

DATE: _____

How did you hear about us? (Referral/Internet/Friend/etc.)	Primary Care Physician Name/Number
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PATIENT INFORMATION

Name		DOB
Address		
	Street	City
	State	Zip
Contact Numbers		
	Cell	Home
	Other	
OK to Leave Msg?	Circle to indicate yes for:	
	Cell	Home
	Other	
E-Mail		
Work Status <i>(Circle)</i>	Employed	Unemployed
	Retired	Other
Marital Status <i>(Circle)</i>	Single	Married
	Divorced	Other
Emergency Contact Name		
Emergency Contact Phone		

RESPONSIBLE PARTY INFORMATION <i>(if different than patient)</i>

Name		DOB
Relationship to Patient <i>(Circle)</i>	Spouse	Parent
	Other	
Contact Numbers		
	Cell	Home
	Other	

INSURANCE INFORMATION

<i>Is your complaint related to a work injury?</i>	Yes	No
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<i>Primary Medical Insurance</i>

Please Circle	Group <small>(Employer)</small>	Individual	Worker's Compensation*	Other
Insurance Company				
Policy Holder Name				
Policy Number			Group Number	
Relationship to Policy Holder <i>(Circle)</i>	Self	Spouse	Child	Other

<i>Secondary Medical Insurance</i> <i>(if any)</i>

Insurance Company				
Policy Holder Name				
Policy Number			Group Number	
Relationship to Policy Holder <i>(Circle)</i>	Self	Spouse	Child	Other

CONSENT FOR CARE AND TREATMENT

I, _____ (patient name) hereby agree and give my consent for Legacy Orthopedics, PLLC to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I hereby have a right to privacy under Health Insurance Portability and Accountability Act (HIPAA) regulations. I understand that Legacy Orthopedics, PLLC is committed to protect this information. A copy of our Privacy Notice will be provided to you upon request. By signing, you acknowledge that you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date.

RELEASE OF INFORMATION AUTHORIZATION

I give Legacy Orthopedics, PLLC authorization for the release of medical records and privacy information, which includes my personal health information, any medical conditions, and/or billing and financial information to the following:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Phone: _____
Address or Cross _____
Streets _____

SUMMARY FINANCIAL POLICY

I hereby authorize Legacy Orthopedics, PLLC to furnish to any designated insurance company or attorney all information necessary to file a health insurance claim form or to obtain reimbursement. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plans to Legacy Orthopedics, PLLC.

All applicable co-payments, deductibles, co-insurance amounts, or other patient responsibilities are due at the time service. I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. Please understand that we are pleased to work with your insurance company by filing claims on your behalf, but we are not responsible for any limitations in coverage included in your plan. The restrictions and limitations of healthcare plan coverages continue to increase, and we will do our best to inform you of your plan's limitations (if any) as we encounter them during your treatment at our office. As always, you may contact your insurance carrier for specifics regarding your policy.

PAPERWORK AND NO-SHOW FEES

In today's medical world and given the type of illnesses our practice works with, the amount of paperwork and forms that need attending to is often overwhelming. Due to the time-consuming nature of filling out and managing insurance claims, disability forms, as well as other length forms, we (as with most medical offices) find it necessary to charge a nominal fee for this service.

If our providers are required to fill out a form or dictate a note regarding a matter, our office will charge the following fees: \$10.00 for 1st page and \$5.00 for each additional page. ONLY during a post-operative global period will there be no charge for disability of FMLA paperwork.

We will do our best to expedite the handling of your requests, however, the speed with which we will be able to do is dependent on many factors, including how many forms we have pending at any given time. For this reason, please allow two weeks to process your request.

For any appointment that you either no-show or cancel within 24 hours, there will be a \$25.00 fee assigned to your account. Out of consideration for all patients, we request that you inform us of any cancellation as soon as feasible so that we may offer your appointment slot to others in need.

DISCLOSURE OF PHYSICIAN FINANCIAL INTEREST

Our providers are committed to helping facilitate exceptional care at various healthcare facilities in North Texas. By maintaining ownership in the facilities, our providers are able to have a voice in administrative and operational direction, resulting in a higher overall quality of care. Pursuant to Federal and Texas Law, I have been informed that either Legacy Orthopedics, PLLC or one or more of its affiliates, physicians, or owners have a financial interest in one or more of the following organizations: Methodist McKinney Hospital and SurgCenter of Plano. We want you to know that you do have the option to use an alternative health care provider, should you choose.

