



## Patient Profile

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Home#: ( ) \_\_\_\_\_ Work#: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Preferred Contact Method: email/cell/work/home

Marital Status: \_\_\_\_\_ Sex: Male/Female SS#: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone # ( ): \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone # ( ): \_\_\_\_\_

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: Latino/Not Latino/Decline

Next of Kin/Emergency Contact & Phone #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

If you are being seen for an injury, please indicate if it is the following:  Work injury claim  School injury claim

**INSURANCE INFORMATION:** (If you have Medicare and a secondary plan, please inform the receptionist)

Insurance Carrier: \_\_\_\_\_ Member ID#: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Insured: Self/Spouse/ Child/Other

Insured's Date of Birth: \_\_\_\_\_ Insured's SS# \_\_\_\_\_

I authorize Orthopedic Specialists to release medical information that may be necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with Orthopedic Specialists. If surgery is required I assign all medical and or surgical benefits to include major medical benefits to which I am entitled to Orthopedic Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of assignment is to be considered as valid as an original. I understand that this office does not accept returns or issue refunds for any durable medical equipment. I understand that all refunds for my account must be requested by myself or my guarantor, and may take up to 90 days to process. I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed. This includes the knowledge that all communications via email are not secure, and any information I send/receive is also not secure.

In the event I should need surgery, I understand Dr. Cook, Noack, and Grantham are in partnership with a group of surgeons and Texas Health Resources in the ownership of Texas Institute for Surgery.

By signing below, I acknowledge that I have read and agree to the above information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Orthopedic Specialists  
8440 Walnut Hill Ln., Ste 110  
Dallas, TX 75231



## Financial Policy

Thank you for choosing our office as your health care providers. We are committed to providing excellent health care services. As part of our professional relationship, it is necessary that you have an understanding of our financial policy.

**ALL PARENTS/PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING ANY TREATMENT.**

You understand and accept that it is your responsibility to:

Provide us with your current active insurance at every visit. Failure to do this may prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied. Failure to do this may prevent this office from filing your claims to meet insurance timely filing deadlines, and you will be financially responsible for any services denied.

Provide us with your current billing and contact information. You may call us at any time to update this information. Know and understand your contractual insurance benefits including if we are participating providers for your insurance plan.

Copays, deductibles, and coinsurances are due at the time of services rendered.

All fees collected at the time of service are estimates based on your plan benefits verified through your insurance, and you may receive additional charges or a credit after insurance has processed all claims.

You will receive a statement (to the billing address you provide) notifying you of any balance due on your account. If you have any questions, it is your responsibility to contact our billing department within 30 days of receipt of your statement.

Refunds can only be issued after your insurance has processed all outstanding claims, and may take up to 90 days to process.

Failure to keep your account balance current may require us to cancel your appointment.

You will be charged a **\$25 Returned Check Fee** for any checks that the bank returns unpaid for any reason as well as any credit card chargebacks.

You may be charged a **NO SHOW Fee of \$35** if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

**WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND DISCOVER.**

By signing this form, you acknowledge you have read, understand, and accept this policy.

**Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## HIPAA AUTHORIZATION & CONSENT TO CARE

### HIPAA Authorization:

I, (patient name) \_\_\_\_\_ give permission to Orthopedic Specialists to release my protected health information described below to:

Name(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DO NOT** leave a voice message with any of my protected health information when calling my phone number(s) provided

### Health information to be released (check all that apply):

My complete medical records (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions)

**OR**

My complete medical records with the exception of the following information: \_\_\_\_\_

By signing below, I understand that this medical information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes or related reasons. I also understand this will be effective until I revoke it in writing by notifying my healthcare provider(s) in writing.

**Signature of Patient/Authorized Person:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### General Consent to Care:

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical care and treatment including but not limited to x-rays and cortisone injections, as ordered by a provider, while such medical care and treatment is provided through Orthopedic Specialists (Drs. Cook, Noack, & Grantham) on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Orthopedic Specialists is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Orthopedic Specialists facilities.

By signing below, I acknowledge that I have read and agree to the above information. I hereby give my consent to receive medical care and/or treatment from the providers of Orthopedic Specialists.

