Southwest Orthopaedic Group

Patient Information

First Name:_____ Middle:_____ Last: _____ Date Birth: ____/_____/_____
Social Security #: _____-_____-_____ Sex: ☐ Male ☐ Female
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____
Preferred Language: _____ Marital Status: _____

Currently living in a Skilled Nursing Facility? If Yes:
Name_____ Phone Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Referring Physician (***REQUIRED FIELD***)

Referring Physician: _____ and
Primary Care Physician: _____

Preferred Pharmacy (***REQUIRED FIELD***: If you do ***NOT*** have a pharmacy, please choose one today).

Name: _____Phone Number: _____
Address: _____ City: _____
State: _____ Zip Code: _____

Interpretation Services

Do you need an Interpreter for your visits with us? ☐ Yes ☐ No
If YES, Please state:

☐ Hearing Impaired ☐ Language _____

In Case of Emergency: Emergency Contact

First Name: _____ Last: _____ Cell:____-_____
Secondary Phone: _____-_____ Relationship to patient: _____

Billing Information : If Guarantor is not patient, please provide additional contact below.

Name of person responsible for Bill:_____
Address: _____ City: _____ State: _____
Zip Code: _____ Social Security #: _____-____-_____ D O.B._____
Primary Phone: _____

Employer Name: _____ Phone: _____

Insurance Information

Primary Insurance Carrier: _____ Telephone #: _____
Address on Back of Card: _____
City: _____ State: _____ Zip: _____
Secondary Insurance Carrier: _____ Telephone #: _____
Address on Back of Card: _____
City: _____ State: _____ Zip: _____

Is your visit due to:
☐ Work Related Injury ☐ Auto Accident ☐ Personal Injury Date of Injury: _____/_____/_____

Please briefly describe what brings you in today?

_____
_____

Past Surgical and Medical History

Please List All **Past Surgeries** And Dates:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Please List **ALL** Current Medications:

_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____
_____ Strength: _____ Dosage: _____

Drug Allergies: Please List all Medications You Are Allergic to:

Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____
Name: _____ Reaction: _____

Past Medical History: Please **Check** All items that Apply:

☐Anemia	☐Colon/Intestinal	☐Hepatitis	☐Migraines	☐Seizures/ Epilepsy
☐Asthma	☐COPD	☐Hiatal Hernia	☐Mitral Valve Prolapse	☐Sleep Apnea
☐Blood Clots	☐Cubital Tunnel	☐High Cholesterol	☐Pacemaker/Defibrillator	☐Stent Placement
☐Breast	☐Diabetes	☐Hypertension	☐Pancreatitis	☐Stomach
☐Bronchitis	☐Emphysema	☐Hypoglycemia	☐Pneumonia	☐Stroke
☐Bunions	☐Gallbladder	☐Jaundice	☐Polio	☐Thyroid Problems
☐Cancer	☐Gout	☐Kidney Disease	☐Prostate Disease	
☐Carpal Tunnel	☐Heart Attack	☐Liver Disease	☐Rheumatoid Arthritis	
☐Colitis	☐Heart Disease	☐Mental Illness	☐Rotator Cuff Injury	

Other:

_____
_____

Are you being seen by a Cardiologist? YES _____ NO_____
If Yes, by whom? _____ Date of last visit: _____
Have you ever had an adverse reaction to anesthesia? YES _____ NO _____
If yes, please describe:

_____

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Orthopaedic and Systems Screen: Please **CHECK** all items that apply

Constitutional: ☐Weight Gain ☐Weight Loss ☐Fever ☐Night Sweats ☐Exercise Intolerance

Eyes: ☐Irritation ☐Dryness ☐Change in Vision

ENMT: ☐Difficulty hearing ☐Ear Pain ☐Nosebleeds ☐Sinus Problems ☐Snoring ☐Sore Throat ☐Bleeding Gums ☐Dry Mouth ☐Mouth Ulcers ☐Oral Abnormalities ☐Teeth Problems

Cardiovascular: ☐Shortness of Breath ☐Palpitations ☐Chest Pain ☐Arm Pain ☐Heart Murmur

Respiratory: ☐Cough ☐Wheezing ☐Shortness of Breath ☐Coughing up Blood

Gastrointestinal: ☐Vomiting ☐Diarrhea ☐Abdominal Pain ☐Loss of Appetite ☐Vomiting Blood

Genitourinary: ☐Incontinence ☐Hematuria ☐Difficulty Urinating ☐Urination Frequency

