Fondren Orthopedic Group L.L.P.

Patient Information	**Provider #:**	**Account Number:**	
Patient's Name (First MI Last)	**Gender DOB Age** ☐M ☐F / /	**DL#**	**SSN**
Address	**City and State**	**Zip Code**	**Phone** **Home:** **Cell:**
Patient's Employer	**Business Phone**	**Marital Status** ☐ M ☐ S ☐ D ☐ W	**Referring / Primary MD**
Spouse's Name	**Spouse's Employer**	**DOB**	**SSN**

Race: □ African American/Black □ Asian □ Caucasian/White □ Chinese □ Filipino □ Hispanic □ Japanese □ Am. Indian/Alaska Native □ Native Hawaiian/Other

Preferred Language: □ English □ Spanish □ Vietnamese □ Chinese □ French □ German

Guarantor Information (if patient is a minor)			
Guarantor's Name	**Relationship to Patient**	**DOB**	**SSN**
Billing Address	**City and State**	**Zip Code**	**Emergency Phone**

Insurance Information			
Insurance Carrier Name- Primary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN DOB**	**Relationship**
Insurance Carrier Name – Secondary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN DOB**	**Relationship**

What other ways may we contact you? Please circle YES or NO if you would like us to leave a message at the numbers you provide:
Home #: YES or NO **Work #:** YES or NO **Cell:**_____ YES or NO **Other #:** _____ YES or NO
Email address: _____

FAMILY AND FRIENDS: Please let us know what persons we may share info with (ie.family, friends, other doctors etc.) and list them below:

NAME	RELATIONSHIP TO YOU	PHONE #
1.		
2.		
3.		

Please check one of the following: □ This **IS** a work-related injury. □ This **IS NOT** a work-related injury

MEDICARE / MEDICAID – PATIENT'S ONLY

I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office. I have read and understand the above statement regarding MEDICARE coverage.

□ Medicare is my **primary** coverage.
□ Medicare is my **secondary** coverage.
□ I **am not** covered by Medicare or a Medicare HMO
□ Medicaid is my **primary** coverage.
□ Medicaid is my **secondary** coverage.
□ I **am not** covered by Medicaid or a Medicaid HMO

ASSIGNMENT OF BENEFITS: I hereby authorize Payment to the Fondren Orthopedic Group, L.L.P. for the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.
FINANCIAL OBLIGATION: The undersigned Hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

□ Payment is required today for all co-pays, deductibles, or co-insurance amounts that may be due by the patient.

X_____ _____
Signature of Patient/Parent/or Guardian Date

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and / or treatment. I understand that this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

X_____
_____
Signature of Patient/Parent/or Guardian Date

CONSENT TO CARE: I authorize and direct Fondren Orthopedic Group, L.L.P. to perform upon me injections, draw blood and / or any other procedure or treatments the doctor may in his best judgment determine advisable for my well being.

X_____ _____
Signature of Patient/Parent/or Guardian Date

ACKNOWLEDGEMENT OF NOTICES

Fondren Orthopedic Group, L.L.P.

_____ I acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's Notice of Privacy Practices and have completed the form below to the best of my knowledge.

_____ I acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's WELCOME TO OUR PRACTICE and understand that I will be asked for copays/deductibles at the time of check-in.

- **_____ I also understand that I must have a referral if I have an HMO or POS plan.**
- **_____ I also understand that I must call the pharmacy to request a prescription refill. Refills ARE NOT approved after normal business hours, weekends or holidays.**
- **_____ Minor Children (under age of 18 years) must be accompanied by a parent during an office visit.**
- **_____ FMLA/Disability/Insurance Forms all incur a $25.00 per form charge to be filled out.**

_____ Pursuant to the requirements of Section 105.002 of the Texas Occupations Code, this is to inform you that each of the physicians in the Pearland and Pasadena Practice has a financial ownership interest in the entities listed below, and may, indirectly, receive compensation for services you receive at these entities.

Fondren Orthopedic Group – Pearland MRI
10223 Broadway, Suite A
Pearland, Texas 77584

Fondren Orthopedic Group – Physical Therapy
10223 Broadway, Suite A
Pearland, Texas 77584

You, as the patient of one of these physicians, have the option of using an alternative health care facility, other than the entities listed above, if you so desire.

_____ _____ _____

Signature of Patient or Guardian **Relationship to Patient** **Date**

Clinic Use Only

Fondren Orthopedic Group, L.L.P. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices, Welcome to our Practice and Patient Financial Disclosure Notice.

