Patient Information

Patient Name: _____
Height: _____
Weight: _____

Race: Caucasian African American
Arabic Asian
Other

Ethnicity: Hispanic Non-Hispanic
Other

Preferred Language: _____

Preferred Pharmacy: _____

Referral Source: Doctor: (Name) _____
Other: (ex: Google) _____

PLEASE PRINT

PATIENT REGISTRATION

Account #_____

PATIENT LAST NAME	FIRST NAME		MIDDLE	SUFFIX
SOCIAL SECURITY NUMBER	EMAIL	DRIVER'S LICENSE	DL #	DL STATE
DATE OF BIRTH	AGE	SEX	RACE	ETHNICITY
ADDRESS(PERMANENT) STREET	APT#	CITY	STATE	ZIP CODE
HOME PHONE	CELL PHONE	MARITAL STATUS	NUMBER OF DEPENDENTS	
EMPLOYED BY	EMPLOYER'S ADDRESS		OCCUPATION	BUS PHONE
SPOUSE'S NAME	EMPLOYED BY	EMPLOYER'S ADDRESS	BUS PHONE	DATE OF BIRTH
PATIENT'S (TEMPORARY ADRESS)	SPOUSE'S OCCUPATION			
EMERGENCY CONACT NAME	RELATIONSHIP TO PATIENT	EMERGENCY CONTACT PHONE #		
SIGNATURE OF PATIENT OR LEGAL GUARDIAN				
IF PATIENT NOT RESPONSIBLE FOR THE BILL, PLEASE IND ICATE WHO IS RESPONSIBLE FOR THE BILL: NAME ADDRESS CITY STATE ZIP CODE				

EMPLOYER	EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE	BUS PHONE
Insurance Name:					
Insurance Claims Mailing Address:					
INSURED PARTY'S NAME:	SOCIAL SECURITY #			RELATIONSHIP TO PATIENT	

REQUEST FOR PAYMENT OF, MEDICAL SERVICES AND LABORATORY TESTS AT OUR OFFICE WILL BE MADE AT THE TIME OF YOUR VISIT.BY ASKING YOU TO DO THIS WE CAN DOWN THE COST OF BILLING, BOOKKEEPING: AND HOPEFULLY, KEEP YOUR MEDICAL FEES DOWN.

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENTS OF ALL CHARGES INCURRED ON BEHALF OF MYSELF AND MY FANILY REGARDLESS OF INSLRANCE BENEFITS.

Medication List

Name: _____

Please list all current medications:

Name of Medication	Dose	How Often	Reason for Taking Medication

IF you are currently having any of these symptoms, Please check all that apply:

_ Addiction
_ Ankle Swelling
_ Bleeding Problems
_ Blood clotting problems
_ Breathing Difficulty or Respiratory problems
_ Calf Cramping
_ Cardiovascular or Chest Symptoms
_ Chest pain
_ Constitutional Problems: Fever, Headache, Nausea
_ Cough
_ Dyspnea on exertion
_ Fatigue
_ Flu-like Symptoms
_ GI symptoms
_ Gout Attack
_ GU Symptoms
_ Joint Swelling
_ Leg Swelling
_ Non-Healing Wound
_ Numbness
_ Pacemaker
_ Shortness of Breath
_ Tightness of Chest
_ Varicosities
_ Weakness
_ Weight Changes

I verify that these are all the medications that I am taking at this moment. If at anytime they change I will call or let the office know that changes have been made to my medication list.

Signature: x_____ Date:_____

Past Medical History

Name: _____ Date: _____

Occupation: _____ Referring Physician: _____

This form **MUST** be filled out **COMPLETELY**:

Check **ALL** that apply:

_ High Blood pressure
_ Diabetes
_ High Cholesterol
_ Gout
_ HIV or AIDS
_ Asthma
_ Liver Disease
_ Anxiety Disorder
_ Kidney Disease
_ COPD
_ CHF
_ Hepatitis C
_ Pace Maker
_ Blood clotting problems
_ Sickle Cell Anemia
_ Seizures
_ Rheumatoid Arthritis
_ Hypothyroid
_ Migraines
_ GERD
_ STD Which One:_____
_ Defibrillator
_ Depression Which One:_____
_Other(Please list in space below):

_____

_____

Check **ALL** Surgical Procedures you have had:

_ Gallbladder
_ Tubal ligation
_ Hemorrhoidectomy
_ Cervical
_ CABG
_ Appendectomy
_ Tonsillectomy
_ Back
_ Heart Stent
_ Other (Please list in space below)
_ Hysterectomy
_ Hernia Repair
_ Knee arthroscopy (Left or Right)
_ Shoulder arthroscopy (Left or Right)

