Waxahachie Orthopaedics & Sports Medicine

Welcome to our practice! We hope that the following will be helpful for you. We respect you and your time and we would like to make your visit to our office as pleasant and as efficient as possible.

LOCATION:

We are located at 1328 W. Hwy 287 Bypass, Ste. 100, Waxahachie, TX 75165.

CANCELLATIONS:

Please give us 24 hour prior notice if you are unable to make your appointment. If you **NO SHOW** your appointment there will be a $25 charge billed to you. If you are more than 15 minutes late we may reschedule your appointment.

PRESCRIPTIONS:

If you need a refill on a prescription, **you** need to call your pharmacy and request a refill. Refills are to be called in during office hours within 24 hrs from the request from the pharmacy. **PLEASE TRY TO CALL IN FOR A REFILL A FEW DAYS PRIOR TO RUNNING OUT OF THE MEDICATION.**

FINANCIAL POLICY:

We collect patient co-pays and/or deductible/coinsurance at the time of service.

MEDICAL INSURANCE:

Your insurance may not cover the full cost of your charges, regardless of insurance payments; remains are your personal responsibility.

DISABILITY FORMS:

If you are taken off work you may have disability forms for us to complete. We ask for 5-7 days for completion. Each form has a $25 charge, which is required prior to the completion of the form.

MEDICAL RECORDS:

We charge $25 for the first 20 pages and $.15 per page thereafter. The fee is collected prior to the release of records. When requesting medical records, please contact our office at least 5 days prior to needing them.

PATIENT PORTAL:

Our patient portal allows you access to review your medical records, billing statements, the ability to update your demographic information, request appointments, and communicate with our office staff through the message center. **Please let our staff know if you are interested in signing up for our patient portal and completing the portal consent.**

I acknowledge that I have been presented with a copy of Waxahachie Orthopaedics & Sports Medicine's notice of Privacy Practices and understand the office policies.

______________________________________ ____________________________

Signature Date

PLEASE COMPLETE ALL ATTACHED INFORMATION

OFFICE: 972-923-9999 FAX: 972-923-9488

1328 W. Hwy 287 Bypass, Ste. 100 // Waxahachie, Texas 75165

PATIENT'S NAME: ______________________________________ DATE OF BIRTH: ____________________
SEX: M F SOCIAL SECURITY NUMBER: ____
HOME ADDRESS: ____ APT# _________
CITY: ______________________________________ ST: ___________ ZIP CODE: ___________
HOME PHONE#: ____________________________ WORK#: ___________________________________
CELL#: ____________________________________ OTHER#: _________________________________

If you have an answering machine/voicemail may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Waxahachie Orthopaedics & Sports Medicine?
_____ YES ______NO OTHER (EXPLAIN): ____

EMPLOYER: ____________________________________ OCCUPATION: ____________________________
EMPLOYER ADDRESS: ____
CITY: ___________________________________ ST: ________________ ZIP CODE: _________________
MARTIAL STATUS: ___________ SPOUSE'S NAME: ___________________ WORK#: _________________
INCASE OF EMERGENCY WHO MAY WE CONTACT? ____
EMERGENCY CONTACT#: ______________________________ RELATIONSHIP: _____________________

WHICH BEST DESCRIBES YOUR WORK STATUS?
________ WORKING WITHOUT RESTRICTIONS
________ WORKING WITH RESTRICTIONS (MODIFIED DUTY)
________ UNABLE TO WORK DUE TO INJURY DATE LAST WORKED: ______________________
________ HOMEMAKER _____ STUDENT _____ RETIRED _____OTHER: __________________________

IS THE REASON FOR YOUR VISIT TODAY A RESULT FROM **ANY** TYPE OF INJURY? YES/NO
IS YOUR VISIT TODAY RELATED TO AN AUTO ACCIDENT? YES/NO
IF AN INJURY, WHERE DID THE INJURY OCCUR? (CIRCLE ONE) HOME WORK SCHOOL OTHER
IF OTHER, PLEASE EXPLAIN: ____

WHERE XRAYS TAKEN OF THIS INJURY/PROBLEM: NO/YES-WHERE? ___________________________
HAVE YOU HAD AN MRI OR ANY OTHER TEST? NO/YES-WHERE? ___________________________

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INSURANCE INFORMATION

PRIMARY INSURANCE: _________________________ SECONDARY INSURANCE ___________________
IS YOUR INSURANCE THROUGH YOUR EMPLOYER OR YOUR SPOUSE'S? ____________________________
IF INSURANCE IS THROUGH YOUR SPOUSE'S EMPLOYER, PLEASE COMPLETE THE FOLLOWING:
SPOUSE'S EMPLOYER: ____
SOCIAL SECURITY#: _______________________ SPOUSE'S DATE OF BIRTH: __________________

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I IRREVOCABLY CERITY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE.

SIGNATURE: ____ DATE: _____________________

Waxahachie Orthopaedics & Sports Medicine

PLEASE READ AND SIGN:

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician to perform and/or order another person to perform all exams, procedures, and other care deemed necessary or advisable for the diagnosis and treatment of my/my child's medical condition. This consent is valid for each visit I make to Waxahachie Orthopaedics & Sports Medicine unless revoked by me in writing.

____ ____________________

Signature of Responsible Party/Patient/Parent/Legal Guardian Date

AUTHORIZATION FOR RELASE OF INFORMATION

I hereby authorize Waxahachie Orthopaedics & Sports Medicine to furnish medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to me/my child. I understand this information includes my/my child's insurer. If necessary, this may include all medical records, laboratory test, radio graphic examinations, reports and/or other materials in the possession of Waxahachie Orthopaedics & Sports Medicine relating to my/my child's medical condition and proposed or actual treatment.

