Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City: State:	Zip	SS#
Home Phone: Cell Phone:	Email Address:		Driver's License #
Race: ☐ American Indian ☐ Asian ☐ Black/African American ☐ White ☐ Hawaiian/Pacific Islander ☐ Other Race _____ ☐ Unknown ☐ Declined	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined		
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Employer:		Work Phone:
Employer Address:	Occupation:	Referred by:	

SPOUSE OR LEGAL GUARDIAN

Name: (Last, First, MI)	Legal Guardian: Yes No		Birth Date:
Street Address:	City: State:		Zip:
Home Phone: Cell Phone:	Work Phone:		SS#:
Employer:	Address:		Email Address:

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:		
Home Phone: Cell Phone:	Work Phone:		Relation:
Name (2): (Last, First)	Address:		
Home Phone: Cell Phone:	Work Phone:		Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insured & SS#: Relationship to the insured ↑Self ↑Spouse ↑Child ↑Other
Group #:	Insured's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#: Relationship to the insured ↑Self ↑Spouse ↑Child ↑Other
Group #:	Insured's DOB:	Insurance ID#

Pharmacy: _____ I ☐ **DO** ☐ **DO NOT** give Authorization for Urgent Orthopedic Specialists to obtain my prescription history electronically.

I authorize Urgent Orthopedic Specialists to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Urgent Orthopedic Specialists. I understand that I am responsible for amounts not covered by insurance. This order will remain in effect until revoked by me in writing.

_____ _____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE

This acknowledgment of notice and consent authorizes **URGENT ORTHOPEDIC SPECIALISTS** to use and disclose health information for treatment, payment and health care operation purposes.

Notice of Privacy Practice. Urgent Orthopedic Specialist has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information (PHI) and how you can access your PHI and exercise other rights concerning your PHI. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all PHI that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer. You can contact our Privacy Officer by Mail, phone or facsimile: Urgent Orthopedic Specialists 4304 Andrews Hwy Midland Texas 79703 or Telephone: (432) 520-3020 Facsimile: (432) 699-1981.

The following person (s) may receive the health information designated below:

1. _____
   Name Phone Relationship
2. _____
   Name Phone Relationship

The following health information may be disclosed to the person (s) listed above:

☐ Medical - My Health Care Providers are expressly authorized to answer questions posed by the Personal Representatives listed below and openly discuss with them my condition, treatment, test results, prognosis, and all other information pertinent to my health care, even if I am fully competent to ask questions and discuss my medical condition. This document constitutes a full authorization to disclose any Individually Identifiable Health Information to the Personal Representatives named in this authorization.

☐ Billing/Financial Information ☐ Other _____

I hereby release Urgent Orthopedic Specialists Physician's, doctors, nurses and staff who acts in reliance on this Authorization from any liability that may accrue from releasing my Individually Identifiable Health Information and for any actions taken by my Personal Representatives. I understand that I may revoke this authorization at any time by providing a written notice.

Consent for Treatment: I hereby voluntarily consent to the evaluation, diagnostic testing and treatment by authorized members of the staff or their designees. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations and treatment.

Ownership Disclosure: Disclosure of Interest: Dr. Floyd has ownership interest in D1 Physical Therapy and the Texas Surgical Center (TSC) and as a result, may financially benefit from the referral of services to D1 and TSC in the form of increased dividends or distributions. Please let us know if you have any concerns regarding the financial relationship between the Doctor listed above and his affiliations. You do have the option of using an alternative health care facility.

_____ _____

Patient Signature or personal authorized representative **Date**

_____ _____

Printed Name **Relationship to patient (or other authority)**

Patient's Name: _____

Workers' Compensation Disclaimer

(Please read carefully and sign the program that applies to you)

Urgent Orthopedic Specialists appreciates your business. Our goal is to provide excellent care to the community and those injured while on the job. Due to the rising cost of healthcare, lower reimbursements to providers, billing deadlines and rules associated with the Texas Workers Compensation Program, we have had to make some adjustments in how we process work related injuries.

Read and sign statement below if you **are not** being treated today for a WORK RELATED injury.

The injury/condition that I am seeking treatment for today is **NOT** work related. I will **NOT** be filing a workers compensation claim. I understand that failure to disclose this information will result in all charges becoming my responsibility. I understand that in the event I inform my personal health insurance company this injury/condition is work related, my personal insurance company may not accept responsibility for the charges incurred therefore, I will be responsible for payment in full.

Here if not work related.

_____ _____ _____

Print Patient Name Signature Date

Work Related Injury Employee Acknowledgement Agreement

An employer has many options when determining the type of coverage for their injured employees. Therefore, we must determine what type of coverage you have prior to being evaluated so that proper procedures can be followed.