Musculoskeletal: ☐Muscle Aches ☐Weakness ☐Arthralgia ☐Joint Pain ☐Back Pain ☐Swelling

Integumentary: ☐Jaundice ☐Rashes ☐Moles

Neurologic: ☐Weakness ☐Numbness ☐Seizures ☐Headaches ☐Loss of Consciousness

Psychiatric: ☐Depression ☐Sleep Disturbance ☐Alcohol Abuse

Endocrine: ☐Fatigue ☐Weight Gain ☐Weight Loss

Hematologic/Lymphatic: ☐Bruising ☐Swollen Glands

Allergic/Immunologic: ☐Itching ☐Hives ☐Runny Nose ☐Sinus Pressure ☐Frequent Sneezing

Social History

Do you Smoke? YES _____ NO _____ Former Smoker: YES _____ NO _____
If Yes, How many packs per week? _____ Years of use: _____
Chewing Tobacco? YES _____ NO _____ Years of use: _____

Do You Drink Alcohol? YES _____ NO _____ If yes please circle what applies below:
Rarely Daily Alcoholic Socially Weekly Recovering Alcoholic

Drug Use? Never _____ Past _____ Currently _____

Work Status: Employed____ Unemployed____ Light Duty _____ Full Duty ____ Retired____

Family History: Please Write **Immediate Family** member that has had indications below:

Diabetes _____ High Blood Pressure _____
Heart Disease _____ Low Blood Pressure _____
Vascular Disease _____ Cancer _____
Bleeding Disorders _____ Other _____
High Cholesterol _____

Women Only: Are you pregnant? YES_____ NO _____ If Yes, Due Date: _____

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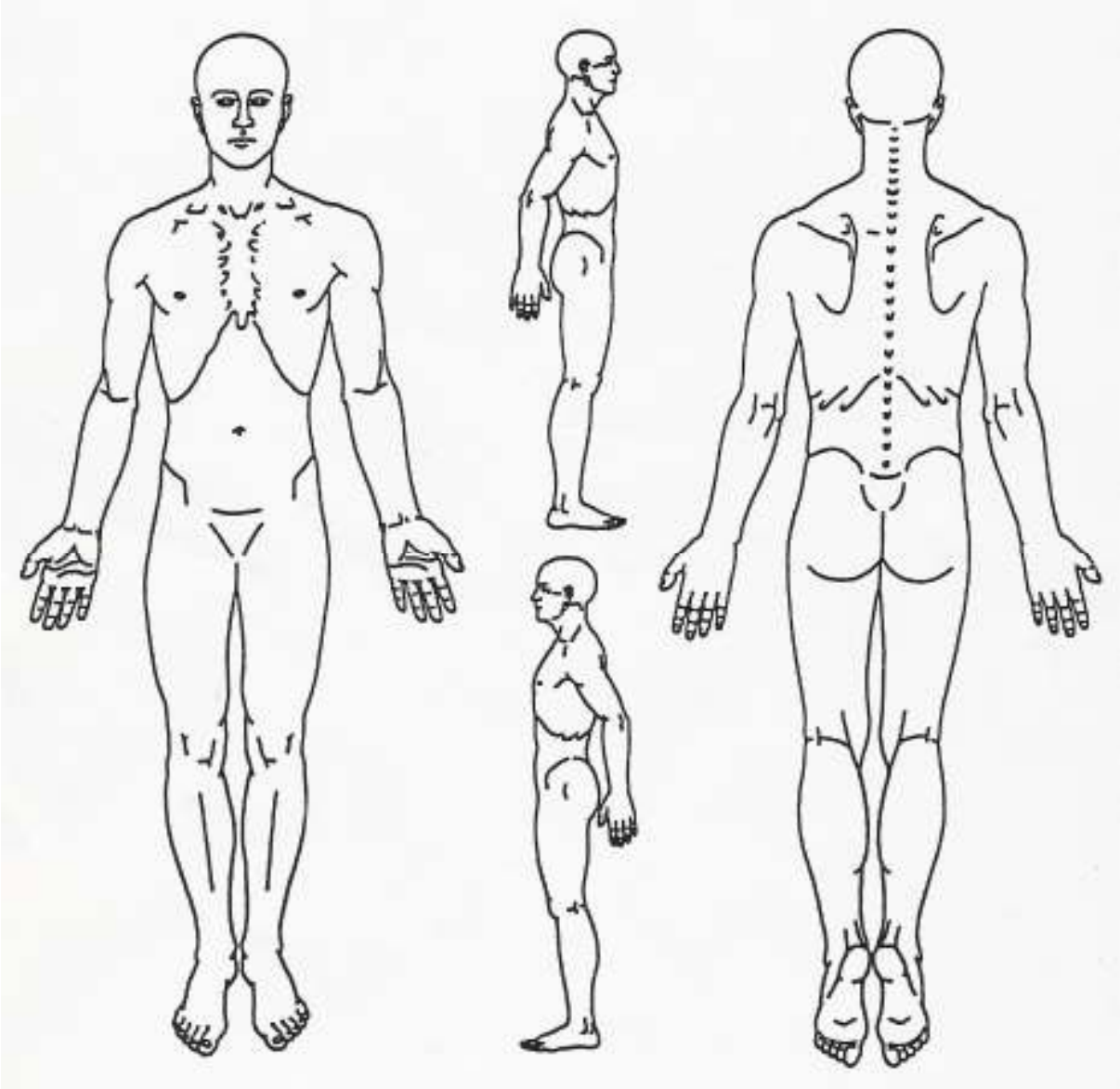
PAIN DRAWING

