Today's Date: _____

Patient Last Name: _____ **First Name**: _____ **Initial**: _____

Mailing Address:_____

City: _____ **State**: _____ **Zip**: _____ **Phone w/area code**: (_____)_____

Date of Birth: ____-____-____ **Age**: _____ **Sex**: M F **Patient SS#**: _____

Occupation/employer:_____ **Work Phone #**: _____

Cell Phone #: _____

Spouse's Full Name: _____ **Work Phone #**: _____

Occupation/employer:_____ **Cell Phone #:** _____

Patient's Primary Care Doctor Name: _____ **Phone #**:_____
(Required)

Primary Insurance Name: _____ **Policy Holder's Full Name**: _____
(This will be the name of the person who the insurance is under, usually Mom or Dad)

Policy Holder's Date of Birth: _____ **Policy Holder's SS#:** _____
(Required) **(Required)**

****(Only complete if patient has a secondary insurance)***
Secondary Insurance Name: _____ Policy Holder's Full Name:_____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Medicaid Recipient #: _____ (if applicable)

If policyholder's address & phone # are different from patients (please provide): _____

_____

****

PLEASE READ CAREFULLY AND SIGN BELOW:

If you are on a HMO, PPO or other type of managed care plan that we are providers for, it is OUR POLICY TO COLLECT PAYMENT IN FULL AT THE TIME OF THE VISIT. Sometimes exceptions are made so please discuss this with the receptionist or financial manager **BEFORE SEEING THE DOCTOR.** If you are on any type of Managed Care insurance: referrals to ancillary services will be made within your network, as stated by your insurance, unless you specifically request otherwise. Any services not covered by your insurance, HMO, PPO will be the responsibility of the insured. **IT IS THE INSURER'S RESPONSIBILITY TO OBTAIN REFERRALS AND/OR PRE-AUTHORIZATIONS REQUIRED BY THE INSURANCE COMPANY.** With the signature below, I hereby authorize treatment for the named child. I authorize the release of any information as deemed necessary, including x-rays, medical records, and insurance information to another Provider of service, Doctor's office or insurance company. I also authorize the assignment of benefits to **CENTRAL TEXAS PEDIATRIC ORTHOPEDICS AND SCOLIOSIS SURGERY, PA** and/or the physician rendering medical care. I understand that I am financially responsible for any non-covered services required for the care of the above named patient. **I understand the financial policies and agree to abide by them.**

_____ _____

Patient's Signature **Date**

MEDICAL INFORMATON

Referring Doctor's Name: _____ **Phone w/area code**: _____

State specific symptoms, problems, or reasons for visit today: _____

_____

If related to an accident or injury, please give full details. **Date of Incident**: _____

How & where did it happen: _____

_____

Was a motor vehicle involved? _____ If yes, please advise if the other party liability and/or other insurance coverage applies (Please specify details): _____

_____

Patient History

Please describe any unusual medical history: _____

_____

List any family history of medical problems or orthopedic problems: _____

_____

Is patient currently on any medications? _____ If yes, please list: _____

****Any medication allergies?** _____ If yes, please list: _____

Preferred Pharmacy: _____ **Phone Number**: _____

Pharmacy Address: _____

In the event of an emergency, who may we contact, other than the spouse, and release information to:

_____ _____ _____

Name **Phone # w/area code** **Relationship to patient**

****

Notice concerning complaints: Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners/Attention: Investigations/1812 Centre Creek Drive, Suite 300/PO Box 149134/Austin, TX 78714-9134. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353.

Aviso sobre quejas: Se pueden presentar quejas acerca de médicos, así también como de otras personas autorizadas y registradas por la junta de Examinadores Médicos del Estado de Texas, incluyendo ayudantes médicos y acupunturitas, para investigación en la siguiente dirección: Texas State Board of Medical Examiners/Attention: Investigations/1812 Centre Creek Drive, Suite 300/PO Box 149134/Austin, TX 78714-9134. Se puede obtener ayuda para presentar una queja llamando al siguiente número telefónico: 1-800-201-9353.

For Doctor's Notations:

HEALTH HISTORY: Adult Patient Questionnaire

PATIENT NAME: _____ BIRTH DATE: _____/_____/_____

This history form provides us with information to help us meet all your healthcare needs. Please complete this form, answering each question. This is a confidential part of your medical record and will be kept in this office.