NOTICE – Urgent Orthopedic Specialists does not accept or file Out of State Work Comp.

Please fill out all information below & read each option and mark which best describes your situation. Keep in mind if the information provided is incorrect, your insurance company may not accept responsibility and charges incurred may become your/patient responsibility.

☐ Workers Compensation Under Texas Guidelines: Your first report of injury must be on file with the workers compensation insurance company and the first office visit must be approved.

☐ Nonsubscriber: The term nonsubscriber is commonly used to identify businesses that do not "subscribe" to Workers' compensation; however, employer has agreed to provide payment for treatment. We will require a credit card to be on file. The credit card will be charged on the date service is provided and a receipt will be given to the patient to return to his/her employer. It will be the responsibility of the employee and the employer to communicate upcoming appointments.

☐ Occupational Workers Compensation: Limited policy, no life time medical. Occupational policy has a predetermined time frame that treatment will be provided. It is your responsibility to know that time frame. Any and all charges after that date will become the responsibility of the patient and payment is expected at time of service.

☐ Employers with no coverage: Payment is due at time of service. Your employer will need to sign a contract prior to visit.

I have read and understand the above requirements for an injured worker to be seen.

_____ _____

Employee Signature Date

Urgent Orthopedic Specialists

4304 Andrews Hwy Midland, Texas 79703
(432) 520-3020 Fax (432) 699-1981

Name: _____ **DATE:** _____

DOB: _____ **AGE:** _____ **Referred by:** _____

☐ Female ☐ Male ☐ Right Handed ☐ Left Handed Height_____ Weight _____

Describe your current Problem/Complaint (be specific, for example right vs left) _____
_____
Describe how the injury or problem occurred _____
_____
Date of Injury or date problem began? _____

Have you been treated for the current problem? ☐ Yes ☐ No If yes, by whom? _____
If yes, describe treatment: _____
_____

Was this an on the job injury? ☐ Yes ☐ No If yes, was Employer notified? ☐ Yes ☐ No

Is the injury/problem due to an auto accident? ☐ Yes ☐ No If yes, were you at fault? ☐ Yes ☐ No

Have you had any of the following diagnostic studies for this injury?

X-rays	☐ Yes ☐ No	Date _____ Where? _____	Myelogram	☐ Yes ☐ No	Date _____ Where? _____
MRI	☐ Yes ☐ No	Date _____ Where? _____	Discogram	☐ Yes ☐ No	Date _____ Where? _____
CAT Scan	☐ Yes ☐ No	Date _____ Where? _____	EMG/NCV	☐ Yes ☐ No	Date _____ Where? _____

Is there any possibility of being pregnant? ☐ Yes ☐ No ☐ NA (If yes, please tell X-ray Tech prior to any x-rays)

Family Physician/Location _____

Pharmacy _____ Location _____

ALLERGIES/REACTIONS:

- ☐ No known allergies
- ☐ Medications allergies/reaction: _____
- ☐ Food /Latex/Environmental _____ ☐ IV contrast ☐ Topical Iodine

MEDICATIONS: (Please list any herbs, vitamins or supplements) ☐ **None**

Medication	Dose	Times/Day	Medication	Dose	Times/Day

Name: _____

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Education: ☐ High School Graduate, if not last grade completed _____ ☐ College ☐ Professional School

Living Arrangements: ☐ Alone ☐ Spouse/Parents/Children ☐ Roommate ☐ Significant Other

Smoking/Tobacco Use: ☐ Current how much _____ ☐ Past ☐ Never ☐ Second hand

Alcohol: ☐ None ☐ Rarely ☐ 1-2 times a week ☐ Daily/how much _____

Recreational Drug Use: ☐ None ☐ Marijuana ☐ Cocaine ☐ Other _____

Diet: ☐ Regular ☐ Cardiac Diet ☐ Diabetic ☐ Other _____

Exercise: ☐ Rarely ☐Daily ☐ 2-3 times a week ☐ Other _____

FAMILY HISTORY: **(Please check the box if yes to any of the following)**

Has anyone in your immediate family ever had? (parents, brother, sister, grandparents – *Please specify maternal or paternal*)

	Who?		Who?
☐ Adopted history unknown		☐ High Blood Pressure	_____
☐ Anesthesia Problems	_____	☐ High Cholesterol	_____
☐ Arthritis	_____	☐ Kidney Disease	_____
☐ Asthma, Hay Fever, Allergy	_____	☐ Leukemia	_____
☐ Blood Clots/DVT	_____	☐ Lung Disease	_____
☐ Cancer:Type _____	_____	☐ Mental Illness	_____
☐ COPD	_____	☐ Seizures/Convulsions	_____
☐ Depression	_____	☐ Sickle Cell Anemia	_____
☐ Diabetes	_____	☐ Stents	_____
☐ Drug/alcohol Abuse	_____	☐ Stroke	_____
☐ Glaucoma	_____	☐ Thyroid Disorder	_____
☐ Headache/Migraine	_____	☐ Tuberculosis	_____
☐ Heart Attack/Problems	_____	☐ Ulcers	_____

