LEGACY ORTHOPEDICS & SPORTS MEDICINE

DATE: ______________________

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

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 *(Circle)*	Employed	Unemployed	Retired	Other
Marital Status *(Circle)*	Single	Married	Divorced	Other
Emergency Contact Name				
Emergency Contact Phone				

RESPONSIBLE PARTY INFORMATION *(if different than patient)*

Name			DOB
Relationship to Patient *(Circle)*	Spouse	Parent	Other
Contact Numbers	Cell	Home	Other

INSURANCE INFORMATION

Is your complaint related to a work injury?	***Yes***	***No***

Primary Medical Insurance

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

Secondary Medical Insurance *(if any)*

Insurance Company				
Policy Holder Name				
Policy Number			Group Number	
Relationship to Policy Holder *(Circle)*	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.

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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, SurgCenter of Plano, and Gateway Diagnostic Imaging. 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:

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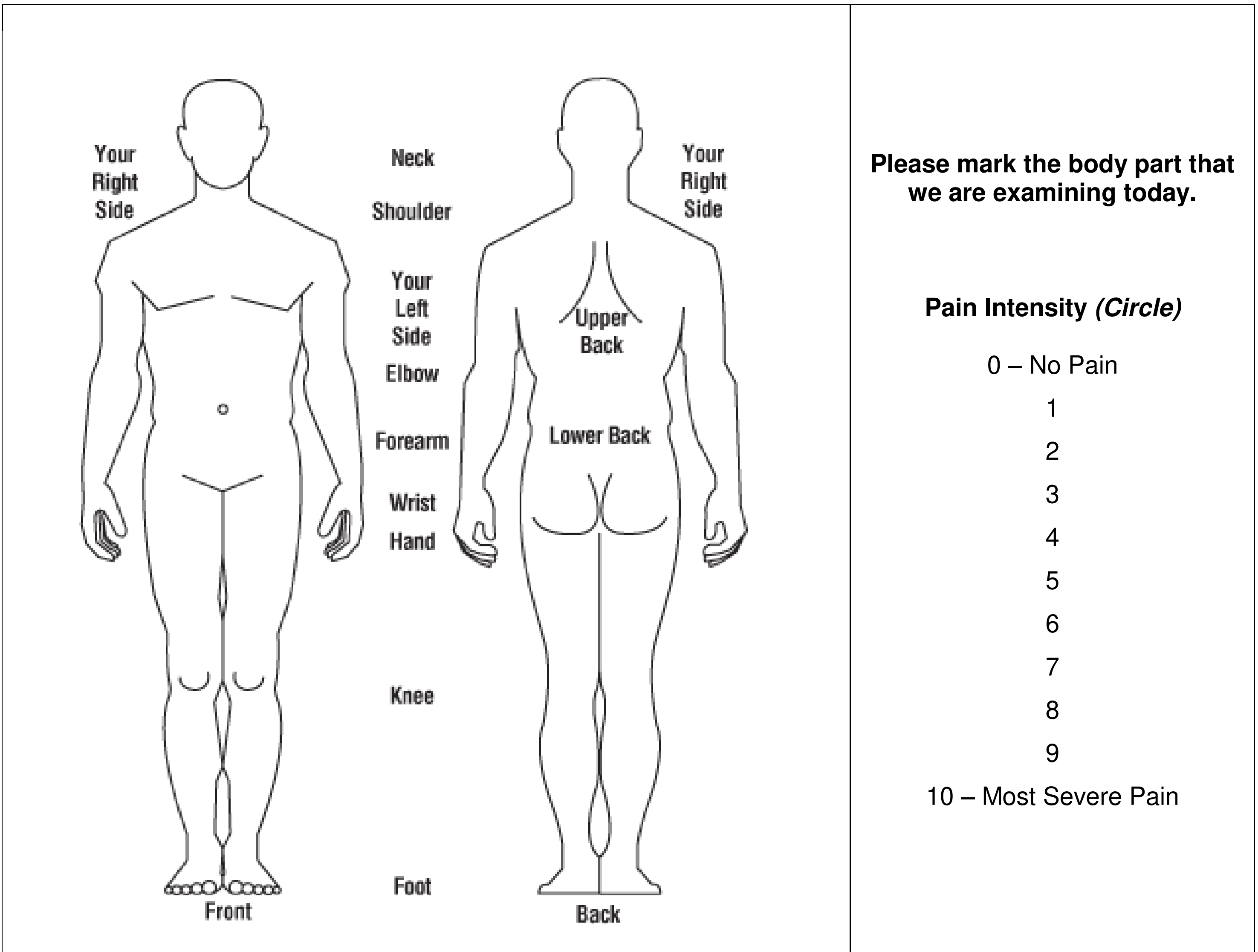
MEDICAL HISTORY

