



**PATIENT INFORMATION FORM**

**PATIENT DATA:**

PATIENT NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ SEX \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
 HOME PHONE NUMBER MOBILE PHONE NUMBER  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
 DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
 EMPLOYER NAME & ADDRESS \_\_\_\_\_ ( ) \_\_\_\_\_  
 WORK PHONE NUMBER  
 IN CASE OF EMERGENCY: NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ EMERGENCY PHONE NUMBER \_\_\_\_\_

**GUARANTOR INFORMATION:**

POLICY HOLDER NAME \_\_\_\_\_ GUARANTOR SOCIAL SECURITY # \_\_\_\_\_ DATE OF BIRTH (MM/DD/YYYY) \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 EMPLOYER NAME & ADDRESS \_\_\_\_\_ ( ) \_\_\_\_\_  
 BUSINESS PHONE NUMBER

**IS THIS VISIT DUE TO A:    PERSONAL INJURY    AUTOMOBILE ACCIDENT    WORK RELATED INJURY**

**PRIMARY INSURANCE INFORMATION:**

NAME OF PRIMARY INSURANCE \_\_\_\_\_ ( ) \_\_\_\_\_  
 VERIFICATION PHONE #  
 CLAIMS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 MEMBER ID/SUBSCRIBER ID \_\_\_\_\_ GROUP NUMBER/POLICY NUMBER \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION:**

NAME OF SECONDARY INSURANCE \_\_\_\_\_ ( ) \_\_\_\_\_  
 VERIFICATION PHONE #  
 CLAIMS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
 MEMBER ID/SUBSCRIBER ID \_\_\_\_\_ GROUP NUMBER/POLICY NUMBER \_\_\_\_\_

***PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED.  
THANK YOU!***

Last Name	First name	Age
Email Address: _____		Pharmacy Phone and Address: _____
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Occupation / Company: _____		
Work status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Volunteer <input type="checkbox"/> Not Currently Employed		
Students only:	School: _____	Grade: _____
Who is your Primary Care Physician? _____		Last visit to him/her? ___ / ___ / ___
Current Height: _____		Current Weight: _____
<b>WHERE DID THE INJURY OCCUR:</b> HOME    AUTO    WORK    WHEN: _____		
NO SPECIFIC INJURY: _____		

**MEDICAL HISTORY**

Have you ever had any of the following medical conditions? PLEASE CIRCLE

**NONE:**

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

Please list your current medical conditions:


**SURGICAL HISTORY:**

**None:**

Surgeries or Hospitalizations	Year	Complications (if any)

**ALLERGIES** to medications/medical equipment,  
Please list the medications you are allergic to:

**NONE:** \_\_\_\_\_

Medication	Type of reaction

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

**Immunizations:** Are your immunizations up to date?  Yes  No

Tetanus (Year)?		Flu Shot (Year)?		Pneumonia Vaccine (Year)?	
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**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 / Habits 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					
<b>How would you describe your overall health</b>	<b>Excellent</b>		<b>Good</b>		<b>Fair</b>		<b>Poor</b>	

What type of exercise or sport do you participate in?

Sport	Daily	Weekly	Monthly	Rarely

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT TO TREAT**

I voluntarily consent to the physicians and other clinical personnel of The Methodist Hospital, Department of Orthopedics and Sports Medicine, 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 Sports Medicine 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 and Sports Medicine. I understand that this consent may be revoked in writing at any time.

\_\_\_\_\_  
**PATIENT NAME (PRINT 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 and Sports Medicine, realizing I am responsible to pay non-covered services. I certify that the information given by me to The Methodist Hospital, Department of Orthopedics and Sports Medicine, 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.**

\_\_\_\_\_  
**PATIENT NAME (PRINT NAME)**

\_\_\_\_\_  
**SIGNATURE OF PATIENT or GUARANTOR, if minor**

\_\_\_\_\_  
**DATE SIGNED**

**PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION  
TO INDIVIDUALS INVOLVED IN MY HEALTH CARE**

**I GIVE PERMISSION** for **The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

**I DO NOT GIVE PERMISSION** for **The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

**I GIVE PERMISSION** for any **surgery centers or hospitals associated with The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

**I DO NOT GIVE PERMISSION** for any **surgery centers or hospitals associated with The Center for Orthopaedic Surgery and Sports Medicine** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

\* Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient's Printed Name: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

\* Patient is a minor ( \_\_\_\_ years of age) \*OR is unable to give permission because: \_\_\_\_\_

Signature of Individual Signing on Behalf of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Legal authority to act on the patient's behalf: \_\_\_\_\_

**TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS**

**NOTICE OF PRIVACY PRACTICES  
ACKNOWLEDGMENT**

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call the Privacy Official at 713.383.5129.

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Patient Name: \_\_\_\_\_

Signature of Patient or  
Patient's Qualified Personal Representative: \_\_\_\_\_

Date \_\_\_\_\_

Printed name of Qualified Personal Representative: \_\_\_\_\_

Legal Authority to Act on Behalf of the Patient: \_\_\_\_\_

**Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).**

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**For Staff Use Only**

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Date Acknowledgment noted in HIS/patient management system: \_\_\_\_\_

Comments if Notice not provided or Acknowledgment not obtained: \_\_\_\_\_

Processed by: \_\_\_\_\_