Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC

Patient Information

Last Name:____________________ First Name: ____________________

Preferred Name:____________________ Marital Status: [ ] Single [ ] Married [ ] Other __________

Date of Birth: ____________ Social Security # ____________ Sex: [ ] F [ ] M

Address: ____________________ City: ____________ State: _____ Zip: ________

Home # ____________ Work # ____________ Cell # ____________

Referring Physician: ____________________ Phone # ____________

Primary Care Physician: ____________________ Phone # ____________

Emergency Contact Name: ____________________ Relationship: ____________

Home # ____________ Work # ____________ Cell # ____________

Responsible Party

[ ] Same as patient

Last Name: ____________________ First Name: ____________________

Date of Birth: ____________ Social Security # ____________

Address: ____________________ City: ____________ State: _____ Zip: ________

Home # ____________ Work # ____________ Cell # ____________

Pharmacy Information:

Pharmacy Name: ____

Pharmacy Address: ____

City: ____________ State: ________ Zip: ____________

Phone # ____________ Fax # ____________

Worker's Compensation

IS THIS A WORK RELATED INJURY [ ] Yes [ ] No

Date of Injury: ____________ Claim # ____________

Employer Name: ____

Address: ____________________ City: ____________ State: _____ Zip: ________

Employer Contact: ____________ Phone # ____________ Fax # ____________

Adjuster's Name: ____________ Phone # ____________ Fax # ____________

Primary Insurance/Worker's Compensation Insurance

Insurance Company Name: ____

Claims Address: ____

City: ____________ State: ________ Zip: ____________ Phone # ____________

Policy # ____________ Group # ____________

Employer Name: ____________________ Phone # ____________

Address: ____________________ City: ____________ State: _____ Zip: ________

Who is the primary insured party [ ] Patient [ ] Responsible Party [ ] Other (complete below)

Last Name: ____________________ First Name: ____________________

Date of Birth: ____________ Social Security # ____________

Address: ____________________ City: ____________ State: _____ Zip: ________

Home # ____________ Work # ____________ Cell # ____________

Patient's Relation to Insured [ ] Spouse [ ] Child [ ] Other ____________

Secondary Insurance

Insurance Company Name: ______________________________

Claims Address: ______________________________

City: ______________ State: ________ Zip: ____________ Phone # ______________

Policy # ______________ Group # ______________

Employer Name: ______________________________ Phone # ______________

Address: ______________________________ City: ____________ State: ____ Zip: __________

Who is the secondary insured party [ ] Patient [ ] Responsible Party [ ] Other (complete below)

Last Name: ______________________ First Name: ______________________

Date of Birth: ______________ Social Security # ______________

Address: ______________________________ City: ____________ State: ____ Zip: __________

Home # ______________ Work # ______________ Cell # ______________

Patient's Relation to Insured [ ] Spouse [ ] Child [ ] Other ______________

Medicare Patients

Are you a resident of a [ ] Skilled Nursing Facility or [ ] Rehab Facility Admit Date: ______________

Name of Facility: ______________________________ Phone # ______________

Facility Address: ______________________________

City: ______________ State:________ Zip: ______________

Authorization and Acknowledgement

I hereby assign payment of medical benefits to **[ ]** Dr. Khan **[ ]** Dr. Khubchandani for all services rendered. I understand that I am financially responsible for all charges, whether or not paid by the above said insurance companies.

Please list the people with whom we can discuss your care and leave messages.

1.) ______________________ Relationship______________ Phone # ______________

2.) ______________________ Relationship______________ Phone # ______________

May we leave messages on your answering machine regarding your care? **[ ] Yes [ ] No**
(Please understand that if we cannot leave messages, it will be your responsibility to initiate contact with us regarding follow up of labs, appointments, etc.)