ELECTRONIC COMMUNICATION

Our office uses text messaging and e-mail for appointment reminders/alerts. If you do not consent to this or choose not to utilize this service, please inform our staff so that we can note your preference.

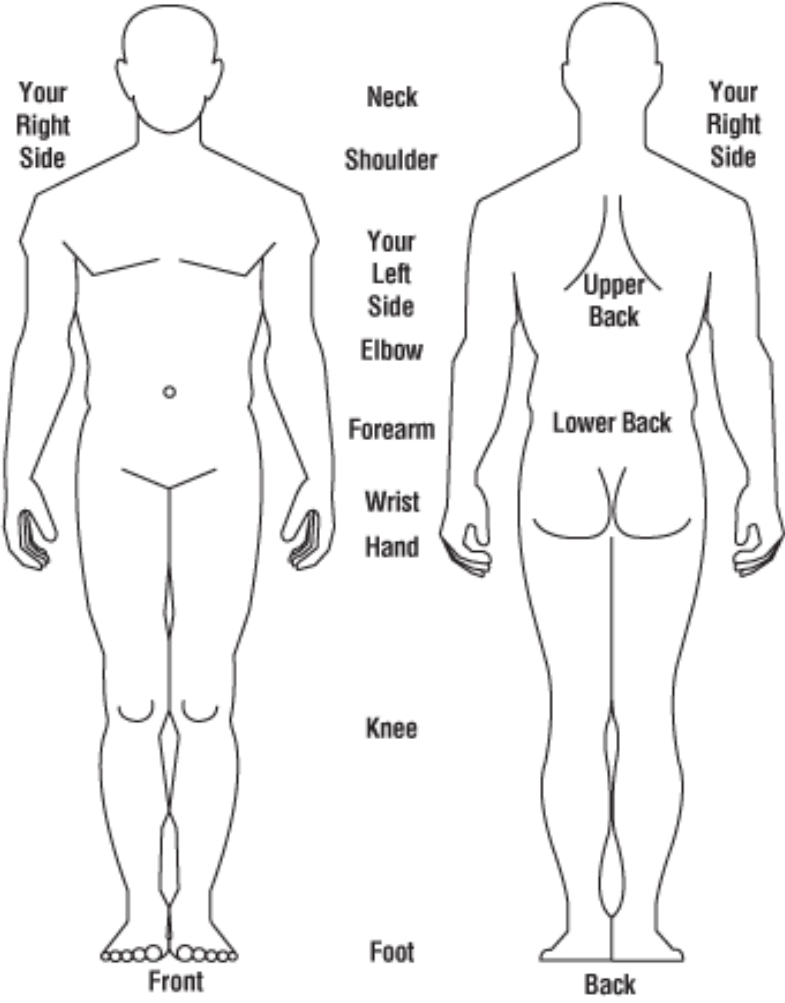
ACKNOWLEDGEMENT AND AGREEMENT

By signing below, I acknowledge that I have read and agree to the above policies or information, including Financial Policy, Paperwork and No-Show Fees, Disclosure of Physician Financial Interest, and Electronic Communication. I have been given an opportunity to ask questions, if any.

 Patient Name: _____ DOB: _____

 Patient Signature: _____

MEDICAL HISTORY
PATIENT NAME: _____ **DOB:** _____ **Height** _____ **Weight** _____



Please mark the body part that we are examining today.

Pain Intensity (Circle)

0 – No Pain

1

2

3

4

5

6

7

8

9

10 – Most Severe Pain

Main Problem					
How long have you had your pain/concern?					
Pain related to injury or MVA?	Yes	No	Date of Injury?		
Previous imaging or treatments for THIS problem.	CT Scan	MRI	Discogram	EMG	Myelogram
	Physical Therapy		Steroid Injections		Prior Surgery
List any medications being taken for THIS problem					

MEDICAL HISTORY (Continued)

