PHYSICAL – REGISTRATION

<table>
<tr><td colspan="2">Name: (Last, First, MI)</td><td>Age:</td><td>Sex:
M F</td><td>Birth Date:</td></tr>
<tr><td colspan="2">Street Address:</td><td colspan="2">City: State:</td><td>Zip</td><td>SS#</td></tr>
<tr><td colspan="2">Home Phone: Cell Phone:</td><td colspan="4">Email Address: Driver's License #</td></tr>
<tr><td colspan="2">Race: ☐ American Indian ☐ Asian ☐ Black/African American
☐ White ☐ Hawaiian/Pacific Islander ☐ Other Race _________
☐ Unknown ☐ Declined</td><td colspan="4">Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Unknown ☐ Declined</td></tr>
<tr><td>Marital Status: ☐ Single ☐ Married
☐ Divorced ☐ Separated ☐ Widowed</td><td colspan="3">Employer:</td><td colspan="2">Work Phone:</td></tr>
<tr><td colspan="2">Employer Address:</td><td colspan="2">Occupation:</td><td colspan="2">Referred by:</td></tr>
<tr><th colspan="6">In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)</th></tr>
<tr><td colspan="2">Name (1): (Last, First)</td><td colspan="4">Address:</td></tr>
<tr><td>Home Phone: Cell Phone:</td><td colspan="3">Work Phone:</td><td colspan="2">Relation:</td></tr>
<tr><td colspan="2">Name (2): (Last, First)</td><td colspan="4">Address:</td></tr>
<tr><td>Home Phone: Cell Phone:</td><td colspan="3">Work Phone:</td><td colspan="2">Relation:</td></tr>
</table>

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

I am being seen for a physical only and I understand payment is expected at the time service is rendered. A physical includes a review of your health history, hearing and vision tests, blood pressure and pulse rate assessments, and a physical exam. Some employers require medical examinations to assess physical abilities and identify potential health issues for people whose jobs are physically demanding. The point of this exam is to identify any physical issues that could affect your safety or the safety of others. 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.

____ __________________

SIGNATURE of PATIENT DATE

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)**

Urgent Orthopedic Specialists
Physical - History Form

Name: ________________________________ **DOB:** ___________ **AGE:** _________ **DATE:** _____________

☐ Female ☐ Male ☐ Right Handed ☐ Left Handed Height ______ Weight ______ Family Physician___________

ALLERGIES/REACTIONS: ☐ No known allergies

☐ Medication allergies: ____

☐ Food /Latex/Environmental ___________________ ☐ IV contrast ☐ Topical Iodine

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

Medication	Dose	Times/Day	Medication	Dose	Times/Day

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 ____________________________

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

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

SURGICAL HISTORY: ☐ **None**

Surgery	Date	Surgery	Date
________________________________	_______________	___________________________	______________
________________________________	_______________	___________________________	______________
________________________________	_______________	___________________________	______________
________________________________	_______________	___________________________	______________

_________________ ____

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