Southwest Orthopaedic Clinic

☐ New Patient ☐ Update

Last Name_____ First Name_____ MI_____

DOB _____/_____/_____ Social Security #_____

Address _____ Apt #_____

City _____ State _____ Zip _____

Phone # _____ ☐ Okay to leave message Sex: ☐Male ☐Female

Cell # _____ ☐ Okay to leave message

EMAIL _____

Emergency Contact _____Relationship_____ Phone# (____)_____

Pharmacy/Drug Store _____ Location_____

Employer _____ Work # (_____)_____

Address _____City _____ST_____

Family Physician/PCP _____

Do you have a Power Of Attorney? ☐ Yes ☐ No Do you have an Advance Directive? ☐ Yes ☐ No

PRIMARY INSURANCE COVERAGE

Primary Insurance _____ Secondary Insurance _____

Policy Holder Name _____ Policy Holder Name _____

Birth Date _____ Birth Date _____

Relationship to Patient _____ Relationship to Patient _____

ID# _____Group#_____ ID# _____Group#_____

If Patient is a Minor

Student Status: ☐ Full time ☐ Part Time

Father's Name_____ Mother's Name_____

DOB_____ DOB_____

Cell Phone# _____ Cell Phone #_____

Personal Demographic

Race: ☐ White ☐ African American ☐ Other_____ ☐ Refuse to Report

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other_____ ☐ Refuse to report

Preferred language: ☐ English ☐ Spanish

How did you hear about us?

☐ Physician ☐ Family/Friend ☐ Website ☐ Internet Search ☐ Sign ☐ Other_____

Each Patient (or Responsible Party) is financially responsible for services rendered. While we are pleased to assist in the preparation of Insurance Forms, the obligation for payment of our fees remains that of the patient. I hereby authorize payment to Southwest Orthopaedic Clinic for medical services rendered. I authorize the release of any information required in the course of my examination of treatment.

Signature: _____Name (Print) _____Date ____ /____/____

Reason for visit:_____

_____

How long have you had this pain? (Months, Years)_____

How severe is your pain? (circle one)

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Was this a result of an injury? ☐ Yes ☐ No

If yes, date of injury _____

Do you use any of the following: ☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair

How far can you walk before limited by pain? _____

How do you walk up stairs? ☐ Lead with same leg each time ☐ One leg after the other (normal)

Do you need a rail to walk up/down the stairs ☐ Yes ☐ No

Can you put on your own socks and shoes? ☐ Yes ☐ No

What have you tried to help with the pain? ☐ Ice ☐ Rest/Decreased activity ☐ Physical Therapy

Pain Medication (list):_____

Have you had any Injections?_____ If yes, check below all that apply.

☐ Hip ☐ Knee ☐ Spine ☐ Shoulder

When was your last injection?_____

How long did your injection last?_____

Social History

Occupation:_____

☐ Full Time ☐ Part Time ☐ Student

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you smoke tobacco? ☐ Yes ☐ No ☐ I Quit Number of packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No Number of drinks per week? _____

Do you use street drugs? ☐ Yes ☐ No

*If you are a female between the ages of 10-65, are you pregnant? _____

PREVIOUS SURGERY HISTORY (List Dates)

Appendectomy_____ Knee Arthroscopy_____
Tonsillectomy_____ Total Knee Replacement_____
Hernia Repair_____ Total Hip Replacement_____
Gallbladder_____ Hysterectomy_____
Other_____ Shoulder Replacement_____

☐ Check if you have never had any surgeries.

