TEXAS SPORTS MEDICINE
AND ORTHOPAEDIC GROUP

Patient Demographic & Information Sheet

PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION

TODAY'S DATE:_____

Name: _____ Nickname:_____
(FULL LEGAL NAME: FIRST, THEN LAST NAME) (IF ANY)

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Gender: ☐ Male ☐ Female

SS#:_____ Birth Date:_____ Height:_____ Weight:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed E-mail address:_____

Employer:_____ Occupation:_____

If student, School: _____

HOW DID YOU HERE ABOUT US? (Circle) REFFERED BY PHYSICIAN INTERNET RADIO SHOW WORD OF MOUTH INSURANCE CO.

OTHER_____

IF REFERRED, WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

Address:_____ Phone:_____

EMERGENCY CONTACT PERSON: (MUST ALSO BE LISTED ON YOUR HIPAA FORM)_____

RELATIONSHIP TO YOU:_____ PHONE #:_____

PRIMARY INSURANCE COMPANY:_____ Phone:_____

Claims Address: _____ City: _____ State:_____ Zip:_____

Policyholder's Name:_____ Policyholder's DOB:_____

Policyholder's SS#:_____ ID# on Card:_____ Health Plan:_____

Grp/Policy # _____ Relationship to the policyholder: ☐SELF ☐SPOUSE ☐DEPENDANT

SECONDARY INSURANCE COMPANY_____ Phone:_____

Claims Address: _____ City: _____ State:_____ Zip:_____

Policyholder's Name:_____ Policyholder's DOB:_____

Policyholder's SS#:_____ ID# on Card:_____ Health Plan:_____

Grp/Policy # _____ Relationship to the policyholder: ☐SELF ☐SPOUSE ☐DEPENDANT

RESPONSIBLE PARTY FOR THIS ACCOUNT? _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

HISTORY:

What are we seeing you for today? ☐Left / ☐Right_____ ☐Cervical / ☐Thoracic / ☐Lumbar Spine
(BODY PART)

Is this injury sports related? ☐Yes ☐No Date of Injury: _____

Please give the details of how injury occurred:_____

_____

Where did injury occur? (Geographical location, not body part)_____

Where is the pain located?_____

Is it getting... better worse same? What is your pain level? (1-10)_____

What makes it worse?_____

What makes it better?_____

What treatments have you tried? (Please circle all that apply)

Rest Activity Modification Ice Heat NSAIDs Pain Meds Braces/Splints Therapy Injections Surgery

Other_____

PAST MEDICAL HISTORY:

Check if you have had any of these **medical problems** in the PAST:

MAJOR ILLNESS	YES	NO	**MAJOR ILLNESS**	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrhythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type:			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis – TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER:		

PAST SURGICAL HISTORY: Please list any **operations/surgeries** you have had:

SURGERY/ REASON	YEAR	**SURGERY/REASON**	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

FAMILY HISTORY: Please list major illnesses that affect immediate family:

MEDICAL ILLNESS	RELATION	**MEDICAL ILLNESS**	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

SOCIAL HISTORY:

Alcohol use:	Yes	No	Drinks per week: _____
Cigarette use:	Yes	No	Packs per day: _____Years: _____
Smokeless Tobacco use:	Yes	No	Years: _____
Illicit Drug use:	Yes	No	Type: _____

MEDICATIONS Please list any medications (including diet pills) that you are currently taking:

	DOSE		DOSE
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

Do you have any **allergies** to **LATEX?** Yes No

Do you have any **allergies** to medications/substances? Yes No
If **YES,** please describe the allergy?

_____

I hereby give permission to **Texas Sports Medicine & Orthopaedic Group** and its staff to provide my daughter/son with evaluation (including X-rays) and treatment for his/her injuries.

> ****DIVORCED PARENTS:** IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL CHARGES REGARDLESS OF THE INSURANCE OR FINANCIAL RESPONSIBLITY. TEXAS SPORTS MEDICINE & ORTHOPAEDIC GROUP WILL NOT BILL OR DISCUSS TREATMENT WITH THE OTHER PARENT.*

I hereby authorize Texas Sports Medicine & Orthopaedic Group to furnish information to insurance carrier concerning me and/or my dependents' illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account and / or my dependents for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information on this form is true and correct to the best of my knowledge and I will notify Texas Sports Medicine & Orthopaedic Group of any changes. (A copy of this authorization shall be as valid as the original.)

Your receipt will provide all the necessary information for you to file with your insurance company if our office is not contracted with or filing to your insurance carrier.

I WILL BE PAYING TODAY BY: ☐CASH ☐CREDIT CARD ☐MASTERCARD ☐VISA ☐ATM/DEBIT

If you prefer to leave a Credit Card on file for further treatment: CC #_____ Exp Date:_____

SIGNATURE of PATIENT or Legal Guardian: _____DATE:_____

If patient is a minor (under the age of 18), parent or legal guardian must sign.

Please circle any of the following symptoms or conditions that apply to you. The purpose of this section is to identify problems that may put you at risk for anesthesia or surgery. Since Texas Sports Medicine is sub-specialized and does not treat some conditions causing the symptoms listed below; please consult your family physician or internist about any of these symptoms of which he/she is not aware.

REVIEW OF SYSTEMS: Please mark any of the symptoms that apply to you:

SYMPTOM	YES	NO	**SYMPTOM**	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Joint Stiffness		
Cough			Muscle Pain or Swelling		
Shortness of Breath			Frequent/Easy Bruising		
Rash			Cuts that don’t stop Bleeding		
Wound Healing Problem			Anxiety		
Weight Loss			Depression		
Weight Gain			Sleep problems		
Fever/Chills			OTHER:		