



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. Ellington Orthopaedic Patient History Form:

Name & Relationship of adults with patient today: _____

Dominant Hand (if upper extremity injury): Right Left

Reason for today's visit: _____

When did the problem begin (or date of injury)? _____

Has the problem gotten Better / Worse / Or stayed the same since it began?

Was there an injury? Yes No

If yes, briefly describe what happened

Is there pain? Yes No

If yes, please rate the pain on scale of 1 (almost no pain) to 10 (worst pain possible) _____

What makes the pain better? _____

What makes the pain worse? _____

Does the pain limit activities? Yes No

How long does the pain last? seconds/ minutes/ hours/ days

Swelling? Yes No

Locking / Popping / Catching / Giving way in the extremity

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: _____

Birth History:

Birth Weight: _____ Full Term? Yes No

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

Growth and Development:

Age at walking: _____

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

Current medications: _____

Allergies with reaction (medications, food, etc.) _____

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
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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 | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Appetite/weight loss/weight gain | <input type="checkbox"/> | <input type="checkbox"/> | Other skin concern |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Concussion |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent or unexplained fevers | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision/blurry sight | <input type="checkbox"/> | <input type="checkbox"/> | Numbness/tingling/weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing/ringing in the ears/swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain/irregular heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Psychological concern/depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath/asthma | <input type="checkbox"/> | <input type="checkbox"/> | Attention Deficit Hyperactivity Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain/vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Early or delayed puberty/diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidneys/urination/bedwetting | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding or clotting/sickle cell/anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Disordered eating/nutrition problem | <input type="checkbox"/> | <input type="checkbox"/> | Immune system/Celiac disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash | <input type="checkbox"/> | <input type="checkbox"/> | Anesthesia |

Questions regarding today's problem: _____

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. 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

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