

**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 <b>yes</b> 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 (if different than patient)**

Name				DOB
Relationship to Patient ( <i>Circle</i> )	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 ( <i>Circle</i> )	Self	Spouse	Child	Other

***Secondary Medical Insurance (if any)***

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 1<sup>st</sup> 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 Baylor Frisco Hospital. 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.

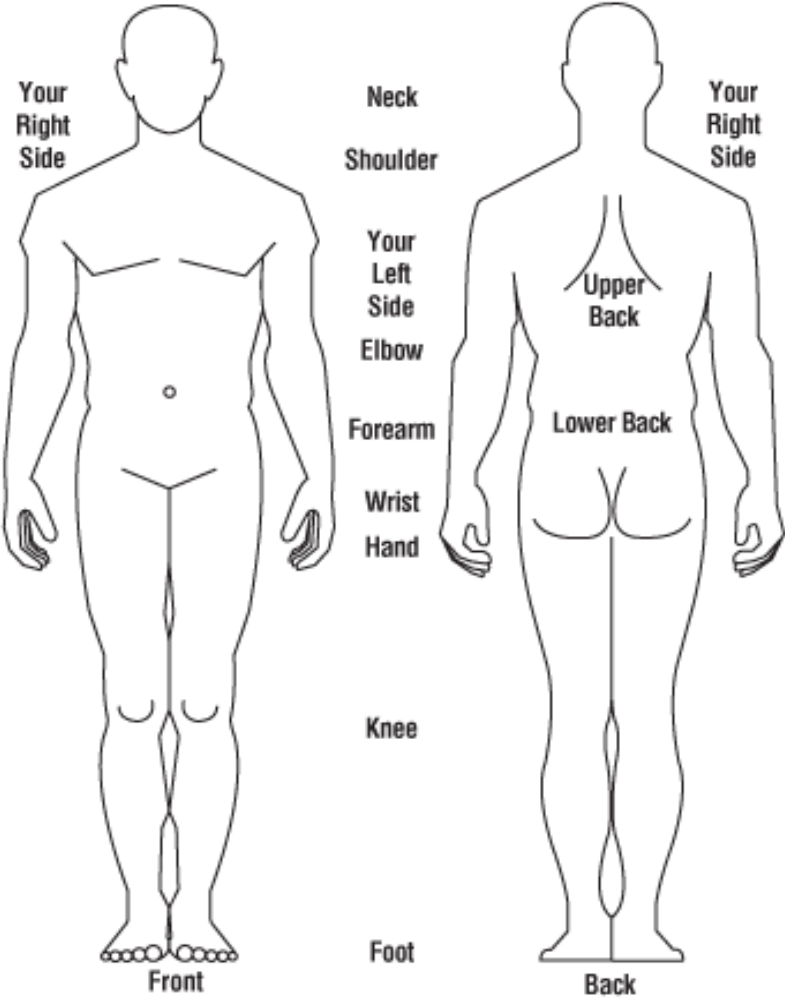
### **ACKNOWLEDGEMENT AND AGREEMENT**

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** \_\_\_\_\_

	<p><b>Please mark the body part that we are examining today.</b></p> <p><b>Pain Intensity (Circle)</b></p> <p>0 – No Pain</p> <p style="text-align: center;">1</p> <p style="text-align: center;">2</p> <p style="text-align: center;">3</p> <p style="text-align: center;">4</p> <p style="text-align: center;">5</p> <p style="text-align: center;">6</p> <p style="text-align: center;">7</p> <p style="text-align: center;">8</p> <p style="text-align: center;">9</p> <p>10 – Most Severe Pain</p>
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<b>Main Problem</b>					
<b>How long have you had your pain/concern?</b>					
<b>Pain related to injury or MVA?</b>	Yes	No	<b>Date of Injury?</b>		
<b>Previous imaging or treatments for THIS problem.</b>	CT Scan	MRI	Discogram	EMG	Myelogram
	Physical Therapy		Steroid Injections		Prior Surgery
<b>List any medications being taken for THIS problem</b>					

**MEDICAL HISTORY (Continued)**

<b>PLEASE GIVE US MORE INFORMATION REGARDING YOUR SYMPTOMS</b>						
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						
<b>Please Circle: Yes (list) or No</b>						
<b>Allergies/Intolerances:</b>						
<b>Social History:</b>		Have you ever smoked?	Yes	No	Packs/Day	
		If quit, when?				
		Drink alcohol?	Yes	No	Drinks/Week	
		Use recreational drugs?	Yes	No	Drugs Used	
<b>Please Circle: Yes (list below) or No</b>		<b>MEDICATION LIST</b>				
Please list all medications you are currently taking and dose						
1.						7.
2.						8.
3.						9.
4.						10.
<b>Please Circle: Yes (list below) or No</b>		<b>MEDICAL HISTORY (Personal)</b>				
<b>Please check any conditions you have or have had in the past:</b>						
<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
<b>Please Circle: Yes (list below) or No</b>		<b>ORTHOPEDIC SIGNIFICANT HISTORY (FAMILIAL OR PERSONAL)</b>				
<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)**

Please Circle: Yes (list below) or No	SURGICAL HISTORY
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Please Circle: Yes (list below) or No	FAMILY MEDICAL HISTORY
<b>Please check all conditions that occur in your family:</b>	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Pulmonary embolism
<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Stroke
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Epilepsy (seizures)
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Angina	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Kidney stones
	<input type="checkbox"/> Crohn's disease
	<input type="checkbox"/> Colitis
	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Jaundice
	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Stomach or peptic ulcer
	<input type="checkbox"/> Rheumatic fever
	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> HIV/AIDS

Please Circle: Yes (list below) or No	SYSTEMS REVIEW
<b>In the past month, have you had any of the following problems?</b>	
<b>GENERAL</b> <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	<b>GASTROINTESTINAL</b> <input type="checkbox"/> Change in bowel habits <input type="checkbox"/> Reflux <input type="checkbox"/> Other gastrointestinal problems <input type="checkbox"/> Vomiting
<b>EYES</b> <input type="checkbox"/> Vision loss <input type="checkbox"/> Visual Disturbance	<b>GENITOURINARY</b> <input type="checkbox"/> Incontinence <input type="checkbox"/> Other genitourinary problems
<b>EAR/NOSE/THROAT</b> <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Sinus pressure/pain <input type="checkbox"/> Tinnitus	<b>MUSCLE/JOINTS/BONES</b> <input type="checkbox"/> Numbness <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint swelling
<b>CARDIOVASCULAR</b> <input type="checkbox"/> Chest pains <input type="checkbox"/> Palpitations <input type="checkbox"/> Other cardiac problems	<b>SKIN</b> <input type="checkbox"/> Itching <input type="checkbox"/> Lesions <input type="checkbox"/> Rash/Redness <input type="checkbox"/> Other skin problems
<b>RESPIRATORY</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other respiratory problems	<b>NERVOUS SYSTEM</b> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness or tingling
	<b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Other psychiatric conditions
	<b>ENDOCRINE</b> <input type="checkbox"/> Fatigue <input type="checkbox"/> Unusual weight gain <input type="checkbox"/> Other endocrine problems
	<b>HEMATOLOGIC</b> <input type="checkbox"/> Abnormal bruising <input type="checkbox"/> Bleeding <input type="checkbox"/> Other hematologic problems
	<b>ALLERGIC/IMMUNOLOGIC</b> <input type="checkbox"/> Allergic rash <input type="checkbox"/> Sinus complaints <input type="checkbox"/> Other allergy complaints
	<b>OTHER PROBLEMS:</b>