_____

_____

List **ALL Drug Allergies** and **Reactions**: _____

Do you live (Please check):

_ Alone _ Family _ Nursing Home _ Assisted Living

Please **check** yes or no on the following questions:

Do you smoke or chew tobacco? _ Yes _ No

Do you drink alcohol? _ Yes _ No

Do you currently use illegal drugs? _ Yes _ No

Do you have a history of addiction? _ Yes _ No If so, to what? _____

Are you currently under treatment for pain pain management? _ Yes _ No

Ht_____ Wt _____

Patient's Full Name:_____

Account#_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize Signature Orthopaedics to furnish requested information from the patient's medical and other records to 1) any insurance company or third-party payer for the purpose of obtaining payment on the account of Signature Orthopaedics, 2) any other person(s) or entities financially re-sponsible for the patient's care or treatment, and 3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome (AIDS). I authorize the release of information from or the review of the patient's records for the purpose of conducting any medical audit, utilization reviews, or quality assurance reviews. I authorize Signature Orthopaedics to release information from or copies of the patient's medical record to any referring physician or to any skilled nursing facility or other health care facility to which patient may be transferred.

Patient's Signature_____

Spouse/Guardian's Signature_____

Witness's Signature_____ Date_____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign Signature Orthopaedics all right, title, and interest in any payment due me for services described herein as provided in any policy or policies of insurance. I understand that I am responsible for providing to Signature Orthopaedics all insurance information at the time of my admission or during my hospital stay to al-low for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

Patient's Signature_____

Spouse/Guardian's Signature_____

Witness's Signature_____ Date_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

Please PRTNT

Patient Name:_____Acct#_____

I consent to the use or disclosure of my protected health information by Signature Orthopaedics for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Signature Orthopaedics. I understand that diagnosis or treatment of me by Dr. Osuji may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Signature Orthopaedics is not required to agree to the restrictions that I may request. However, if Signature Orthopaedics agrees to a restriction that I request, the restriction is binding on Signature Orthopaedics and Dr. Osuji. I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Osuji or Signature Orthopaedics has taken action in reliance on this consent.

My "protected health information" means health information, including my demo-graphic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to, believe the information may identify me.

I understand I have a right to review Signature Orthopaedics' Notice of Privacy Practices prior to signing this document. Signature Orthopaedics ' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Signature Orthopaedics. The Notice of Privacy Practices for Signature Orthopaedics is also provided at 2540N Galloway Ave., Suite 302, Mesquite, TX __5150. This Notice of Privacy Practices also describes my rights and the Signature Orthopaedics' duties with respect to my protected health information.

Signature Orthopaedics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Signature Orthopaedics' website, calling the office, and requesting a re-vised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative:_____

Name of Patient or Personal Representative:_____

Date:_____

Description of Personal Representative's Authority:_____

Signature Orthopedics
Notice of Surgery

We know patients have many options when choosing a health care provider. We would like to express our sincere appreciation for having had the chance to be yours. More importantly, we enjoy having you as part of our family.

We also hope your experience with us has surpassed your expectations and that you have been pleased with our service. We appreciate the confidence you've shown in selecting us as your health care provider and we will continue our commitment to provide the highest quality of care.

There are times when a patient will require surgery. This is the information that you will need to inform you of that process.

- Your surgery will not be scheduled until we receive clearance from your physician(s). We will send orders to your physicians. You will need to schedule an appointment with them.

- Our office will obtain any necessary authorization required for your surgery. If you decide that you do not want to proceed with the surgery after the authorization has been obtained and allowed to expire, you, as the patient, will be responsible for contacting your insurance company and requesting the authorization for any future surgery for that same procedure.

- Our office will schedule a pre-op appointment with Dr. Osuji prior to your surgery for you to discuss any concerns you have, sign consents, and discuss expectations with Dr. Osuji. If the patient cancels or no-shows for the pre-op appointment, your surgery WILL be canceled and there will be a $300 cancellation fee. If you need to cancel your surgery you must call our office 48 hours prior to your surgery date to cancel. If you do not show up to your surgery you will be charged a no-show fee of $300.00. If you have questions, or need to reschedule, you can contact our office at 972-863-9828.

- There may be up to 3 payments associated with your surgery: Dr. Osuji's professional fees, the facility fee, and an anesthesia fee. If there is a biopsy taken during your procedure, there will be a pathology fee. If your procedure requires an assistant, there will be an assistant surgeon's fee. We do not have access to fees other than Dr. Osuji's fees and it is our best estimate of the contract rate. Please call your insurance if you have any questions regarding fees.

- We collect any applicable deductible/coinsurance prior to your procedure. Your portion is expected 48 hours prior to your surgery.

Patient Signature of Acknowledgment: _____

Date: _____

Witness: _____

Date: _____