_____ _____

Signature of Employee **Date**

Fondren Orthopedic Group, L.L.P.
7401 South Main Street
Houston, TX 77030-4509
713-799-2300

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.,** your medical provider, to: (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from the redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

_____
Print Patient's Name

_____ _____
Patient's Signature **Date**

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

_____
Print Legal Representative's Name

_____ _____
Legal Representative's Signature **Date**

PATIENT QUESTIONNAIRE

NAME:_____ **DOB:**_____**TODAY'S DATE:**_____
OCCUPATION: _____ **AFFECTED SIDE? R or L Who referred you?:**_____
What body part are we treating today:_____**DESCRIBE PROBLEM:**_____
RACE: □ CAUCASIAN □ AFRICAN AMERICAN □ HISPANIC □ ASIAN □ UNKNOWN □ OTHER
LANGUAGE OF CHOICE:_____ **Weight: _____ Height: _____ Do you write with your Left___ or Right___ hand**
Gender: Male_____ **Female**_____ **Female patients is there a possibility you may be pregnant: _____**
Injury: Yes ____ No_____ If Yes date of Injury: _____ How did injury happen?:_____

PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ANEMIA	___CA LUNG	___HEART STENT	___NEUROLOGICAL DISORDER
___ANXIETY	___CA OVARIAN	___HEPATITIS A B C	___NUMBNESS/TINGLING
___ASBESTOSIS	___CA PROSTATE	___IRREGULAR HEARTBEAT	___OSTEOARTHRITIS
___ASTHMA	___CA THYROID	___HIATAL HERNIA	___PNEUMONIA
___BIPOLAR DISORDER	___CHEST PAIN	___HIGH CHOLESTEROL	___POOR CIRCULATION
___BLEEDING DISORDER	___CHRONIC BACK PAIN	___HIV	___PULMONARY EMBOLISM
___BLOOD CLOT	___COR. ARTERY DISEASE	___HYPERTHYROIDISM	___REFLUX
___BRONCHITIS	___CON. HEART FAILURE	___HYPOTHYROIDISM	___RHEUMATOID ARTHRITIS
___CANCER	___DEPRESSION	___KIDNEY STONES	___SEIZURE
___CA BRAIN	___DIABETES	___LIVER PROBLEMS	___SLEEP APNEA
___CA BREAST	___EMPHYSEMA	___LUNG PROBLEMS	___STROKE
___CA CERVICAL	___HEART ATTACK	___LUPUS	___TUBERCULOSIS
___CA COLON	___HEART MURMUR	___MIGRAINES	___UTI
___CA KIDNEY	___HYPERTENSION	___OTHER_____	

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ABDOMINAL SURGERY	___GALLBLADDER REMOVAL	___PARATHYROIDECTOMY
___AMPUTATION	___GASTRIC BYPASS/BANDING	___PNEUMONECTOMY
___ANGIOPLASTY	___HEART SURGERY	___PROSTATECTOMY
___APPENDECTOMY	___HEMORRHOIDECTOMY	___ROTATOR CUFF REPAIR
___ARTHROSCOPY KNEE	___HIP REPLACEMENT	___SPINE SURGERY CERVICAL
___ARTHROSCOPY SHOULDER	___HYSTERECTOMY COMPLETE	___SPINE SURGERY THORACIC
___BRONCHOSCOPY	___HYSTERECTOMY PARTIAL	___SPINE SURGERY LUMBAR
___CABG	___INTERVENTIONAL PAIN PROCEDURES	___TONSILLECTOMY
___CAROTID ENDARTERECTOMY	___KNEE REPLACEMENT	___T U R P
___COLON RESECTION	___KYPHOPLASTY	___VASECTOMY
___FEMORAL BYPASS	___NEPHRECTOMY	___VERTEBROPLASTY
___FRACTURE REPAIR	___PACEMAKER	___OTHER_____

FAMILY HISTORY (CHECK ANY THAT APPLY) ___NONE APPLY

___ANESTHESIA PROBLEMS	___BLEEDING DISORDER	___ASTHMA	___DIABETES
___OSTEOPOROSIS	___ARTHRITIS	___HYPERTENSION (MOM)	___HYPERTENSION (DAD)
___STROKE	___TUBERCULOSIS	___CANCER	___CA BREAST
___CA CERVICAL	___CA COLON/RECTAL	___CA BRAIN	___CA LUNG
___CA OVARIAN	___CA PROSTATE	___CA KIDNEY	___CA THYROID

___OTHER_____

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) ___NONE APPLY

___SINGLE	___CHILD	___PHYSICAL WORK	___STUDENT
___MARRIED	___PIPE SMOKING	___SEDENTARY WORK	___REGULAR DUTY
___DIVORCED	___CHEWING TOBACCO	___RETIRED	___LIGHT DUTY
___WIDOWED	___ALCOHOL	___HOMEMAKER	___OUT OF WORK