Have you ever had a surgical infection? ☐ Yes ☐ No If yes, where? _____
Have you ever had general anesthesia? ☐ Yes ☐ No
Did you experience any problems with anesthesia? ☐ Yes ☐ No Problem? _____

Family History

Do you or your family have a history of:

Diabetes	☐ Mother	☐ Father	☐ Self	☐ Unknown
High Blood Pressure	☐ Mother	☐ Father	☐ Self	☐ Unknown
Heart Disease	☐ Mother	☐ Father	☐ Self	☐ Unknown
Stroke	☐ Mother	☐ Father	☐ Self	☐ Unknown
Arthritis	☐ Mother	☐ Father	☐ Self	☐ Unknown

CURRENT MEDICATIONS (with doses): Please list

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Allergies to Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Review of Systems:

Have you ever experienced any of these symptoms: (Check all that apply)

General
☐ Fever/Chills
☐ Pain
☐ Weight Loss

Eyes
☐ Vision/Eye Problems
☐ Glaucoma
☐ Other:_____

ENT
☐ Hearing Loss

Respiratory
☐ COPD
☐ Emphysema
☐ Asthma
☐ Pneumonia
☐ Tuberculosis
☐ Shortness of Breath

Cardiovascular
☐ Blood clot in legs
☐ Heart attack
☐ Heart Surgery
☐ Dizziness
☐ Heart murmur
☐ High blood Pressure
☐ Irregular heartbeat
☐ Other vascular anomalies

Allergy/Immunology
☐ Skin Rash
☐ AIDS/ HIV
☐ Other:_____

Gastrointestinal
☐ Peptic Ulcer Disease
☐ Hiatal Hernia
☐ Gallbladder Disease
☐ Diverticulitis
☐ Blood in stool
☐ Vomiting

Hematology
Cancer
☐ Breast
☐ Lung
☐ Prostate
☐ Thyroid
☐ Skin
☐ Other_____
☐ Bleeding Disorders

Musculoskeletal
☐ Tingling
☐ Numbness
☐ Swelling of feet/ankles

Arthritis/arthralgia
☐ Hands
☐ Hip
☐ Knee
☐ Cervical Spine
☐ Lumber Spine
☐ Other:_____
☐ History of Gout

Neurological
☐ Epilepsy/Seizures
☐ Migraine headaches
☐ Stroke
☐ Anxiety
☐ Depressed mood
☐ Psychiatric condition

Endocrine
☐ Kidney Stones
☐ Kidney failure/Dialysis
☐ Recurrent Bladder Infections
☐ Blood in urine
☐ Diabetes

Thyroid disease
☐ Hypothyroidism
☐ Hyperthyroidism
☐ Other:_____

☐ Check Box if none of the above apply to you.

Thank you for choosing Southwest Orthopaedic Clinic as your health care provider. We are committed to providing excellent health care services to you, our patient. As part of our professional relationship, it is important that you have an understanding of our financial policies.

All patients must read and sign this form prior to receiving services.

It is your responsibility to provide us with your most current insurance information.

- If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.
- Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, we will file the initial claim as a courtesy. Payment, however is due in full at the time of service.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim- regardless of our estimations.
- You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30- days after receipt of the initial statement. You can call (915)592-3323.
- Full payment is due upon receipt of the statement. Patient balances not paid in full within 30 days of the statement issued date are deemed past due and we will seek any legal actions provided to us under Texas law to receive all payments due.
- **In the event you do not attend your appointment and/or do not call to cancel 24 hours in advance a 25.00 fee will be applied to your account as a service fee**.
- Any FMLA, Disability, or Medical Records paperwork that needs to be completed will be charged as a $25.00 service fee that is due at time of pick up**. ALL completed paperwork can only be picked up on Tuesdays or Thursdays.**

Your account balance is due in full at the time of service. We accept cash and credit cards.

I have read and understand this Financial Policy.

Patient Name_____

Patient Signature_____

Southwest Orthopaedic Clinic

Acceptance of 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 Southwest Orthopaedic Clinic reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy on the clinic website 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 Guardian Signature Date

_____
Relationship to Patient

_____ _____
Witness Date

The following names are of people I would like to be involved in and have access to my protected health information on a routine basis. I give permission for Southwest Orthopaedic Clinic to share my protected health information with:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship