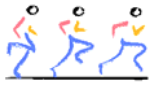
Fondren Orthopedic Group L.L.P.



Patient Information	**Provider #:**		**Account Number:**	
Patient's Name (First MI Last)	**Gender** ☐M ☐F	**DOB** **Age**	**DL#**	**SSN**
Address	**City**	**State**	**Zip Code**	**Phone** Home: Cell:
Email Address	**Race**		**Ethnicity**	**Preferred Language**
Patient's Employer	**Business Phone**		**Marital Status** ☐ M ☐S ☐D ☐W	**Referring / Primary MD**
Spouse's Name	**Spouse's Employer**		**DOB**	**SSN**

Guarantor Information (if patient is a minor)			
Guarantor's Name	**Relationship to Patient**	**DOB**	**SSN**
Billing Address	**City** **State**	**Zip Code**	**Emergency Phone**

Insurance Information			
Insurance Carrier Name-Primary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN** **DOB**	**Relationship**
Insurance Carrier Name – Secondary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN** **DOB**	**Relationship**

What other ways may we contact you? Please circle YES or NO if you would like us to leave a message at the numbers you provide:

Home #: YES or NO **Work #:** YES or NO **Cell:**_____ YES or NO **Other #:** _____ YES or NO

FAMILY AND FRIENDS: Please let us know what persons we may share info with (i.e. family, friends, other doctors etc.) and list them below:

NAME RELATIONSHIP TO YOU PHONE #

1. _____ _____ _____

2. _____ _____ _____

3. _____ _____ _____

Please check one of the following: ☐ This **IS** a work-related injury. ☐ This **IS NOT** a work-related injury

MEDICARE / MEDICAID – PATIENT'S ONLY

I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office. I have read and understand the above statement regarding MEDICARE coverage.

☐ Medicare is my **primary** coverage.
☐ Medicare is my **secondary** coverage.
☐ I **am not** covered by Medicare or a Medicare HMO

☐ Medicaid is my **primary** coverage.
☐ Medicaid is my **secondary** coverage.
☐ I **am not** covered by Medicaid or a Medicaid HMO

ASSIGNMENT OF BENEFITS: I hereby authorize Payment to the Fondren Orthopedic Group, L.L.P. for the surgical and/or medical benefits, if any, otherwise payable to me for services I have received. **FINANCIAL OBLIGATION:** The undersigned Hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

☐ Payment is required today for all co-pays, deductibles, or co-insurance amounts that may be due by the patient.

X_____ _____
Signature of Patient/Parent/or Guardian Date

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and / or treatment. I understand that this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

X_____ _____
Signature of Patient/Parent/or Guardian Date

CONSENT TO CARE: I authorize and direct Fondren Orthopedic Group, L.L.P. to perform upon me injections, draw blood and / or any other procedure or treatments the doctor may in his best judgment determine advisable for my well being.

X_____ _____
Signature of Patient/Parent/or Guardian Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

FONDREN ORTHOPEDIC GROUP L.L.P.

I, **[name of patient]** _____, acknowledge and agree that I have reviewed a copy of **Fondren Orthopedic Group's Notice of Privacy Practices**.

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to patient

Clinic Use Only:

Fondren Orthopedic Group, LLP made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

_____

_____

_____

_____ _____
Signature of Employee Date

_____ _____
Print Name of Employee Title

Fondren Orthopedic Group, L.L.P.
7401 South Main Street
Houston, TX 77030-4509
713-799-2300

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.,** your medical provider, to: (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from the redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

_____

Print Patient's Name

_____ _____

Patient's Signature **Date**

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

_____

Print Legal Representative's Name

_____ _____

Legal Representative's Signature **Date**

PATIENT QUESTIONNAIRE

NAME:_____ **DOB:**_____**TODAY'S DATE:**_____
OCCUPATION: _____**HEIGHT:** ____ **WEIGHT:** ____ **DOMINANT HAND:** __ **R** __ **L**
CHIEF COMPLAINT:_____ **DATE OF INJURY:**_____
AFFECTED SIDE? __ **R or** __ **L DESCRIBE PROBLEM:** _____
INJURY LOCATION: _____ **INJ. RELIEVED:** _____ **INJ. AGGREVATED:** _____

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY) ___ **NONE APPLY**

___ANEMIA
___ANXIETY
___ASBESTOSIS
___ASTHMA
___BIPOLAR DISORDER
___BLEEDING DISORDER
___BLOOD CLOT
___BRONCHITIS
___CANCER
___CA BRAIN
___CA BREAST
___CA CERVICAL
___CA COLON
___CA KIDNEY
___CA LUNG
___CA OVARIAN
___CA PROSTATE
___CA THYROID
___CHEST PAIN
___CHRONIC BACK PAIN
___COR. ARTERY DISEASE
___CON. HEART FAILURE
___DEPRESSION
___DIABETES
___EMPHYSEMA
___HEART ATTACK
___HEART MURMUR
___HYPERTENSION
___HEART STENT
___HEPATITIS A B C
___IRR. HEARTBEAT
___HIATAL HERNIA
___HIGH CHOLESTEROL
___HIV
___HYPERTHYROIDISM
___HYPOTHYROIDISM
___KIDNEY STONES
___LIVER PROBLEMS
___LUNG PROBLEMS
___LUPUS
___MIGRAINES
___OTHER_____ _____
___NUMBNESS/TINGLING
___OSTEOARTHRITIS
___PNEUMONIA
___POOR CIRCULATION
___PULMONARY EMBOLISM
___REFLUX
___RHEUMATOID ARTHRITIS
___SEIZURE
___SLEEP APNEA
___STROKE
___TUBERCULOSIS
___UTI

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY) ___ **NONE APPLY**

___ABDOMINAL SURGERY
___AMPUTATION
___ANGIOPLASTY
___APPENDECTOMY
___ARTHROSCOPY KNEE
___ARTHROSCOPY SHOULDER
___BRONCHOSCOPY
___CABG
___CAROTID ENDARTERECTOMY
___COLON RESECTION
___FEMORAL BYPASS
___FRACTURE REPAIR
___GALLBLADDER REMOVAL
___GASTRIC BYPASS/BANDING
___HEART SURGERY
___HEMORRHOIDECTOMY
___HIP REPLACEMENT
___HYSTERECTOMY COMPLETE
___HYSTERECTOMY PARTIAL
___INTERVENTIONAL PAIN PROCEDURES
___KNEE REPLACEMENT
___KYPHOPLASTY
___NEPHRECTOMY
___PACEMAKER
___PARATHYROIDECTOMY
___PNEUMONECTOMY
___PROSTATECTOMY
___ROTATOR CUFF REPAIR
___SPINE SURGERY CERVICAL
___SPINE SURGERY THORACIC
___SPINE SURGERY LUMBAR
___TONSILLECTOMY
___T U R P
___VASECTOMY
___VERTEBROPLASTY
___OTHER_____

FAMILY HISTORY (CHECK ALL THAT APPLY) ___ **NONE APPLY**

___ANESTHESIA PROBLEMS
___ARTHRITIS
___ASTHMA
___BLEEDING DISORDER
___CA BRAIN
___CA BREAST
___CA CERVICAL
___CA COLON/RECTAL
___CA KIDNEY
___CA LUNG
___CA OVARIAN
___CA PROSTATE
___CA THYROID
___CANCER
___DIABETES
___HYPERTENSION (DAD)
___HYPERTENSION (MOM)
___OSTEOPOROSIS
___STROKE
___TUBERCULOSIS
___OTHER_____

SOCIAL HISTORY (CHECK ALL THAT APPLY) ___ **NONE APPLY**

___SINGLE
___MARRIED
___DIVORCED
___WIDOWED
___CIGARETTES
___PIPE SMOKING
___CHEWING TOBACCO
smoke years: packs/day:
___ALCOHOL **drinks/day:**
___PHYSICAL WORK
___SEDENTARY WORK
___RETIRED
___HOMEMAKER
___STUDENT
___REGULAR DUTY
___LIGHT DUTY
___OUT OF WORK

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) ___**NONE**

_____ _____ _____
_____ _____ _____
_____ _____ _____

PHARMACY USED: _____ **PH#**_____

ALLERGIES TO MEDICINE: (LIST ALL) ___ **NO ALLERGIES**

_____
_____

WAS THIS RELATED TO AN AUTOMOBILE ACCIDENT? __ **Y** __ **N**

REVIEW OF SYSTEMS

*(Please circle **YES or NO** if any currently apply to you)*

PRINT PATIENT NAME:_____ **PATIENT DOB:** _____ **DATE:** _____

Have you had any new symptoms?	Yes	No

GENERAL:

Fever?	Yes	No
Chills?	Yes	No
Sweats?	Yes	No
Weakness?	Yes	No
Malaise?(discomfort)	Yes	No
Abnormal Weight Loss?	Yes	No
Sleep Disturbance?	Yes	No

EYES, EARS, NOSE, THROAT:

Double Vision?	Yes	No
Blurred Vision?	Yes	No
Eye Irritation?	Yes	No
Eye Discharge?	Yes	No
Vision Loss?	Yes	No
Eye Pain?	Yes	No
Light Sensitivity?	Yes	No
Earache?	Yes	No
Ringing in Ears?	Yes	No
Nasal Congestion?	Yes	No
Nosebleeds?	Yes	No
Sore Throat?	Yes	No
Difficulty Swallowing?	Yes	No
Hearing Loss?	Yes	No