**Signature of Patient/Authorized Person:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## Patient Questionnaire

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please describe the problem you are here for today:  Left  Right  Ankle  Foot  Knee  Shoulder  Elbow

Other (Please explain) : \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_ Date of injury (if applicable): \_\_\_\_\_

If it is an injury, how did the injury happen and where did it occur: \_\_\_\_\_

Is this a work related injury? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please check mark the type of symptoms you have: (check all that apply)

Sharp  Aching  Stabbing  Dull  Cramping  Throbbing  Pins & Needles  Numbness  Constant  Intermittent

On a scale of 1-10, how severe is the pain? No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

What makes it worse?  Daily activities  Walking  Running  Sports  Other: \_\_\_\_\_

What makes it better?  Rest  Ice  Heat  NSAIDS  Pain medication  Injections  Other: \_\_\_\_\_

Do you walk with an assistive device?  Cane  Crutches  Walker

What physician(s) have you seen for this problem? \_\_\_\_\_

Did you bring:  X-rays  MRI  CT  Bone Scan  Other: \_\_\_\_\_

**MEDICAL HISTORY:** Please check any health issues that apply to you:  No medical problems

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Cancer, breast    | <input type="checkbox"/> Gout                  | <input type="checkbox"/> Childhood diseases                        |
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Cancer, colon     | <input type="checkbox"/> Heart attack          | <input type="checkbox"/> Liver problems                            |
| <input type="checkbox"/> Alzheimer's          | <input type="checkbox"/> Cancer, lung      | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Bleeding problems                         |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Cancer, prostate  | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> History of infections                     |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> COPD              | <input type="checkbox"/> Kidney problems       | <input type="checkbox"/> Neuromuscular disorder (Parkinson's, etc) |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Depression        | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Other heart problems                      |
| <input type="checkbox"/> Blood clot, leg      | <input type="checkbox"/> Diabetes, I or II | <input type="checkbox"/> Seizures              |  |
| <input type="checkbox"/> Blood clot, lung     | <input type="checkbox"/> Drug abuse        | <input type="checkbox"/> Bleeding ulcers       |  |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Sleep apnea       | <input type="checkbox"/> Use of blood thinners |  |

Please describe any other health problems you have not checked in the above list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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# Patient Questionnaire

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SURGICAL HISTORY: Please list any surgeries you have had in the past  No surgical history

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Have you ever had general anesthesia?  Yes  No If yes, any problems?  Yes  No

CURRENT MEDICATIONS: Please list prescription and over the counter medications  No Medications

Name of medication:	Dosage:	How often do you take it:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: \_\_\_\_\_

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FAMILY MEDICAL HISTORY: Please check any of the following family medical problems (immediate family)

- Heart problems  Asthma/emphysema  Bleeding problems
- Drug abuse  Psychiatric problems  Alcoholism
- Stroke  Anesthesia problems  Tuberculosis

SOCIAL HISTORY:  Employed  Student  Disabled  Retired

Do you smoke:  Yes  No If yes, how many per day? \_\_\_\_\_ if no, have you smoked in the past regularly? \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Shoe size: \_\_\_\_\_

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## Fall Risk Assessment

**\*\*\*Complete ONLY if you are 65 years of age or older\*\*\***

Please circle **YES** or **NO** for each statement below:

- YES (3) NO** I have fallen more than once in the past year.
- YES (2) NO** I have fallen once in the past year.
- YES (2) NO** I use or have been advised to use a can or walker to get around safely.
- YES (1) NO** I sometimes feel unsteady or lose my balance when walking.
- YES (1) NO** I sometimes steady myself by holding onto furniture or walls.
- YES (1) NO** I need to push myself up from out of a chair with my hands.
- YES (1) NO** I sometimes have trouble stepping up onto a curb.
- YES (1) NO** I frequently have to rush to the toilet.
- YES (1) NO** I have lost some feeling in both of my feet.
- YES (1) NO** The medication I take sometimes makes me feel light headed or sleepy.
- YES (1) NO** I take medicine to help me sleep or improve my mood.
- YES (1) NO** I often feel sad or depressed.

\_\_\_\_\_ Total Add up the number of points from your circled answers.

If you scored 4 or more points, you may be at risk for falling. Please discuss ways that may help prevent future falls with your physician.

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