I have received information regarding the notice of privacy practices from
[ ] I want a copy **[ ] I do not want a copy**

Signature of Patient/Parent/Guardian: ______________________________

Printed Name: ______________________________ Date: ______________

Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC
815 Ira E Woods Ave Ste 100 Grapevine, TX 76051
Ph: (817) 421-0505. Fax: (817) 421-6060, www.Tiosonline.net

PLEASE COMPLETE ALL SECTIONS **HISTORY & PHYSICAL**

NAME____**DATE**________

PRIMARY CARE DOCTOR:____________________**WHO REFERRED YOU HERE:** ________________

AGE ______**HEIGHT**________**inches, WEIGHT**_______**lbs,** **CIRCLE: ARE YOU *RIGHT* OR *LEFT* HANDED?**

IS THIS A WORK RELATED INJURY? YES or NO, IF YES PLEASE INFORM THE RECEPTIONIST.

Current injury/problem details:

REASON FOR VISIT______________________________**DATE PROBLEM BEGAN?**______________

HOW INJURY or PROBLEM OCCURRED?____

____

DID YOU GO TO EMERGENCY ROOM? YES or NO, When?________________________

DID YOU HAVE XRAYS OF YOUR INJURED AREA? YES or NO, When?________________________

DID YOU SEE YOUR Primary care doc FOR THIS INJURY? YES or NO, When?________________________

DID YOU USE: (Circle) SPLINT, BRACE, CRUTUCHES, CANE, WALKER, WHEELCHAIR

(if 100%= your function before injury) *AT THIS TIME* WHAT IS THE FUNCTION OF INJURED AREA? _____%

PRESENTLY DO YOU FEEL: ***much improved, somewhat improved, unchanged, worse, much worse***

Circle all that apply to your pain or symptoms:

WHERE IS YOUR PAIN LOCATED NOW?______________________________________

DOES YOUR PAIN RADIATE YES or NO, WHERE?______________________________________

On a scale of 0 to 10, (10 being the worst pain), rate the *pain* that you experience? ______

pain quality is: **sharp, stabbing, dull, achy, throbbing, electric, pins and needles**

pain frequency is: **constant, frequent, intermittent, rare, positional, activity related, unpredictable**

LIST WHAT RELIEVES YOUR INJURY____

LIST WHAT AGGRAVATES YOUR INJURY____

ANY NECK PAIN Yes or No **LOW BACK PAIN Yes or No**

ANY NUMBNESS OR TINGLING Yes or No WHERE?______________________________________

List past medical history: circle: *None or……….. list below:*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

List past surgeries and dates of surgeries: circle: *None or…….. list below:*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

List *current* medications and doses: circle: *None or……… list below:*

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

List drug allergies: circle: *None* **Are you allergic to latex? Yes or No** **Contrast dye? Yes or No**

Tape? Yes or No

____________________ ____________________ ____________________

List Family history of medical problems: circle: *None or list below:*

Father:______________________________**Mother:**______________________________

Sister(s):______________________________**Brother(s):**______________________________

Other important history in the family:____

List Social History: circle: *None ………..or list below:*

Do you smoke? YES or NO, How many Packs/day?__________ **How many Years did you smoke?**__________

Do you Drink? YES or NO, How many drinks/day?__________**How many days per week?**__________

Drug use? YES or NO, If yes circle: RECREATIONAL , DRUG ADDICTIONS, CHRONIC PAIN CONTROL