Mother Living: ☐ Yes ☐ No Current age, or age at time of death? _____

Father Living: ☐ Yes ☐ No Current age, or age at time of death? _____

PAST MEDICAL HISTORY: **(Please check the box if yes to any of the following)**

☐ None	☐ Depression	☐ Irregular Heart Beat
☐ Acid Reflux	☐ Diabetes: Type 1 or Type 2	☐ Kidney Disease
☐ Anemia	☐ Gallbladder Attacks: Removal Y or N	☐ Liver Disease
☐ Anesthesia Problems	☐ Headaches/Migraines	☐ Lung Disease
☐ Arthritis	☐ Heart Attack/Problems	☐ Pacemaker
☐ Asthma	☐ Hepatitis: Type _____	☐ Seizures
☐ Blood Clot/DVT	☐ High Blood Pressure	☐ Stents
☐ Cancer: Type _____	☐ High Cholesterol	☐ Stroke (CVA)
☐ COPD/Emphysema	☐ HIV/AIDS	☐ Thyroid Disease
		Other: _____

SURGICAL HISTORY: ☐ None

Surgery	Date	Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name: _____

Do you *CURRENTLY* have any of the following symptoms? **(If yes, please check the appropriate box or boxes)**

General
- ☐ Body Aches
- ☐ Fatigue / Malaise
- ☐ Fever / Chills
- ☐ Weight Loss / Gain

Eyes
- ☐ Blurred Vision
- ☐ Discharge
- ☐ Pain

Head/Ears/Nose/Throat
- ☐ Cold/Sinus Pain
- ☐ Dizziness
- ☐ Hard of Hearing
- ☐ Headaches
- ☐ Light headedness
- ☐ Nasal Congestion / Drip
- ☐ Painful Swallowing
- ☐ Sore Throat

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beat

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea / Vomiting
- ☐ Ulcers

Genitourinary
- ☐ Blood in the urine
- ☐ Frequent urination
- ☐ Incontinence
- ☐ Painful urination

Skin
- ☐ Discoloration of Skin
- ☐ Dry Skin
- ☐ Itching
- ☐ Lesion
- ☐ Rash
- ☐

Neurologic
- ☐ Alzheimer's
- ☐ Dizziness
- ☐ Loss of Balance
- ☐ Memory Loss
- ☐ Numbness

Musculoskeletal
- ☐ Joint Pain
- ☐ Limited Range of Motion
- ☐ Muscle Pain / Weakness
- ☐ Swelling

Endocrine
- ☐ Diabetes
- ☐ Thyroid

Heme/Lymphatic
- ☐ Bruising
- ☐ Lump or Swelling of Glands

If you have answered yes to any of the above and/or have additional information the physician needs to know, please provide additional information: _____

_____

_____

PRESCRIPTION MEDICATION POLICY/CONTRACT:

Pain medications (Narcotics) can be very useful, but have high potential for misuse and abuse and are, therefore, closely controlled by the local, state, and federal governments. Used properly, they are very effective in relieving pain symptoms. If used excessively, however, they can cause adverse effects such as vomiting, constipation, lethargy, or even death. To insure these medications are used properly, **I agree to the following conditions:**

1. I understand that if my prescription is lost, misplaced or stolen, or if I finish it sooner than prescribed, it will not be replaced.
2. I will not request nor accept pain medications from any other physician or individual.
3. I agree to use one and only one pharmacy.
4. Call your pharmacy first to initiate a Refill. Refills requested by the pharmacy before 4pm will be called in on the same day if approved. However, it may be as late as 6:00 or 7:00 pm before all prescriptions and call backs are done. If the pharmacy calls us after 4pm, the refill will not be called in until the next business day. ***Do not call after hours. The on call doctor will not call in any pain medication.***
5. For all NSAIDS (anti-inflammatory medications) you may be asked to undergo lab work at least every 6 months.
6. I understand that **if I violate any of the above conditions**, my prescriptions/refills will be canceled and my physician may terminate my treatment and care. If the violation involves obtaining controlled substances from another individual or physician, I may also be reported to my primary physician, local medical facilities, pharmacies or other local authorities.

I attest that the information given above in my medical history is true and correct to the best of my knowledge. I also agree to the terms and conditions outlined in the above prescription contract.

_____ Date: _____

Patient or Legal Guardian Signature

_____

Physician Signature