Today's Date: _____

Place of Birth: _____

Highest level in school: _____

Occupation: _____

Previous occupations: _____

Marital Status: _____

Hobbies: _____

Exercise/recreation: _____

Habits:

Smoking (type & amount per day) _____

If former smoker, date quit: _____

Alcohol (type & amount per week): _____

Caffeine (type & amount per day): _____

Street drugs (type & amount per day): _____

Usual weight: _____ My ideal weight: _____

Date of last dental exam: _____

Please list all allergies (food, drugs, environment): _____

_____

_____

_____

When was your last physical exam? _____

Name of doctor: _____ Phone: _____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year occurred: _____

_____

_____

_____

_____

_____

Please list all medicines you are currently taking (include non-prescription drugs):

_____

_____

_____

_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

_____

_____

Any history of family violence? _____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

_____

_____

PAST MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles:	no	yes	Heart Disease:	no	yes	Diabetes:	no	yes
Mumps:	no	yes	Arthritis:	no	yes	Cancer:	no	yes
Chickenpox:	no	yes	Venereal			Polio:	no	yes
Whooping			Disease:	no	yes	Glaucoma:	no	yes
Cough:	no	yes	Anemia:	no	yes	Hernia:	no	yes
Scarlet Fever:	no	yes	Bladder			Blood or Plasma		
Diphtheria:	no	yes	Infections:	no	yes	Transfusions:	no	yes
Smallpox:	no	yes	Epilepsy:	no	yes	Back trouble:	no	yes
Pneumonia:	no	yes	Migraine			High/low Blood		
Rheumatic			Headaches:	no	yes	Pressure:	no	yes
Fever:	no	yes	Tuberculosis	no	yes	Hemorrhoids	no	yes

MEDICAL HISTORY CONT...

Do you have now or have you had within the past year:

(Please mark the correct response beside each question)

	Never	Occasionally	Often
Weakness or Paralysis:	☐	☐	☐
Tire Easily:	☐	☐	☐
Weight Changes:	☐	☐	☐
Change in Appetite:	☐	☐	☐
Sensitivity to cold or heat:	☐	☐	☐
Persistent Fever:	☐	☐	☐
Night Sweats:	☐	☐	☐
Hot Flashes:	☐	☐	☐
Skin Rash:	☐	☐	☐
Skin Problems:	☐	☐	☐
Changes in Nails or Hair:	☐	☐	☐
Headaches:	☐	☐	☐
Easy bleeding:	☐	☐	☐
Easy bruising:	☐	☐	☐
Double vision:	☐	☐	☐
Blurred vision:	☐	☐	☐
Eye pain:	☐	☐	☐
Infected eyes:	☐	☐	☐
Do you wear Glasses or Contacts?	☐	☐	☐
Last eye exam: _____			
Ringing in Ears	☐	☐	☐
Discharge from ears:	☐	☐	☐
Ear pain:	☐	☐	☐
Hearing loss:	☐	☐	☐
Frequent nose Bleeds:	☐	☐	☐
Frequent colds:	☐	☐	☐
Sinus problems:	☐	☐	☐
Loss of smell:	☐	☐	☐
Persistent Hoarseness:	☐	☐	☐
Sore Throat:	☐	☐	☐
Sore Tongue or Gums:	☐	☐	☐
Breast lump or Discharge:	☐	☐	☐
Chronic Cough:	☐	☐	☐
Shortness of Breath:	☐	☐	☐
Bloody Sputum:	☐	☐	☐
Wheezing:	☐	☐	☐
Chest Pain or Discomfort:	☐	☐	☐
Purple Fingers or Lips:	☐	☐	☐
Swelling of Hands, Feet or Ankle:	☐	☐	☐

	Never	Occasionally	Often
Difficulty Breathing:	☐	☐	☐
Palpitations or Fluttering of Heart:	☐	☐	☐
Leg Cramps:	☐	☐	☐
Enlarged Veins:	☐	☐	☐
Difficulty Swallowing:	☐	☐	☐
Heartburn:	☐	☐	☐
Frequent Belching:	☐	☐	☐
Abdominal Cramping:	☐	☐	☐
Nausea:	☐	☐	☐
Vomiting:	☐	☐	☐
Vomited or coughed up blood:	☐	☐	☐
Chronic Diarrhea:	☐	☐	☐
Chronic Constipation:	☐	☐	☐
Rectal Bleeding:	☐	☐	☐
Black, tarry stools:	☐	☐	☐
Dark urine:	☐	☐	☐
Yellow Jaundice:	☐	☐	☐
Frequent Urination (day)	☐	☐	☐
Frequent Urination (night)	☐	☐	☐
Increase in Thirst:	☐	☐	☐
Painful Urination:	☐	☐	☐
Leakage of Urine:	☐	☐	☐
Difficulty Starting Urine:	☐	☐	☐
Blood in Urine:	☐	☐	☐
Hemorrhoids:	☐	☐	☐
Backaches:	☐	☐	☐
Joint pain or stiffness:	☐	☐	☐
Swollen Joints:	☐	☐	☐
Muscle cramps or spasms:	☐	☐	☐
Sleeplessness:	☐	☐	☐
Seizures:	☐	☐	☐
Depression:	☐	☐	☐
Memory loss:	☐	☐	☐
Poor Coordination:	☐	☐	☐
Dizziness:	☐	☐	☐
Fainting:	☐	☐	☐

