ADAMS
Bone & Joint
ORTHOPEDIC SURGERY

Brook Adams M.D.
7000 Bryant Irvin Rd. Ste 108
Fort Worth, TX 76132
Ph: 682-499-2663 Fax: 682-703-1193

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle) (Suffix)

Sex: (circle) Male Female Date of Birth: _____ Social Security Number: _____-_____-_____

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

Home Phone: _____ Work Phone: _____Cell Phone: _____

E-Mail Address: _____

Marital Status: (circle) Single Married Separated Divorced Widow/Widower

Employed: (circle) Yes No Occupation: _____

Employer's Name and Address: _____

BILLING INFORMATION

Person Responsible for paying bill: Self Parent Spouse Other: _____

Name (if different from above): _____ Date of Birth:_____

Address (if different from above): _____

Social Security Number: _____-_____-_____ Best Contact Number: _____

Employer's Name and Address: _____

EMERGENCY CONTACT

Person to Contact in Case of Emergency: _____

Name: _____ Date of Birth: _____ Phone Number: _____

Address: _____ Relationship: _____

PRACTICE INFORMATION

Referring Provider: _____

How did you hear about us: (please circle one) Advertising Primary Care Physician Specialist Physician

Word of Mouth Patient in Practice Hospital Insurance Company

Preferred Pharmacy: _____

Primary Care Physician: _____

RACE AND ETHNICITY

Race: White African American American Indian European Other: _____

Ethnicity: Central American Cuban Dominican Hispanic or Latino/Spanish Latin American/Latin, Latino Mexican

Not Hispanic or Latino Puerto Rican South American Spaniard

FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

FINANCIAL/INSURANCE AGREEMENTS:

Please initial:

_____ In the event I have no insurance coverage, I understand that I am responsible for payment of services rendered to me or my dependents at the time of service. I understand if I fail to pay amounts owed: the clinic has the right to secure an outside collection agency and/ or attorney to collect the unpaid debt and to report the unpaid debt to a credit- reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees. I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or to me. I understand I am responsible at the time of service for paying any required co-payment and deductible.

I have read and understand the payment policy of this office and agree to abide by the said policy. I understand a $30.00 charge will be assessed on all returned checks

_____ _____ _____

Patient / Parent / Guardian Relationship to Patient Date

HIPAA

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually. Your rights are posted in the waiting rooms at Adams Bone & Joint, Copies of the rights are also available at the receptionist desk if you would like to keep this information for your records.

I authorize Adams Bone & Joint to release any of my medical or insurance information necessary to process my medical claims and coordinate/manage my healthcare.

With whom may we discuss information about your care, treatment or diagnosis?

_____Relationship: _____

_____Relationship: _____

_____Relationship: _____

I acknowledge the HIPAA Patient Rights and Privacy forms. I have read and understand my rights.

_____ _____ _____

Signature (Patient or Parent if minor) Date Printed Name

ELECTRONIC MEDICAL RECORDS HISTORY

Adams Bone & Joint utilize an Electronic Medical Records (EMR) System in our office.

- We now have the ability to check your prescription eligibility and download your pharmacy history into our system.
- We also have the added ability to fax mail order prescriptions, review prescription benefits, and drug formulary all while you are in our office.

By signing below, you are granting Adams Bone & Joint permission to obtain this information on your behalf.

I, the patient/parent of a minor, give my consent to Adams Bone & Joint to obtain my pharmacy benefits.

_____ _____ _____

Signature Printed Name Date

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ORTHOPEDIC PATIENT QUESTIONNAIRE

Name: _____ Today's Date:_____

Date of Birth: _____ Dominate hand: (circle) R or L

MAIN PROBLEM / COMPLAINT: In relation to your primary complaint:

When did you first seek treatment for this problem?_____ Has another doctor(s) treated you for this condition? Yes / No

If yes with whom? _____ Treatment(s): _____

Have you had intolerance or reactions to treatments? _____

If this is a recurrence, when was the first time you noticed this problem? _____

How did it originally occur? _____ Has it worsened recently? _____

How frequent is the condition? (circle) *Constant* *Daily* *Intermittent* *Nightly only*

How long does it last? (circle) *All day* *A few hours* *A few minutes*

Describe the pain: (circle) *Sharp* *Dull* *Numbness* *Tingling* *Aching* *Burning* *Stabbing* *other*: _____

What makes the problem worse? (circle) Standing Sitting Lying Bending Lifting Twisting Other? _____

Is there anything that you can do to relieve the problem? (circle) Yes / No Describe: _____

PAST MEDICAL HISTORTY: Have you ever been treated or are currently being treated for any of the following (please

Hypertension / High blood pressure	Heart Arrhythmias / Palpitations/ Atrial Fibrillation	Thyroid Problems
High Cholesterol	Heart Attack I Coronary Artery Disease (CAD)	Hepatitis I HIV
Diabetes	Peripheral Vascular / Artery Disease (PVO l' PAD)	Anxiety/Depression
Asthma / Emphysema / COPD	Heart Failure / CHF	Headache
Heartburn I Reflux	Stroke / CVA	Poor Circulation
Stomach I Intestinal Ulcers	Dementia I Alzheimer's Disease	Neuropathy
Anemia / Blood Transfusions	Osteoporosis / Osteopenia	
Blood Clots I Deep Vein Thrombosis	Arthritis (type): _____	

circle all that apply):

Bladder Problems Cancer (type): _____

Other: _____

Last Bone Density / DEXA Scan: _____Fractures / Bone & Joint Injuries: _____

SURGERIES: Please list any previous surgeries and approximate date performed: _____

_____

Have you or your family ever had problems with anesthesia? (circle) Yes / No

History of medical problems that run in the family? Yes / No _____

_____

Have you ever been hospitalized for any other reason? _____

MEDICATIONS: Please list all medications and frequency of use (please include ALL medications and vitamin supplements that you are currently taking).

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Please List Medication Allergies: _____

_____

Are you allergic to: (circle) Metal Latex Adhesives Iodine Other: _____

Tobacco Use? _____ No _____Yes; If yes, how much / What kind? _____

Alcohol Use? _____No _____Yes; If Yes, ___ 1-2 drinks monthly; ___ 1-2 drinks weekly; ___1-2 drinks daily

Recreational Drug Use? ____ No ____ Yes; How often? _____

REVIEW OF SYSTEMS (Please circle if you have any of the following symptoms):

General: fatigue weight loss poor appetite fever chills

HEENT: hearing loss
double vision blurry vision nosebleeds
dizziness balance problems

Skin: itching rash fungal infection of fingernails/toenails open wounds

Lungs: chronic cough shortness of breath wheezing blood in sputum

Heart: chest pain shortness of breath with exertion irregular pulse/palpitations
Are you on a blood thinner? _____

Vascular: leg cramps when walking varicose veins blood clots "poor circulation" extremity ulcers swelling in feet/legs

Gastrointestinal: heartburn nausea vomiting diarrhea constipation

Urinary: blood in urine pain/burning urination increase frequency

Hematology: anemia bleeding gums low platelets immune problems easy bruising

Endocrine: overweight underweight excessive thirst excessive sweating excessive urination hot flashes

Musculoskeletal: joint pain back pain stiffness muscle aches muscle weakness

Neurological: confusion dementia memory loss tremors headaches

Psychiatric: depression anxiety suicidal thoughts

Patient Signature: _____Date: _____

Both Sides Reviewed by: _____Date: _____