Please mark the figures below with the letters that best describe the sensation or pain you are feeling. Please mark areas where pain radiates or spreads with a ↑, ↓, or ←, → arrow to indicate the direction of radiating pain. (Include all affected areas)

A =	**Ache**	**B =**	**Burning**	**R =**	**Radiating Pain**	**D =**	**Dull Pain**
N =	**Numbness**	**S =**	**Stabbing**	**P =**	**Pins & Needles**	**O =**	**Other**



Please indicate how you would rate your pain **(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH) (HIGH)**

Acknowledgement – Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received Southwest Orthopaedic Group's Notice of Privacy Practices.

_____ **Date:** ____/_____/_____

Signature
Patient or Patient Representative

_____ **Date:** ____/_____/_____

Patient Refusal to Sign / Employee

Who may we give information to regarding your condition, treatment, or diagnosis?

Name	Phone	Relationship

Is there anyone who should **never** have this information:

Name	Phone	Relationship

Please list the contact phone numbers where we are able to contact you:

Place	Phone Number	Able to Leave a Message?
Home		
Answering Machine or Service		
Work		
Cell Phone		

May we send you emails related to patient information or appointments? YES _____ NO _____
Email Address: _____

☐ I give SWOG permission to obtain my 2 year medication history from SureScripts.

Please sign and date below:

_____ **Date:** ____/_____/_____

Print - Patient or Patient Representative

_____ **Date:** ____/_____/_____

Signature - Patient or Patient Representative

Southwest Orthopaedic Group

Financial Policies

This document provides you with the financial policies used by Southwest Orthopaedic Group. In order to be seen by one of our providers you must initial and sign this form. If you have any questions please ask a staff member.
Consent to pay for services rendered: Copayment, co-insurance and deductibles are required for all services at the time the services are rendered. We accept Medicare, Worker's Comp and many commercial insurance plans. We will send your claim to your insurance company and any balance that is unpaid by your insurance company will be forwarded to you for payment. It is your responsibility to verify with your insurance plan if we are a contracted provider and to understand your coverage benefits under your policy. For your convenience, we accept Visa, MasterCard, American Express and Discover.

Please read and initial the following regarding our financial policies:

_____ I understand that I am responsible for any remaining balance not covered by my insurance company.
_____ Due to the large volume of missed appointments, we now require 24 hours notice if you need to cancel an appointment. If you miss an appointment or cancel an appointment without giving 24 hours notice you will be charged a $25 missed appointment fee.
_____ If you have to schedule surgery, we require 24 hours advanced cancellation notice. There will be a $150 charge for surgeries that are cancelled with less than 24 business hours notice. If your surgery is scheduled for less than 24 hrs out, we will review your situation case-by-case.
_____ We refer delinquent accounts to an outside collection agency. If it became necessary to refer your account to a collection agency, an administrative service fee of $25 plus a collection fee of 30% of your balance will be assessed to your account.
_____ Our office charges a $25 administration fee for FMLA paperwork, Short-term disability paperwork, and any requests for medical records that are under 25 pages. There will be an additional charge of $.50 per page over 25 pages. Payment is due in advance and please allow 48 business hours for processing.
_____ Our office charges a $25 administration fee for NSF / Returned Checks per occurrence. We will reserve the right to no longer accept checks made to your account.