___CIGARETTE SMOKING (IF YES) HOW LONG: ___ HOW MANY: ___ PACKS PER DAY

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) ___NONE

_____ _____ _____
_____ _____ _____
_____ _____ _____

PHARMACY USED: _____**PH#**_____

ALLERGIES TO MEDICINE: (LIST ALL) ___ NO ALLERGIES

_____
_____

Patient Signature:_____ **Date:**_____

REVIEW OF SYSTEMS

*(Please circle **YES or NO** if any currently apply to you)*

PRINT PATIENT NAME:_____ **PATIENT DOB:** _____ **DATE:** _____

Have you had any new symptoms?	Yes	No

GENERAL:

Fever?	Yes	No
Chills?	Yes	No
Sweats?	Yes	No
Weakness?	Yes	No
Malaise?(discomfort)	Yes	No
Abnormal Weight Loss?	Yes	No
Sleep Disturbance?	Yes	No

EYES, EARS, NOSE, THROAT:

Double Vision?	Yes	No
Blurred Vision?	Yes	No
Eye Irritation?	Yes	No
Eye Discharge?	Yes	No
Vision Loss?	Yes	No
Eye Pain?	Yes	No
Light Sensitivity?	Yes	No
Earache?	Yes	No
Ringing in Ears?	Yes	No
Nasal Congestion?	Yes	No
Nosebleeds?	Yes	No
Sore Throat?	Yes	No
Difficulty Swallowing?	Yes	No
Hearing Loss?	Yes	No

CARDIAC:

Chest Discomfort?	Yes	No
Chest Pains?	Yes	No
Palpitations?	Yes	No
Syncope? (fainting)	Yes	No
Shortness of Breath?	Yes	No
Numbness in Arms?	Yes	No
Swelling of Limbs?	Yes	No

RESPIRATORY:

Cough?	Yes	No
Shortness of Breath?	Yes	No
Wheezing?	Yes	No
Chest Congestion?	Yes	No

GASTROINTESTINAL:

Nausea?	Yes	No
Vomiting?	Yes	No
Diarrhea?	Yes	No
Constipation?	Yes	No
Abdominal Pain?	Yes	No
Blood in Stool?	Yes	No
Heartburn?	Yes	No

GENITOURINARY:

Painful Urination?	Yes	No
Blood in Urine?	Yes	No
Urinary Frequency?	Yes	No
Urinary Hesitancy?	Yes	No
Incontinence?	Yes	No

MUSCULOSKELETAL:

Back Pain?	Yes	No
Joint Pain?	Yes	No
Joint Swelling?	Yes	No
Muscle Soreness?	Yes	No
Arthritis?	Yes	No

Do you have diabetes?	Yes	No

SKIN:

Sensation Disturbance?	Yes	No
Bruising?	Yes	No
Birthmark?	Yes	No
Rash?	Yes	No
Itching?	Yes	No
Dryness?	Yes	No
Suspicious Lesions?	Yes	No

NEUROLOGICAL:

Headaches?	Yes	No
Memory Loss?	Yes	No
Confusion?	Yes	No
Transient Paralysis?	Yes	No
Weakness?	Yes	No
Numbness?	Yes	No
Tingling?	Yes	No
History of Seizures?	Yes	No
Syncope? (fainting)	Yes	No
Tremors?	Yes	No
Vertigo?(dizzy)	Yes	No

PSYCHIATRIC:

Depression?	Yes	No
Anxiety?	Yes	No
Memory Loss?	Yes	No
Mental Disturbance?	Yes	No
Suicidal Thoughts?	Yes	No
Mood Disorders?	Yes	No
Paranoia?	Yes	No
Sleep Disturbances?	Yes	No
Eating Disorder?	Yes	No

ENDOCRINE:

Sensitivity to Cold?	Yes	No
Sensitivity to Heat?	Yes	No
Abnormal Weight Gain?	Yes	No
Excessive Thirst?	Yes	No
Excessive Urination?	Yes	No
Excessive Hunger?	Yes	No
Diabetes?	Yes	No

HEMATOLOGIC / LYMPHATIC:

Chronic Infections?	Yes	No
Abnormal Bruising?	Yes	No
Bleeding?	Yes	No
Enlarged Lymph Nodes	Yes	No

ALLERGIC / IMMUNOLOGIC:

Hives?	Yes	No
Hay Fever?	Yes	No
Persistent Infections?	Yes	No
HIV Exposure?	Yes	No
Runny Nose?	Yes	No
Sinus Congestion?	Yes	No

EXTREMITIES:

Redness of a limb?	Yes	No
Swelling of a limb?	Yes	No
Discoloration of a limb?	Yes	No

Patient Signature:_____ **Date:**_____