____ ____________________

Signature of Responsible Party/Patient/Parent/Legal Guardian Date

APPROVED HIPAA CONTACTS

I hereby authorize Waxahachie Orthopaedics & Sports Medicine to disclose and discuss any information related to my/my child's medical condition with the following contacts:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

____ ________________

Signature of Responsible Party/Patient/Parent/Legal Guardian Date

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Orthopaedic History Form:

Name: ____ Date: ____________________

Weight: ________________ Height: ___________________

1. Has there been any change in your general health within the past year: ………………………… YES NO
2. My last physical exam was on ____
3. Are you now under the care of a physician other than our physician? …………………………… YES NO
4. The name of my Physician is ____
5. Have you had any serious illness or operations? …………………………………………………… YES NO
    a. What was the name of the illness or operation? ________________________________
6. Do you have or have you had any of the following diseases or problems?
    a. Rheumatic fever or rheumatic heart disease …………………………………………… YES NO
    b. Congenital heart lesions, mitral valve prolapsed heart murmur ………………………… YES NO
    c. Coronary bypass surgery ……………………………………………………………………… YES NO
    d. Heart valve surgery or valve replacement ………………………………………………… YES NO
    e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis) ……………………………………… YES NO
    f. Allergy or hay fever ……………………………………………………………………………… YES NO
    g. Sinus trouble …………………………………………………………………………………… YES NO
    h. Hives or skin rash ……………………………………………………………………………… YES NO
    i. Fainting spells, seizures, convulsions, or epilepsy ………………………………………… YES NO
    j. Stroke ……………………………………………………………………………………………… YES NO
    k. Diabetes …………………………………………………………………………………………… YES NO
        i. Do you have to urinate more than 6 times daily ……………………… YES NO
        ii. Are you thirsty much of the time ………………………………………… YES NO
        iii. Does your mouth frequently become dry ………………………………… YES NO
    l. Liver disease (Hepatitis, Jaundice, Cirrhosis ……………………………………………… YES NO
    m. Arthritis …………………………………………………………………………………………… YES NO
    n. Inflammatory rheumatism (painful swollen joints) ………………………………………… YES NO
    o. Stomach ulcers …………………………………………………………………………………… YES NO
    p. Kidney trouble …………………………………………………………………………………… YES NO
    q. Lung disease (tuberculosis, asthma, emphysema, or other) ……………………………… YES NO
    r. Venereal disease, AIDS, herpes ………………………………………………………………… YES NO
    s. Nervous breakdown or emotional problems ………………………………………………… YES NO
    t. Cancer ……………………………………………………………………………………………… YES NO
    u. Headaches, backaches, neck aches …………………………………………………………… YES NO
    v. Other: ____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma
    a. Do you bruise easily ……………………………………………………………………………… YES NO
    b. Have you ever required a blood transfusion ………………………………………………… YES NO
       If so, explain the circumstances: ____
8. Do you have any blood disorders such as anemia ……………………………………………… YES NO
9. Are you taking any of the following:
    a. Diet pills of any kind ……………………………………………………………………… YES NO
    b. Antibiotics of sulfa drugs ………………………………………………………………… YES NO
    c. Anticoagulants (blood thinners) …………………………………………………………… YES NO
    d. Medicine for high blood pressure ………………………………………………………… YES NO
    e. Cortisone (steroids) ………………………………………………………………………… YES NO
    f. Tranquilizers ………………………………………………………………………………… YES NO
    g. Antihistamines ……………………………………………………………………………… YES NO
    h. Aspirins ……………………………………………………………………………………… YES NO
    i. Insulin, tobutamide (orinase), or similar drugs ………………………………………… YES NO
    j. Nitroglycerin ………………………………………………………………………………… YES NO
    k. Birth control ………………………………………………………………………………… YES NO
    l. Supplements ………………………………………………………………………………… YES NO
    m. Over the counter medicines ……………………………………………………………… YES NO

Please list current medications (including over the counter medications, vitamins, herbal supplements) you are currently taking

10. **Pharmacy Name**:____
    a. Phone# : ________________________
    b. Address: ________________________ City: ___________ Zip: ________
11. Are you allergic or have you reacted adversely to:
    a. Latex ………………………………………………………… YES NO
    b. Tape (surgical, cloth) …………………………………………… YES NO
    c. Local anesthetics ……………………………………………… YES NO
    d. Penicillin or other antibiotic ………………………………… YES NO
    e. Sulfa drugs ……………………………………………………… YES NO
    f. Barbiturates, sedatives, or sleeping pills ……………………… YES NO
    g. Aspirin …………………………………………………………… YES NO
    h. Iodine …………………………………………………………… YES NO
    i. Codeine or other narcotics ……………………………………… YES NO
    j. Demerol …………………………………………………………… YES NO
    k. Valium …………………………………………………………… YES NO
    l. Other (Please list) ____
12. Do you drink alcohol ……… YES NO (If yes, how much/how often) __________________
13. Have you or are you being treated for alcoholism ……………………… YES NO
14. Do you smoke or use other forms of tobacco products ………………… YES NO
    If so, what __________________________ How much ____________________
15. Do you have any disease, condition or problems not listed above that you think we should be aware of? If so, please explain ____
    ____

____ ____________________
Signature of Responsible Party/Patient/Parent/Legal Guardian Date

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