NO SHOW Policy

Your doctor will prescribe an individual treatment plan to care for your condition. This treatment plan will require commitments from both you and your doctor.

Once this treatment plan is agreed to, your doctor will need to monitor your progress and may require you to attend visits in our offices. In order to ensure the availability of appointments for those in need, we have established a "NO SHOW" policy for our practice.

A "NO SHOW" appointment occurs when you do not show up for a scheduled appointment, arrive late, or when you cancel your appointment with less than one business day's notice (24 hours), as noted above. If you fail to attend 3 (three) appointments in a six month period of time, you will be discharged from our practice. If you are discharged, you will not be allowed to make future appointments with any physician in our practice.

If you are unable to make your scheduled appointment, please call our office at least 24 hours in advance. We will make every attempt to reschedule you into a slot that is convenient for you and your doctor based upon the urgency of the appointment.

I have read the above stated financial policy and agree to meet my financial obligation in accordance with this policy.

_____ **Date:** ____/_____/_____
Print - Patient or Patient Representative

_____ **Date:** ____/_____/_____
Signature - Patient or Patient Representative

Southwest Orthopaedic Group

Controlled Substance Contract

Controlled substance medications (i.e. narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function, and/or ability to work.

Because my provider is prescribing controlled substance medications to help manage my pain, I agree to the following:

_____ I am responsible for the controlled substance medications prescribed to me. If my prescriptions are misplaced, stolen, or if I "run out early", I understand that this medication **will not be replaced** regardless of the circumstances.

_____ Refills of controlled substance medications;

- _____ a) will only be made during regular office hours, Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends, or during holidays.
- _____ b) will not be made if "I lost my prescription", ran out early, or misplaced my medication. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.
- _____ c) I understand that I must call ahead within 72 hours to schedule an appointment.

_____ It may be deemed necessary by my doctor that I see a medication-use specialist (pain management) at the time and during the time that I am receiving controlled substance medications. I understand that if I do not attend such an appointment, my medications may be discontinued, or may not be refilled beyond tapering dose completion. I understand that if the specialist feels that I am at risk for psychological dependence (addiction), my medications will no longer be filled.

_____ I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____ I understand that the main treatment goal is to reduce pain, and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoidance of the use of tobacco and alcohol. I must also comply with the treatment plan as prescribed by my physician.

_____ I understand that the long term advantages and disadvantages of chronic opioid use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept and agree that there may be unknown risks associated with the long term use of controlled substances that my physician will advise me of advances in the field and will make necessary treatment changes.

_____ I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I have been fully informed by my provider regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and doing so increases the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.

_____ **Date:** ____/_____/_____

Signature - Patient

_____ **Date:** ____/_____/_____

Signature – Provider

2500 W. William Cannon Drive, Suite 401
Austin, Texas 78745
PH: 512-451-1969 FX: 512-458-2575

AUTHORIZATION FOR RELEASE OF INFORMATION

Records requested:

□ Complete medical records
□ Records of care from (Dates of Service) _____ to _____ only
□ Other (please specify) _____
□ Confer with another person orally about information in my record.

- Name: _____
- Date of Birth: _____/_____/_____
- Contact telephone number: (_____) _____ - _____

I understand that the information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
□ **YES**, I consent to the release of this information. □ **NO**, I do not consent to the release of this information.

Reason for Release: (Article 4495 b, Sec. 5.08 (j) Texas Civil Statutes requires that an authorization for release of medical records include "the reason or purpose for the release.")

□ Change of Physician □ Patient Relocation □ Application for Insurance Coverage
□ Workers' Compensation Claim □ Disability Claim □ Consult w/ another physician for condition
□ Other: _____

Records Requested FROM:

_____
Physician / Person / Facility Name
_____
Address
_____
City / State / Zip

Records Sent TO:

Southwest Orthopaedic Group
Physician / Person / Facility Name
2500 W William Cannon, Ste. 401
Address
Austin, Texas 78745
City / State / Zip

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires automatically in one year.
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Southwest Orthopaedic Group liable for the misinterpretation of the information in my medical record as a result of not consulting with my physician for the correct interpretation.
Patient Name (Please Print): _____
Date of Birth: _____ Social Security #: _____
Patient's Signature: _____
(Patient or person legally authorized to consent on patient's behalf. If not patient, state the relationship to the patient and the reason patient is unable to sign.