Review of body systems: **Please Mark each item Yes or No**

General	Yes	No	Eyes & Ears	Yes	No	Nose/Throat	Yes	No	Circulatory	Yes	No
Fever/Chills			Glasses/contacts			Sinus infections			Chest pain		
Weight loss			Vision loss			Nose bleeds			Irregular rhythm		
Weight gain			Ringing in ears			Mouth lesions			Ankle swelling		
Fatigue			Hearing loss			Dentures/Braces			Poor Circulation		
Gastroint	**Yes**	**No**	**Respiratory**	**Yes**	**No**	**Musculoskel**	**Yes**	**No**	**Neurology**	**Yes**	**No**
Heartburn			Short of breath			Joint pain			Faint/blackouts		
Ulcers			Wake up Short of breath			Joint swelling			Poor coordination		
Nausea/vomit			Sputum in cough			Joint stiffness			Weakness		
Diarrhea			Bloody cough			Gait problems			Seizures		
Skin	**Yes**	**No**	**Psychological**	**Yes**	**No**	**Genitourinary**	**Yes**	**No**	**Patient signature:**		
Rash			Depression			Menopausal					
Itching			Anxiety			Incontinence			________________		
cancer			Substance dependence			Urinary infection			**Date:**		
Allergy	**Yes**	**No**	**Hematology**	**Yes**	**No**	**Endocrine**	**Yes**	**No**	**Physician signature:**		
Dust/pollen			Easy bruising			Always thirsty					
Food			Anemia			Appetite increase			________________		
Hayfever			Blood clots			Sensitive to cold/heat			Date:		

Do not write in this space.
H & P Dates reviewed: ______ ______ ______ ______ ______ ______

Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC

Release of Medical Records

I hereby authorize Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC to send or obtain any medical information needed for my care.

I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease. This does include Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information had been made prior.

You have a right to limit medical information we disclose to someone involved in your care, if you wish to do so please write down any persons or facilities that you do not want to receive information and the information that you want limited. Please note that Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC does not have to agree to your request.

_______________________________________ ____________________
Signature Date

__________________________ ______________________
Date of Birth SSN#

Restriction List:

____
____
____
____
____

Please fill out below any persons that may get information on your behalf.

Authorization List:

____
____
____
____
____

TiOS, PLLC

Texas Institute of Orthopedic Surgery and Sports Medicine, PLLC

Consents and Disclosures: I hereby voluntarily agree to diagnostic procedures, medical and surgical treatment which may be performed on me under the general or special instructions of the attending provider's care and service or the provider's designee(s). I further understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may invoke risks. No guarantees have been made to me as to the results of my treatment at Texas Institute of Orthopedic Surgery and Sports Medicine, PLLC. I understand that Texas Institute of Orthopedic Surgery and Sports Medicine, PLLC encourages me to ask questions and voice concerns about medical care or services and that asking questions or voicing concerns will not compromise my care. (I understand any invasive procedure will be explained, and I will be asked to sign an authorization for that treatment.)

Surgical Facility Interest Disclosure: Should it be determined that surgery is required, a facility, Baylor Medical Center at Trophy Club, is made available to you. However, Dr. Khan and Dr. Khubchandani would like you to know that they have ownership interest in this facility and if imaging is required Dr. Khubchandani has ownership interest in Preferred Imaging. If you do not wish to use them, for any reason, we will be happy to schedule your surgery in another facility.

NOTE: A copy of this agreement may be used with the same effectiveness as an original.

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THIS AGREEMENT AND/OR THAT IT HAS BEEN FULLY EXPLAINED TO ME, THAT I UNDERSTAND ITS CONTENTS, AND THAT I AM THE PATIENT, OR A PERSON DULY AUTHORIZED TO EXECUTE THIS AGREEMENT AND ACCEPT ITS TERMS.

____

Signature of Patient/Personal Representative

____

Description of Personal Representative's Authority

ePrescribing: This office, as a government requirement, utilizes electronic prescriptions. I authorize Texas Institute of Orthopedic Surgery and Sports Medicine, PLLC to check my medication history. By refusing to sign this consent I understand a prescription (if recommended) will not be provided to me.

Signature: _______________________________________ Date: _________________

Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC

Notice of Privacy Practices

I have been provided with a Notice of Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand the Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the office website, www.tiosonline.net, and in the physician's office. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

________________________________ ____________________

Patient's Printed Name Date of Birth

________________________________ ____________________

Patient/Legal Representative Signature Date

____

Relationship to Patient

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Texas Institute of Orthopedic Surgery & Sports Medicine, PLLC to share my protected health information with:

______________________________ _______________________

Name Relationship

______________________________ _______________________

Name Relationship

______________________________ _______________________

Name Relationship