdominal pain
____Constipation
____Diarrhea
____Black Stools
____Rectal bleeding

Renal
____Frequent urination
____Urgent urination
____Painful urination
____Need to awaken to urinate
____Blood in urine
____Penile or vaginal discharge

Endocrine
____Lymph node swelling
____Node tenderness
____Excessive appetite
____Heat intolerance
____Cold intolerance

Signature: _____ Date: _____

I certify that the information provided above is correct and true

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE
Fondren Orthopedic Group L.L.P

I, (name of patient) _____,
acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's Notice of Privacy Practices and have completed the form below to the best of my knowledge.

_____ _____ _____
Signature of Patient or Guardian Relationship to Patient Date

Clinic Use Only
Fondren Orthopedic Group, L.L.P made the following good faith efforts to obtain athe above referenced individual's written acknowledgement of the Notice of Privacy Practices:

_____ _____
Signature of Employee Date

Family and Friends

Persons who are involved in your care(family, spouses, friends, other doctors "PCP" etc.) may inquire about your treatment, ab results, prescriptions, etc. **IF THEY ARE NOT ON THE LIST, WE CANNOT SPEAK WITH THEM REGARDING YOUR CARE.** Please let us know what person(s) we may share information with and list them below.

_____ _____
_____ _____
_____ _____
_____ _____

What other ways may we contact you? From time to time we will leave a message for you (as stated in our Privacy Practices) on answering machine, voice mail, or another individual in your absence. **Is it OK to leave message that includes details (such as diagnosis and medication information) at the numbers you have provided below:**

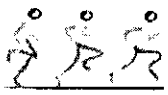
Home Number: _____ YES or NO

Work Number: _____ YES or NO

Cell Number : _____ YES or NO

Other Number: _____ YES or NO

_____
Patient Signature Date



Fondren Orthopedic Group L.L.P.

Patient Name: _____ Clinic ID#: _____

Insurance Company: _____ SS#: _____

Provider Number: 716 Statement Group: _____

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment.

I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

MEDICARE – PATIENT'S CERTIFICATION: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

I have **Medicare Part B** coverage: ☐ Yes ☐ No

If yes, the type of coverage:

☐ Traditional Medicare OR ☐ Medicare Replacement Policy (HMO)

Medicare is my primary or secondary coverage: [-]

I have **Medicaid** coverage: ☐ Yes ☐ No

If yes, the type of coverage is:

☐ Traditional Medicaid OR ☐ Medicaid HMO Policy

Medicaid is my primary or secondary coverage: [-]

I am seeing the doctor for a work-related injury: ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

☐ Payment is required today for all copays, deductibles, or co-insurance amounts that may be due by the patient.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

Signature of Insured/Guardian Date Witness Date

Fondren Orthopedic Group L.L.P.
7401 South Main Street
Houston, TX 77030-4509
281-633-8600

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to : (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

Patient's Name _____ Fondren Account Number _____

Patient's Signature _____ Date _____

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

Legal Representative's Name _____

Legal Representative's Signature _____ Date _____

Fondren Orthopedic Group L.L.P.
J. Michael Bennett, M.D.
4690 Sweetwater Blvd., Suite 240
Sugar Land, Texas 77479

Patient Financial Disclosure Notice

Pursuant to the requirements of Section 105.002 of the Texas Occupations Code, this is to inform you that Dr. J. Michael Bennett has a financial ownership interest in **Texas Sports Medicine Institute, 7830 West Grand Parkway, Richmond, TX77406** **Sugar Land Surgical Hospital, 1211 Highway 6, Sugar Land, TX 77479** and **PLEX 99, 7830 West Grand Parkway, Richmond, TX 77406** and may, indirectly, receive compensation for services you receive at the Facility.

You, as the patient of Dr. J. Michael Bennett, have the option of using an alternative health care facility, other than the ones listed above, if you so desire.
By signing below, you are attesting that you have read and understand the information provided above.

_____
PATIENT'S PRINTED NAME

_____ _____
PATIENT'S SIGNATURE DATE SIGNED