PLEASE GIVE US MORE INFORMATION REGARDING YOUR SYMPTOMS								
QUALITY:	Sharp	Dull	Throbbing	Aching	Burning	Cramping		
SEVERITY:	Mild	Moderate	Severe					
DURATION:	Infrequent	Intermittent	Constant	Hourly	Daily	Weekly		
TIMING:	During Activity	After Activity	Walking	Running	Stairs	Squatting	Pivoting	
	Overhead Use	Throwing	Lifting	Other				
CONTEXT:	Improving	Worsening	Recurrent	More Frequent	Less Frequent	Unchanged		
SYMPTOM RELIEF:	Rest	Heat	Cold	Elevation	Physical Therapy	Brace	Injection	Medication
SYMPTOM AGGRAVATION:	Activity	Position Change	Repetitive Motion	Fatigue				

Allergies/Intolerances:					
Social History:	Have you ever smoked?	Yes	No	Packs/Day	
		If quit, when?			
	Drink alcohol?	Yes	No	Drinks/Week	
	Use recreational drugs?	Yes	No	Drugs Used	

MEDICATION LIST

Please list all medications you are currently taking and dose

1.	7.
2.	8.
3.	9.
4.	10.

MEDICAL HISTORY

Please check any conditions you have or have had in the past:

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Tuberculosis |

ORTHOPEDIC SIGNIFICANT HISTORY (FAMILIAL OR PERSONAL)

- | | | |
|---|---|--|
| <input type="checkbox"/> Skeletal Dysplasia | <input type="checkbox"/> Spondyloepiphyseal dysphasia | <input type="checkbox"/> Duchenna's muscular dystrophy |
| <input type="checkbox"/> Achondroplasia | <input type="checkbox"/> Marfan's syndrome | <input type="checkbox"/> Charcot-Marie Tooth |
| <input type="checkbox"/> Morquio | <input type="checkbox"/> Ehlers-Danlos | <input type="checkbox"/> Arthogryposis Multiplex |
| <input type="checkbox"/> Psuedoachondroplasia | <input type="checkbox"/> Osteogenesis imperfecta | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Diastrophic dwarism | <input type="checkbox"/> Homocystinuria | <input type="checkbox"/> Thrombocytopenia |
| <input type="checkbox"/> Hemi-hypertrophy | <input type="checkbox"/> Pseudocolonesterase deficiency | <input type="checkbox"/> Malignant hyperthermia |

MEDICAL HISTORY (Continued)

SURGICAL HISTORY		
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	
FAMILY MEDICAL HISTORY		
Please check all conditions that occur in your family:		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Colitis
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pulmonary embolism	<input type="checkbox"/> Anemia
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Goiter	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Stroke	<input type="checkbox"/> Stomach or peptic ulcer
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Epilepsy (seizures)	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Kidney stones	

SYSTEMS REVIEW		
In the past month, have you had any of the following problems?		
GENERAL <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue/Weakness <input type="checkbox"/> Malaise <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Weight Loss <input type="checkbox"/> Night sweats EYES <input type="checkbox"/> Vision loss <input type="checkbox"/> Visual Disturbance EAR/NOSE/THROAT <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sinus pressure/pain <input type="checkbox"/> Tinnitus CARDIOVASCULAR <input type="checkbox"/> Chest pains <input type="checkbox"/> Palpitations <input type="checkbox"/> Other cardiac problems RESPIRATORY <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other respiratory problems	GASTROINTESTINAL <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Reflux <input type="checkbox"/> Other gastrointestinal problems <input type="checkbox"/> Vomiting GENITOURINARY <input type="checkbox"/> Incontinence <input type="checkbox"/> Other genitourinary problems MUSCLE/JOINTS/BONES <input type="checkbox"/> Numbness <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint swelling SKIN <input type="checkbox"/> Itching <input type="checkbox"/> Lesions <input type="checkbox"/> Rash/Redness <input type="checkbox"/> Other skin problems NERVOUS SYSTEM <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness or tingling	PSYCHIATRIC <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Other psychiatric conditions ENDOCRINE <input type="checkbox"/> Fatigue <input type="checkbox"/> Unusual weight gain <input type="checkbox"/> Other endocrine problems HEMATOLOGIC <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> Bleeding <input type="checkbox"/> Other hematologic problems ALLERGIC/IMMUNOLOGIC <input type="checkbox"/> Allergic rash <input type="checkbox"/> Sinus complaints <input type="checkbox"/> Other allergy complaints OTHER PROBLEMS: