SEGUIN ORTHOPEDICS

PATIENT INFORMATION

Full name: _____ Date of Birth: _____

Address: _____

Phone #: _____ □ Home □ Cell □ Work Email: _____

Marital Status: □ Single □ Married □ Separated □ Widow

Race: □ White □ Hispanic □ African American □ Other

Please provide your ID & Insurance Card(s) upon check-in. Copays/deductibles due at time of service
Private Pay or Uninsured Patients: Payment for service is due at time of service

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that the Practice has provided me with a copy of the Notice of Privacy Practices, and understand that I am entitled to receive a copy of this document.

□ It is acceptable for you to leave information on my answering machine, including appointment reminder

□ I do not want you to speak with any family members/friends regarding my condition

□ It is acceptable for you to speak with only the following family members/friends regarding my condition

Please list: _____ _____ _____

* It is the patient's responsibility to notify the office staff of any changes to this Authorization*

Employer: _____ Occupation: _____

Referring Dr: _____ Family Dr: _____

Preferred Pharmacy: _____ Location: _____

Height: ___ ft. ___ in. Weight: _____ lbs.

Drug Allergies? □ No □ Yes (Explain) _____

Metal Allergies? □ No □ Yes (Explain) _____

Why are you seeing us today? _____

_____

Date of Injury: _____ Was the injury due to a work-related accident? □ Yes □ No

Prescription medications you are currently taking: (Fill out only if a list is not provided by you)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

PRESCRIPTION REFILL POLICY

- If your medication needs a prior authorization, contact your PCP or your insurance
- We require up to 72 hours to process prescription refill requests
- Requests for a narcotic requires an office visit, no exceptions
- Bring an updated list of all your medications to your office visit
- PLEASE CALL THE OFFICE BEFORE YOU RUN OUT OF A MEDICATION

PATIENT CLINICAL HISTORY

Have you or an immediate family member (parents/siblings/children) ever been diagnosed with:

	Self	Family/Relation			Self	Family/Relation
Asthma	☐	☐	_____	High Blood Pressure	☐	☐ _____
Anemia	☐	☐	_____	Kidney Disease	☐	☐ _____
Anxiety Disorder	☐	☐	_____	Liver Disease	☐	☐ _____
Arthritis	☐	☐	_____	Lung Disease	☐	☐ _____
Bleeding Disorder	☐	☐	_____	Osteoarthritis	☐	☐ _____
Blood Clots or DVT	☐	☐	_____	Osteoporosis	☐	☐ _____
Coronary Artery Disease	☐	☐	_____	Pacemaker	☐	☐ _____
Diabetes	☐	☐	_____	Peripheral Artery Disease	☐	☐ _____
GERD/Reflux	☐	☐	_____	Pulmonary Embolism	☐	☐ _____
Gout	☐	☐	_____	Rheumatoid Arthritis	☐	☐ _____
HIV or AIDS	☐	☐	_____	Stroke	☐	☐ _____
Heart Disease	☐	☐	_____	Tuberculosis	☐	☐ _____
Hepatitis	☐	☐	_____	Ulcers	☐	☐ _____
				Urinary Tract Infections	☐	☐ _____

Tobacco Use: ☐ Never ☐ Former ☐ Current Packs per day ___ ☐ Cigars ☐ Chewing Tobacco

Alcohol Use: ☐ No ☐ Yes Drinks per week _____

Dexa Scan: __No __Yes Have you had osteoporosis screening/scan within the last 2 years?

Advanced Directive: __No __Yes **Medical Power of Attorney:** __No __Yes

Surgical History – List any surgeries you have had:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Review of Systems (Only circle what applies):

General: Weight Loss, Weight Gain, Fever, Exercise Intolerance

Eyes: Irritation, Change in Vision

Head/Mouth/Nose/Throat: Sore Throat, Sinus Problems, Difficulty Hearing, Snoring, Oral Abnormalities

Cardiovascular: Chest Pain, Palpitations, Arm Pain with Exertion

Respiratory: Cough, Shortness of Breath, Sputum, Coughing Blood

Gastrointestinal: Abdominal Pain, Vomiting

Neurological: Headaches, Confusion, Seizures, Weakness, Numbness, Dizziness

Musculoskeletal: Joint Pain, Joint Swelling

Hematologic/Lymphatic: Swollen Glands, Easy Bruising

Allergies/Immune System: Runny Nose, Sinus Pressure, Hives

FINANCIAL POLICY

1. **Permission for Release of Medical Information:** For insurance purposes, I hereby authorize the provider of services to release information concerning my examination and/or treatment from the medical records compiled during the duration of my care. This waiver also authorizes release of copies of my medical records to healthcare providers and organizations who are involved in my continued care. I understand I have the right to obtain copies of my medical records.

2. **Cash discounts:** Cash discounts are offered on most services to uninsured patients who pay in full at the time of service or by the "Due Date." We offer Care Credit as well as reasonable payment plans should expenses pose a financial burden.

3. **Non-Payment:** Please be aware that if a balance remains unpaid, your account will be turned over to a collection agency after the 90th day past due.

4. **Updated Change of Information & Coverage:** It is your responsibility to make us aware of any changes in address, employment, insurance, etc. Failure to provide us with the correct updated information may result in the entire cost of the services rendered be made payable by you at the time of service.

5. **No Show Policy:** Kindly give us 24 hours' notice for rescheduled or cancelled appointments. Multiple no show appointments may be subject to dismissal from the practice.

6. **Referrals:** Some insurance plans require a referral from a primary care physician to obtain services of a specialist. These health plans will not pay for services rendered without a referral. It is YOUR responsibility to obtain a referral prior to treatment, otherwise your appointment may be rescheduled.

7. **Filling Out Forms:** There is a $25.00 fee for filling out FMLA paperwork and any other forms. Please allow 5 business days for the completion of forms.

8. I hereby assign my insurance benefits to be paid directly to the physician.

I have reviewed and both understand and agree with the terms and policies of Seguin Orthopedics.

Patient/Guardian Signature _____ Date _____