CARDIAC:

Chest Discomfort?	Yes	No
Chest Pains?	Yes	No
Palpitations?	Yes	No
Syncope? (fainting)	Yes	No
Shortness of Breath?	Yes	No
Numbness in Arms?	Yes	No
Swelling of Limbs?	Yes	No

RESPIRATORY:

Cough?	Yes	No
Shortness of Breath?	Yes	No
Wheezing?	Yes	No
Chest Congestion?	Yes	No

GASTROINTESTINAL:

Nausea?	Yes	No
Vomiting?	Yes	No
Diarrhea?	Yes	No
Constipation?	Yes	No
Abdominal Pain?	Yes	No
Blood in Stool?	Yes	No
Heartburn?	Yes	No

GENITOURINARY:

Painful Urination?	Yes	No
Blood in Urine?	Yes	No
Urinary Frequency?	Yes	No
Urinary Hesitancy?	Yes	No
Incontinence?	Yes	No

MUSCULOSKELETAL:

Back Pain?	Yes	No
Joint Pain?	Yes	No
Joint Swelling?	Yes	No
Muscle Soreness?	Yes	No
Arthritis?	Yes	No

Do you have diabetes?	Yes	No

SKIN:

Sensation Disturbance?	Yes	No
Bruising?	Yes	No
Birthmark?	Yes	No
Rash?	Yes	No
Itching?	Yes	No
Dryness?	Yes	No
Suspicious Lesions?	Yes	No

NEUROLOGICAL:

Headaches?	Yes	No
Memory Loss?	Yes	No
Confusion?	Yes	No
Transient Paralysis?	Yes	No
Weakness?	Yes	No
Numbness?	Yes	No
Tingling?	Yes	No
History of Seizures?	Yes	No
Syncope? (fainting)	Yes	No
Tremors?	Yes	No
Vertigo?(dizzy)	Yes	No

PSYCHIATRIC:

Depression?	Yes	No
Anxiety?	Yes	No
Memory Loss?	Yes	No
Mental Disturbance?	Yes	No
Suicidal Thoughts?	Yes	No
Mood Disorders?	Yes	No
Paranoia?	Yes	No
Sleep Disturbances?	Yes	No
Eating Disorder?	Yes	No

ENDOCRINE:

Sensitivity to Cold?	Yes	No
Sensitivity to Heat?	Yes	No
Abnormal Weight Gain?	Yes	No
Excessive Thirst?	Yes	No
Excessive Urination?	Yes	No
Excessive Hunger?	Yes	No
Diabetes?	Yes	No

HEMATOLOGIC / LYMPHATIC:

Chronic Infections?	Yes	No
Abnormal Bruising?	Yes	No
Bleeding?	Yes	No
Enlarged Lymph Nodes	Yes	No

ALLERGIC / IMMUNOLOGIC:

Hives?	Yes	No
Hay Fever?	Yes	No
Persistent Infections?	Yes	No
HIV Exposure?	Yes	No
Runny Nose?	Yes	No
Sinus Congestion?	Yes	No

EXTREMITIES:

Redness of a limb?	Yes	No
Swelling of a limb?	Yes	No
Discoloration of a limb?	Yes	No

NEW PATIENT BACK, NECK AND HIP QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

How long have you had this problem? _____

Did you have an injury? YES or NO Was this work related? YES or NO

Date of injury: _____

How injury occurred: _____

Have you seen other physicians for this? YES or NO

List names: _____

What treatment have you had? Please include self treatment. (please circle)

NONE

Medications (list)_____

Brace

Physical Therapy

Home Exercise Program

Injections / Shots

Have you had any trouble with control of your bladder or bowel? YES or NO

Does your pain increase with coughing or sneezing? YES or NO

Does your pain increase with:

