Today's Date: _____

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

Mailing Address: _____

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

Patient's Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** M F **Patient's SS#:** _____

Legal Guardian(s) Name: _____ **Relationship to Patient:** _____

Mother's Full Name: _____ **Cell Phone #:** _____

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

Father's Full Name: _____ **Cell Phone #:** _____

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

Web Enable Patient: Yes____ or No ____ **Secure Email:** _____

(Required to Web Enable Patient)

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

Primary Insurance Name: _____ **Policy Holder's Full Name:** _____

(The name of the person who the insurance is under, usually mom or dad)

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

****Only complete the following if patient has 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 policy holder'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.**

Guardian's Signature: _____ **Date:** _____

Patient Name: _____
Date of Birth: _____/_____/_____
Age: ____ years ____ months
Sex: M F

Dr. Kaufman Orthopaedic Patient History Form:

Name & Relationship of adults with patient today: _____
Dominant Hand: □ Right □ Left □ Not Sure
Reason for today's visit: _____
When did the problem begin (or date of injury)? _____
Describe the problem: _____
_____
_____
Has the patient been seen for this problem before? If so, when and by whom? (Please include any physical therapy, brace, cast, etc.) _____
_____
Please list any previous labs, x-rays, MRI's, etc. performed to evaluate today's concern: _____
_____
Is there pain? □ Yes □ No If yes, please rate the pain on scale of 1 (almost no pain) to 10 (worst pain possible)_____
Current medications: _____
_____
Allergies with reaction (medications, food, etc.) _____
_____
Allergic to Latex? Yes / No Allergic to Iodine? Yes / No
Name of preferred Pharmacy: _____ Phone Number:_____
Pharmacy Address:_____
In the event of an emergency, who may we contact, other than parents, and release information to?

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

Birth History:
Birth Weight: _____ Full Term? Yes / No Weeks of gestation: _____ weeks
Type of delivery: Vaginal / Cesarean delivery Position at time of delivery: Head first / Breech / Other
Were there any complications with the pregnancy, labor, or delivery of the patient? _____
_____ □ None
Did the newborn patient require breathing assistance? Yes / No Required admission to the NICU? Yes / No

Growth and Development:
Age at rolling over: _____ Age at sitting: _____ Age at walking: _____
Has the patient had any physical therapy? Yes / No Occupational therapy? Yes / No Speech therapy? Yes / No
Does the patient use any assistive devices or orthotics? _____ □ None
Has the patient met his/her growth milestones? Yes / No First menstrual period occurred: _____ □ N/A

Past Medical History:
Are routine immunizations up to date? Yes / No
Hospitalizations: _____ □ None
Surgery: _____ □ None
Fractures: _____ □ None
Concussions: _____ □ None
Serious illnesses: _____ □ None
Other health issues: _____ □ None

Social History:

Child lives with: ☐ Mother ☐ Father ☐ Sister(s) (#? ___) ☐ Brother(s) (#? ___) Others: _____

☐ Patient is adopted ☐ Patient lives in foster home ☐ Patient lives in an institution: _____

Grade in school? _____ Name of school? _____

Sports/Dance/Recreational Activities? _____ ☐ None

Does the patient smoke? Yes / No Does anyone in the household smoke? Yes / No

Family History:

Has anyone in the family had:

☐ Scoliosis: _____	☐ None
☐ Neurologic disorder: _____	☐ None
☐ Neuromuscular disorder: _____	☐ None
☐ Muscular dystrophy: _____	☐ None
☐ Hip disorder: _____	☐ None
☐ Clubfoot: _____	☐ None
☐ Cancer: _____	☐ None
☐ Sudden death: _____	☐ None
☐ Arthritis: _____	☐ None
☐ Bleeding/clotting disorder: _____	☐ None
☐ Other bone/joint problem: _____	☐ None
☐ Anesthesia problem: _____	☐ None

Review of Systems:

Does the patient have a problem with:

Yes	No		Yes	No	
☐	☐	Appetite/weight loss/weight gain	☐	☐	Other skin concern
☐	☐	Recent fatigue	☐	☐	Concussion
☐	☐	Recent or unexplained fevers	☐	☐	Dizziness
☐	☐	Vision/blurry sight	☐	☐	Numbness/tingling/weakness
☐	☐	Hearing/ringing in the ears/swallowing	☐	☐	Seizures
☐	☐	Chest pain/irregular heartbeat	☐	☐	Psychological concern/depression
☐	☐	Shortness of breath/asthma	☐	☐	Attention Deficit Hyperactivity Disorder
☐	☐	Abdominal pain/vomiting	☐	☐	Early or delayed puberty/diabetes
☐	☐	Kidneys/urination/bedwetting	☐	☐	Bleeding or clotting/sickle cell/anemia
☐	☐	Disordered eating/nutrition problem	☐	☐	Immune system/Celiac disorder
☐	☐	Rash	☐	☐	Anesthesia

Questions regarding today's problem: _____

_____

Notes needed at today's visit:

☐ School ☐ Gym/Physical Education ☐ Sports ☐ Parent's Work

Thank you!

Physician Signature: _____ Date: _____

PA/APN Signature: _____ 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 order 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 for 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. IW ILL NOTIFY YOU IMMEDIATELY OF ANY CHANGESIN 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**

Authorization to Accompany Minor to Appointment

To Protect Your Child's Confidentiality

Please read this carefully.

Please list the name, relation, date of birth, and contact information for anyone authorized to:

1. **accompany your child to an appointment, and**
2. **make medical decisions in your absence, and**
3. **have access to your child's medical record**

Patient Name: _____ Patient DOB _____

We will not be able to treat your child if accompanied by any person not listed below.

(Please include YOURSELF, parents, step-parents, caregivers, grandparents, legal guardians, etc. that you grant authorization.)

Name: _____ Name: _____

DOB: _____ DOB: _____

Relation: _____ Relation: _____

Contact #: _____ Contact #: _____

Name: _____ Name: _____

DOB: _____ DOB: _____

Relation: _____ Relation: _____

Contact #: _____ Contact #: _____

Name: _____ Name: _____

DOB: _____ DOB: _____

Relation: _____ Relation: _____

Contact #: _____ Contact #: _____

If you wish to change this information at any time – please notify our office in writing.

_____ _____

Parent/Legal Guardian Name **Parent/Legal Guardian Signature**

_____

Date