Women Only:

Age period began _____

# of Days period lasts _____

Days between periods _____

Medical History cont…

Date of last Chest x-ray: _____

Asthma:	no	yes	Mitral Valve Prolapse:	no	yes	Thyroid Disease:	no	yes
Hives/Eczema:	no	yes	Stroke:	no	yes	Bleeding Tendency:	no	yes
AIDS or HIV+:	no	yes	Hepatitis:	no	yes	Any Other Disease:	no	yes
Infections Mono:	no	yes	Ulcer:	no	yes	(Please List) _____		
Bronchitis:	no	yes	Kidney Disease:	no	yes	_____		

FAMILY HISTORY:

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

Cancer:	no	yes _____	Depression:	no	yes _____
Tuberculosis:	no	yes _____	Psychosis:	no	yes _____
Diabetes:	no	yes _____	Suicide:	no	yes _____
Heart Disease:	no	yes _____	Leukemia:	no	yes _____
High Blood Pressure:	no	yes _____	Migraine Headaches:	no	yes _____
Stroke:	no	yes: _____	Obesity:	no	yes _____
Epilepsy:	no	yes: _____	Thyroid Disease:	no	yes _____
Allergies:	no	yes: _____	Ulcer:	no	yes _____
Anemia:	no	yes: _____	High		
Bleeding Tendency:	no	yes: _____	Cholesterol:	no	yes _____
Asthma:	no	yes: _____	Kidney Disease:	no	yes _____
Chronic Lung Disease:	no	yes: _____	Glaucoma:	no	yes _____
Drug/Alcohol Prob.:	no	yes: _____	Gout:	no	yes _____

List the present age or the age of death of each of the following members of your family, also if living, add if their Health is good, fair, or poor. If deceased, list the cause of death.

Father: _____

Mother: _____

Brother(s): _____

_____

_____

Sister(s): _____

_____

_____

Spouse: _____

Son: _____

_____

_____

Daughter: _____

_____

_____

REVIEWED BY: _____ **M.D.** **DATE:** _____

CTPO OFFICE POLICY
ON STANDARD INSURANCE AND MANAGED CARE INSURERS

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each one has different stipulations regarding how often services may be rendered and where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated. Since many insurance companies have multiple claims addresses that can change periodically, you will be asked to provide a copy of your insurance card with each visit. If we are not providers for your health plan, you will be asked to pay for your services at the time of your visit.

Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance contract guidelines if you let us know at EACH time of service exactly what those guidelines are.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently orders services that are not covered, such as lab work or orthopedic equipment, we and/or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

Our common goal is for you to receive all of the benefits offered to you and care for your medical needs. This can be accomplished with your cooperation and help.

Payment of co-pays is required at the time services are provided. HMO participants are responsible for obtaining necessary referrals prior to scheduling an appointment. Unauthorized services will be the responsibility of the patient. Hospital fees and lab reports are billed to your insurance company by the reference lab and/or hospital. You may receive a separate bill from the hospital for any deductible or non-covered services. Should your insurance carrier require you to use specific ancillary facilities (physical therapy, labs, etc.), please inform your nurse. Failure to do so may result in charges that your insurance carrier may not cover.

Should your child need surgery or hospitalization, we file insurance claims with your insurance carrier for our physicians' fees. A copy of your insurance card and a current signed authorization form is required. Follow-up with your insurance carrier for reconsideration of your claim is your responsibility.

Special financial arrangements may be made in the business office for services after verification of coverage for any amounts not covered by insurance or if we are not contracted providers with your insurance company. Please provide us with your complete insurance information as soon as possible, including any secondary coverage which may be needed for coordination of benefits.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED. I WILL NOTIFY YOU IMMEDIATELY OF ANY CHANGES IN INSURANCE COVERAGE OR STATUS, OR OF ANY CHANGES OF ADDRESS OR PHONE NUMBERS.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR CENTRAL TEXAS PEDIATRIC ORTHOPEDICS & SCOLIOSIS SURGERY, PA

Patient Name: _____

Date of Birth: _____

I acknowledge that Central Texas Pediatric Orthopedics & Scoliosis Surgery, PA, provided me with a written copy of the Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient/Guardian Signature Date

_____ _____

Printed Name Relationship to Patient