Sitting? YES or NO

Standing? YES or NO

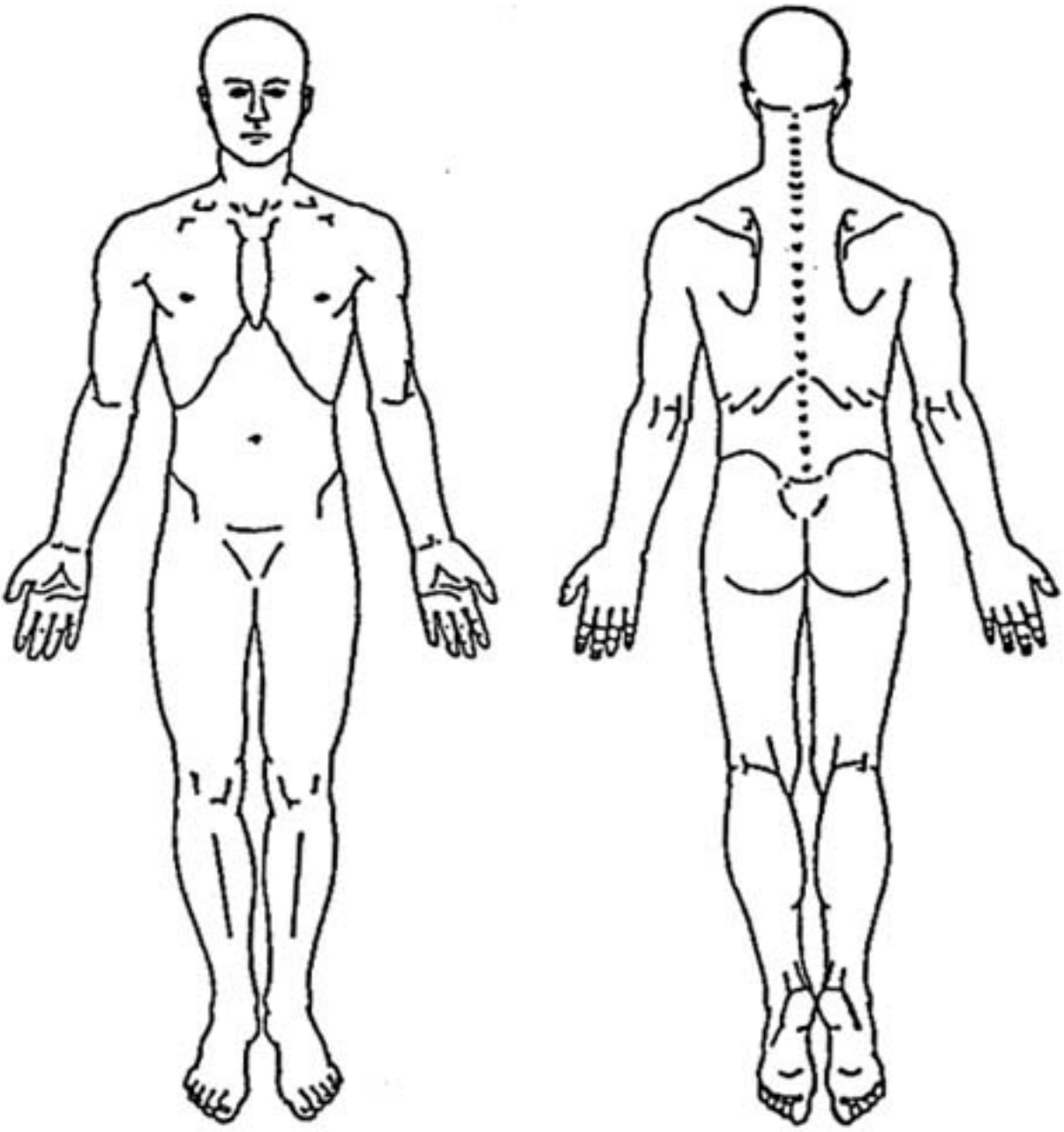
Laying? YES or NO

Have you had any diagnostic testing?

X-rays	**YES or NO**
MRI	**YES or NO**
EMG(nerve studies)	**YES or NO**
CT Scan	**YES or NO**
Myelogram	**YES or NO**

MARK THE AREAS OF YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS: USE THE APPROPRIATE SYMBOL AND INCLUDE ALL THE AREAS, WHICH ARE AFFECTED:

ACHE	NUMB	PINS/NEEDLES	BURNING	STABBING
++++	=====	00000000000000	XXXXXXX	//////////////////



NEW PATIENT KNEE QUESTIONNAIRE

NAME: _____ AGE: _____ DATE: _____

Please Circle One:

RIGHT KNEE LEFT KNEE BOTH KNEES

How long has your knee(s) bothered you? _____

Is this an injury? YES or NO

Date of injury: _____

How injury occurred: _____

Have you seen other physicians for this? YES or NO

(If yes, please list) _____

What treatments have you had? Please include self treatment.

NONE
MEDICATIONS (list) _____
BRACE
PHYSICAL THERAPY
HOME EXERCISE PROGRAM

Does your knee:

Y or N POP
Y or N CLICK
Y or N SWELL
Y or N GIVE OUT
Y or N CATCH
Y or N GET STIFF AFTER SITTING
Y or N WAKE YOU UP AT NIGHT BECAUSE OF PAIN

PLEASE USE GRAPH BELOW TO DEMONSTRATE WHERE YOUR KNEE HURTS