Methodist The Methodist Hospital
Physician Organization

Last Name	First Name	Age
Email Address: _____ Pharmacy: _____		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed		
Occupation/Company:		
Work Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Volunteer ☐ Not Currently Employed		
Students Only:	School:	Grade:
Primary Care Physician _____ Last visit to him/her? __/__/____		
Current Height: _____ Current Weight: _____ Handedness:		

Injury: _____ Prior Injury to the same area: _____

Where did the injury occur: HOME AUTO WORK

Date of Injury/Onset: ____ /____ /_____

MEDICAL HISTORY

Please list your current medical conditions or check the box below:

Have you ever had any of the following medical conditions?

☐ Anemia	☐ Diabetes	☐ Hypothyroidism	☐ Pulmonary Embolism
☐ Angina	☐ DVT	☐ Irregular Heart beat	☐ Reflux
☐ Anxiety	☐ Diverticulitis	☐ Kidney failure	☐ Rheumatoid Arthritis
☐ Asthma	☐ Emphysema	☐ Liver problems	☐ Seizures
☐ Bleeding Disorder	☐ GI bleeding	☐ Lupus	☐ Sleep Apnea
☐ Blood Clot	☐ Heart Attack	☐ Migraines	☐ Stroke
☐ Cancer – type:	☐ Heart Failure	☐ Neurological disorder	☐ Urinary tract infection
☐ Depression	☐ Hepatitis A, B, C	☐ Pregnant? Yes No	☐ Ulcers

SURGICAL HISTORY

Surgeries or Hospitalizations	Year	Complications (if any)

ALLERGIES to medications/medical equipment

Please list the medications you are allergic to:

Medication	Type of reaction

Do you have an allergy to any of the following?	Yes	No	Type of reaction
Latex			
Adhesive or tape			
Anesthetics			
Iodine or IV contrast			

IMMUNIZATIONS: Are your immunizations up to date? ☐ Yes ☐ No

Tetanus (Year)?		Flu Shot (Year)?		Pneumonia Vaccine (Year)?	

FAMILY HISTORY

Do any of the following diseases run in your family?

NONE: _____

Disease	Mother	Father	Siblings	Children
Heart disease / heart attack				
High blood pressure				
Cancer (type)				
Stroke				
Bleeding disorders				
Seizures				
Mental illness				
Diabetes				

SOCIAL HISTORY - PLEASE CIRCLE

Do you smoke cigarettes?	Yes	No	How many packs per day?		For how many years?		Year quit?	
Do you use other tobacco products?	Yes	No	Type and amount:		For how many years?		Year quit?	
Do you drink alcohol?	Yes	No	How many drinks per week?					
Do you use recreational or street drugs?	Yes	No	Type:					

How would you describe your overall health?	Excellent	Good	Fair	Poor

What type of exercise or sport do you participate in?

Sport	Daily	Weekly	Monthly	Rarely

Please list or review all medication and supplements you are taking below:

	Check here if you are not taking any medications or supplements on a regular basis		
Medication		**Dose**	**How often**

Please place a check mark by all of the symptoms you are experiencing <u>today</u>:

☐ If none please check here

System	Symptom	Symptom	Symptom
General Health	☐ Fever/chills	☐ Fatigue	
Eyes	☐ Blurry vision	☐ Eye pain or redness	☐ Double vision
Ears/nose/throat	☐ Decreased hearing	☐ Sore throat	☐ Ear pain
Cardiovascular	☐ Chest pain	☐ Fainting	☐ Palpitations
Respiratory	☐ Shortness of breath	☐ Cough	☐ Wheezing
Gastrointestinal	☐ Nausea/vomiting/diarrhea	☐ Heartburn/constipation	☐ Rectal bleeding
Genitourinary	☐ Pain with urinating	☐ Increased frequency	☐ Incontinence
Musculoskeletal	☐ Joint pain or swelling	☐ Muscle cramps	☐ Weakness
Skin	☐ Rash	☐ Itching	☐ New lesions
Neurologic	☐ Numbness or tingling	☐ Loss of balance	☐ Ringing in ears
Endocrine	☐ Weight change	☐ Increased thirst	
Psychiatric	☐ Anxiety	☐ Depression	☐ Sleep problems
Blood system	☐ Enlarges lymph nodes	☐ Easy bruising	☐ Bleeding
Allergy/Immunology	☐ Hay fever	☐ Hives	

Patient signature: _____ Date: _____

Reviewed by: _____ Date: _____

HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Preferred Method of Telephone Contact

If we need to contact you regarding test results, referral, appointments, or other medical or billing information, please indicate below how you wish to be called. **Please check all that apply and indicate below** whether we may discuss your medical and billing information with family members or other individuals.

Home Telephone _____

Cell Phone Number _____

- ❑ Leave **only a call-back name and telephone number** on my answering machine or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Work Telephone _____

- ❑ Leave **only a call-back name and telephone number** on my voice mail or with any person who answers the telephone.
- ❑ Leave a **detailed message** on my voice mail or answering machine.
- ❑ **Do not** leave any type of message or call-back information if I am not there.

Discussion of Medical and Billing Information with Family Members and Other

- ❑ You may also discuss my medical and billing information with my family members and with other individuals I have listed below.

Name	Relationship	Telephone Number (s)

_____ _____
Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualifies Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualifies Personal Representative: _____

Legal Authority to Act on Behalf of the Patient: _____

HOUSTON Methodist
ORTHOPEDICS & SPORTS MEDICINE

Acknowledgment for Receipt of Notice of Privacy Practices

I have been given a copy of the Notice of Privacy Practices for Houston Methodist Physician Organization and its Physicians. This Notice describes my legal rights regarding my health information and informs me of the legal duties and privacy practices of Houston Methodist Physician Organization and its Physicians with respect to health information created for services generated by Houston Methodist Physician Organization and its Physicians.

_____ _____
Signature of Patient or Patient's Qualified Personal Representative* Date

* In the event the patient is legally unable to sign, please print the name of the patient's Qualified Personal Representative and the individual's legal authority to act on behalf of the patient.

Printed Name of Qualified Personal Representative: _____

Legal Authority to Act on Behalf of the Patient _____

CONSENT TO TREAT

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics, for the evaluation and treatment of the conditions for which I present myself to this office.

I acknowledge that I am legally responsible for all reasonable charges in connection with the medical care and treatment provided by representatives of The Methodist Hospital, Department of Orthopedics and promise to pay whatever charges are not paid by my health plan or insurance in return for the medical care and services that are provided to the patient.

I understand that this consent form will be valid and remain in effect as long as I receive my medical care at The Methodist Hospital, Department of Orthopedics. I understand that this consent may be revoked in writing at any time.

_____ _____
Printed Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Guarantor, if minor Date Signed

ASSIGNMENT OF BENEFITS

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED.

I hereby authorize my insurance benefits to be paid directly to The Methodist Hospital, Department of Orthopedics, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics, in applying for payment under insurance coverage or other protection is correct and complete. I authorize any holder of medical information about me, to release to the insurance company or its agents, any information needed to determine the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ AND UNDERSTAND THIS INFORMATION.

_____
Printed Patient Name

_____ _____
Signature of Patient or Guarantor, if minor Date Signed