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					

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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:

❑ Anemia	❑ Heart problems	❑ Kidney disease
❑ Asthma	❑ High blood pressure	❑ Psoriasis
❑ Colitis	❑ High cholesterol	❑ Stomach or peptic ulcer
❑ Diabetes	❑ HIV/AIDS	❑ Stroke
❑ Heart murmur	❑ Hypothyroidism	❑ Tuberculosis

ORTHOPEDIC SIGNIFICANT HISTORY (FAMILIAL OR PERSONAL)

❑ Skeletal Dysplasia	❑ Spondyloepiphyseal dysphasia	❑ Duchenna's muscular dystrophy
❑ Achondroplasia	❑ Marfan's syndrome	❑ Charcot-Marie Tooth
❑ Morquio	❑ Ehlers-Danlos	❑ Arthogryposis Multiplex
❑ Psuedoachondroplasia	❑ Osteogenesis imperfecta	❑ Sickle cell disease
❑ Diastrophic dwarism	❑ Homocystinuria	❑ Thrombocytopenia
❑ Hemi-hypertrophy	❑ Pseudocolonesterase deficiency	❑ Malignant hyperthermia

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MEDICAL HISTORY (Continued)

SURGICAL HISTORY	
❑	❑
❑	❑
❑	❑

FAMILY MEDICAL HISTORY

Please check all conditions that occur in your family:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) ___________________
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
❑ Chills
❑ Fatigue/Weakness
❑ Malaise
❑ Poor weight gain
❑ Weight Loss
❑ Night sweats

EYES
❑ Vision loss
❑ Visual Disturbance

EAR/NOSE/THROAT
❑ Difficulty swallowing
❑ Sinus pressure/pain
❑ Tinnitus

CARDIOVASCULAR
❑ Chest pains
❑ Palpitations
❑ Other cardiac problems

RESPIRATORY
❑ Asthma
❑ Shortness of breath
❑ Other respiratory problems

GASTROINTESTINAL
❑ Change in bowel habits
❑ Reflux
❑ Other gastrointestinal problems
❑ Vomiting

GENITOURINARY
❑ Incontinence
❑ Other genitourinary problems

MUSCLE/JOINTS/BONES
❑ Numbness
❑ Joint pain
❑ Muscle weakness
❑ Joint swelling

SKIN
❑ Itching
❑ Lesions
❑ Rash/Redness
❑ Other skin problems

NERVOUS SYSTEM
❑ Headaches
❑ Dizziness
❑ Numbness or tingling

PSYCHIATRIC
❑ Anxiety
❑ Depression
❑ Suicidal ideation
❑ Other psychiatric conditions

ENDOCRINE
❑ Fatigue
❑ Unusual weight gain
❑ Other endocrine problems

HEMATOLOGIC
❑ Abnormal bruising
❑ Bleeding
❑ Other hematologic problems

ALLERGIC/IMMUNOLOGIC
❑ Allergic rash
❑ Sinus complaints
❑ Other allergy complaints

OTHER PROBLEMS: