Name:
DOB:
Chart:
Age:
Date:

NORTHEAST ORTHOPAEDICS & SPORTS MEDICINE, LLP

12709 Toepperwein Rd #101
San Antonio, TX 78233
210-477-5151
Fax: 477-5152

18707 Hardy Oak Blvd, Suite 415
San Antonio, TX 78258
210-477-5151
Fax: 210-477-5152

8715 Village Dr #120
San Antonio, TX 78217
210-477-5151
Fax: 210-477-5152

PLEASE PRINT ALL INFORMATION BELOW, THANK YOU.

Today's Date: _____

Patient's Name: _____ Gender: _____
Last First MI

Patient Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Home e-mail: _____

Date of Birth: _____ Driver's License #: _____

Social Security #: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street City State Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Spouse's Name: _____

DEMOGRAPHICS (choose the best description)			SMOKING STATUS
Race Choices	**Ethnicity Choices**	**Language Choices**	☐ Current every day smoker
☐ American Indian	☐ Hispanic Origin	☐ Chinese	☐ Current some day smoker
☐ Asian	☐ Non-Hispanic	☐ English	☐ Former smoker
☐ Black	☐ Type-Unknown	☐ Japanese	☐ Never smoker
☐ Type-Unknown		☐ Portuguese	☐ Smoker, current status unknown
☐ White		☐ Spanish	☐ Unknown if ever smoked

ACCOUNT GUARANTOR / SPOUSE INFORMATION

Name: _____ Phone #: _____
Last First MI

Date of Birth: _____ Social Security #: _____

If patient is under 18 years of age or full-time student, please complete the following:

Parent or Guardian Name: _____ Social Security #: _____

WORKER'S COMPENSATION INJURY: ☐ Yes ☐ No **(if yes, please see receptionist)**

MOTOR VEHICLE ACCIDENT: ☐ Yes ☐ No **(if yes, please see receptionist)**

Assignment / Authorization

I hereby authorize payment of insurance benefits to be made to Northeast Orthopaedics & Sports Medicine, LLP for services provided to me or members of my family. I understand that I am financially responsible for all charges not covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I agree to release pertinent demographic and insurance information to a specialist and/or health services in the event that is necessary in my course of treatment.

I certify the above information is true and correct to the best of my knowledge, and I consent to any medical or surgical treatment rendered the patient under general or special instructions of the physician.

Signature: _____ Date: _____

If you are referred to Sendero Imaging or Christus Santa Rosa Physicians Ambulatory Surgery Center, we are required by law to inform you that Northeast Orthopaedics & Sports Medicine physicians may have ownership interest in those facilities and may receive remunerations indirectly for services rendered.

Name:
DOB:
Chart:
Age:
Date:

NORTHEAST ORTHOPAEDICS
& SPORTS MEDICINE, LLP

PRIMARY - INSURANCE COVERAGE INFORMATION Today's Date: _____

Insurance Co. Name: _____

Insurance Co. Address: _____
Street / P.O. Box City State Zip

Policy ID#: _____ Effective Date of Coverage: _____

Group #: _____ Group / Co. Name: _____

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

SECONDARY - INSURANCE COVERAGE INFORMATION

Insurance Co. Name: _____

Insurance Co. Address: _____
Street / P.O. Box City State Zip

Policy ID#: _____ Effective Date of Coverage: _____

Group #: _____

Policy Holder's Name: _____
Last First MI

Date of Birth: _____

Relationship to Patient: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER: _____

ACCIDENT INFORMATION

Are you being seen as a result of an accident? ☐ YES ☐ NO Date of Injury: _____

If yes, where did the accident occur? _____

Describe your injury (including body part involved): _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed the office's Notice of Privacy Practices of Northeast Orthopaedics & Sports Medicine, L.L.P., which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Print name of Patient or Personal Representative

_____
Description of Personal Representative's Relationship/Authority

Name:
DOB:
Chart:
Age:
Date:

Patient Medical History

Patient Name: _____ Birth Date: _____ Today's Date: _____

Age: _____ Sex: _____ Occupation: _____ Dominant hand: ☐ R ☐ L

Date of Injury: _____ Is this work related? ☐ Yes ☐ No Was it reported? ☐ Yes ☐ No

Primary Care Physician: _____ City: _____

Referring Physician's Name: _____ City: _____

HISTORY OF PRESENT ILLNESS: Problem with: ☐ Right extremity ☐ Left extremity

Chief Complaint / Why are you here today? _____

_____

_____

Location: _____

(Where is the pain/problem? Does it travel to other areas?)

Quality: _____

(Is the pain dull, throbbing, or sharp? If lump, is it warm, tender, red?)

Severity: _____ **Duration:** _____

(On a scale of 1-10 with 10 being the most severe?) (How long have you had the problem?)

Timing: _____ **Context:** _____

(Is the pain rare, intermittent, or constant? Occur at a specific time?) (What were you doing at the onset of the pain / problem?)

Associated signs/symptoms: _____

(Popping, grinding, clicking, swelling, stiffness, instability, night pain, numbness, weakness?)

Modifying factors: _____

(What makes the pain or problem better or worse?)

Have you seen any other physicians regarding **this** condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

Please list any hobbies / sports you enjoy: _____

Which of the above activities are you **unable** to perform due to your pain? _____

PAST MEDICAL HISTORY: Have you ever had any of the following? *Please check all pertinent boxes:*

☐ High Blood Pressure	☐ AIDS or HIV +	☐ Fibromyalgia	☐ Pacemaker / Defibrillator
☐ Heart Disease	☐ Anemia	☐ Fractures _____	☐ Parkinson's Disease
☐ Diabetes ☐ I ☐ II	☐ Asthma	☐ Gout	☐ Polio
☐ Kidney Disease	☐ Back Problems	☐ Hepatitis	☐ Rheumatoid Arthritis
☐ Stomach Ulcers	☐ Bladder Infections	☐ High Cholesterol	☐ Sleep Apnea
☐ Blood Clot (DVT)	☐ Bleeding Tendency	☐ Infectious Mono	☐ Staph Infections (MRSA)
☐ Pulmonary Embolism	☐ Cancer _____	☐ Irregular Heart Rate	☐ Stroke
☐ Thyroid Disease	☐ Epilepsy / Seizures	☐ Osteoporosis	☐ Other _____
☐ Reflux			

Name:
DOB:
Chart:
Age:
Date:

PAST SURGICAL HISTORY:

Date	Surgery	Surgeon	Date	Surgery	Surgeon

Allergies to Medications:

	Drug Name:	Reaction	Mild	Moderate	Severere
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐

MEDICATIONS: Include prescription & non-prescription medications & herbal supplements (or please attach a list)

Social History:

Alcohol use
☐ no ☐ moderate
☐ rare ☐ daily

Tobacco use
☐ never ☐ yes ____ packs / day x ____ years
☐ quit ☐ smokeless

Living status
☐ with family ☐ alone
☐ with friends ☐ other

Family Medical History: Any family history of the following problems? *Please check all pertinent boxes:*

☐ Adverse reaction to anesthesia ☐ Bleeding tendency (hemophilia) ☐ Diabetes ☐ High blood pressure
☐ Arthritis ☐ Cancer _____ ☐ Heart disease ☐ Scoliosis

Review of Systems: Please indicate *current* symptoms that you are having: *Please check all pertinent boxes:*

General, Constitutional
☐ good general health lately
☐ recent weight change
☐ fever

Eyes
☐ visual changes

Ears, Nose, Throat
☐ hearing loss
☐ bleeding gums
☐ teeth pain / cavities

Cardiovascular
☐ chest pain

Respiratory
☐ shortness of breath
☐ asthma or wheezing

Gastrointestinal
☐ indigestion
☐ blood in stool
☐ nausea or vomiting

Genitourinary
☐ incontinence
☐ frequent urination
☐ burning or painful urination
☐ difficulty with urination

Musculoskeletal
☐ joint pain
☐ joint stiffness or swelling
☐ back pain
☐ muscle pain or cramps
☐ difficulty walking
☐ cold extremities

Neurological
☐ numbness
☐ weakness
☐ tremor
☐ light headed or dizzy

Psychiatric
☐ depression
☐ sleep disturbance

Endocrine
☐ excessive thirst
☐ excessive urination

Hematologic
☐ bleeding tendency
☐ anemia

Skin
☐ rash
☐ itching

Height: _____ **Weight:** _____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that it is my responsibility to inform the doctor of any changes in my medical condition.

Signature of Patient, or Parent of Minor _____ Date _____

Physician Initials _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

Orthopaedic Surgery - Arthroscopic Surgery - Joint Replacement - Sports Medicine - Fracture Care

John R. Chance, M.D., David L. Fox, M.D., Jamie L. Lynch, M.D., Brian E. Schulze, M.D., Patrick M. Simon, M.D., Rex E. Wilcox, M.D.
Diplomates, American Board of Orthopaedic Surgery
Kelly A. Cooper, PA-C

Contact Information Authorization

(PLEASE PRINT ALL INFORMATION)

All information in our office is kept confidential. Please list names of anyone that you would like our office to speak with about your condition, treatment, lab results, appointments and any billing or insurance questions. *Please indicate by writing "NONE" if you prefer all information to be kept confidential.

Name	Relationship & Phone Number

Is there anyone that we may discuss your condition with in the event of an emergency?

_____ (Name & Phone Number)

Which phone number do you prefer us to contact you during our regular office hours?

_____ (Home, Work, Cell)

Do you have an answering machine or voice mail that we may leave confidential messages concerning your appointment, lab results or your condition?

If yes, what number? _____

It is your responsibility to notify our office if this information changes.

I agree that Northeast Orthopaedics & Sports Medicine, L.L.P. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I also agree that Northeast Orthopaedics & sports Medicine, L.L.P. may share my health information with medical providers outside of this practice in order to facilitate my care.

Patient Signature: _____ Date _____

12709 Toepperwein Road, Suite 101 San Antonio, Texas 78233
Phone: (210) 477-5151 Facsimile: (210) 477-5152

Name:
DOB:
Chart:
Age:
Date:

NORTHEAST ORTHOPAEDICS & SPORTS MEDICINE, LLP

PATIENT FINANCIAL POLICY STATEMENT

The physicians and staff of Northeast Orthopaedics & Sports Medicine, LLP (NEOSM) are here to serve your needs as our patient. It is our goal to create an experience for our patients that hopefully will limit the amount of stress patients may encounter. Our PATIENT FINANCIAL POLICY is intended to describe our expectations regarding the payment for services we provide. Unless otherwise noted, payment is due at the time of service.

Our staff is prepared to provide patients with any assistance or resources possible in making payment arrangements for services. We can help patients contact the appropriate entities to obtain the documents needed to insure proper payment such as referrals and pre-authorizations for procedures. We ask that patients recognize their responsibility to understand what services their insurance covers as well as what documents are required to assure that payment is made.

The FINANCIAL POLICY details the expectations of our medical group as they relate to patients making payment for provided services. Patients should acknowledge the following policy requirements:

1. The patient, or their designated guarantor, is responsible for payment of services.
2. All office charges, co-payments, and applicable deductible amounts are due at the time of service.
3. The provision of an insurance card for payment of services will be accepted and filed on behalf of the patient; however, the patient is still responsible for payment if their insurance coverage fails to adequately provide payment in a timely or appropriate manner. If you do not have your insurance card, you will considered a self-pay patient.
4. Submitting an expired insurance card or someone else's insurance card is insurance fraud.
5. It is the obligation of the patient to obtain and provide any referral notifications required by the patient's insurance carrier. Without the appropriate referral the patient's appointment may be rescheduled.
6. Arrangements for co-insurance payment estimates must be made prior to the scheduled surgery date in order to prevent possible delays in providing the service.
7. Patient account balances are due within 30 days of the receipt of the billing statement unless otherwise specified.
8. Patients may contact our patient accounts representative to make payment arrangements. After 90 days, if no arrangements have been made for payment, or if no payments have been received, then collection proceedings will begin.
9. Delinquent accounts may be assigned to a collection agency. All collection costs will be added to your outstanding balance and will become an additional cost to you. We will not be held responsible for any collection agency fees.
10. From time to time, various forms including but not limited to disability and FMLA forms need to be filled out. There is a $25 fee to complete each form.
11. We accept MasterCard, Visa, Discover and American Express. Checks returned for closed accounts or non-sufficient funds will be charged a $25 service fee and sent to the Bexar County DA's office.
12. There will be a $25 fee assessed for failure to provide at least 24 hours notice of appointment cancellation.

We ask that each patient/guarantor sign this document as part of his or her registration at Northeast Orthopaedics & Sports Medicine, L.L.P. in accordance with the following statement:

"I _____, (patient/guarantor), acknowledge that I have received and read this financial policy statement."

(Patient/Guarantor Signature) Date