STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

William M. Hayes, MD, FAAOS
N. Brian Flowers, MD, MPT, FAAOS, FAAHKS
Amy Lindsay Howe, MD
Keith W. V. Johnson, MD, FAAOS
William J. Jackson, DO
Elaina Wickman, PA-C
Paul Chin, MD, PhD, FAAOS
Mark A. Eilers, MD, MS

WELCOME!

Thank you for choosing our practice to serve your medical needs. We are looking forward to seeing you soon.

We pre-register patients prior to their visit. Please complete the forms and bring them to your scheduled appointment along with your Driver's License, Medical Insurance card, and Pharmacy Insurance card.

If needed, directions to our office are on our web site (www.srosm.com) or you can use Yahoo's "Maps". Convenient parking is located at our office.

Please bring any of your X-Rays/MRI images and reports with you to the visit. Your doctor will want to see those images. If you do not have the images with you, new ones will need to be taken.

And remember, if you can't make your appointment; call us one business day ahead so that another patient can be scheduled.

If you have questions or need more help, feel free to call our Woodlands office (281-364-1122) or Spring office (832-698-0111) at your convenience.

Sincerely,

The Doctors and Staff of Sterling Ridge Orthopaedics and Sports Medicine

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Patient Information and Assignment of Benefits

Patient Last Name _____First Name_____ Middle Initial_____

Street Address _____ Home Phone _____

City_____ State_____ Zip_____ Cell Phone _____ Work Phone _____

Sex ☐ M ☐ F Age_____ Date of Birth_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #_____ Driver's License #_____ Email _____

Language _____ Race _____ Ethnicity_____

How did you learn about our clinic? _____ Referring Physician _____

Person to contact in emergency (Name and Phone #)_____

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____ ☐ Full-time ☐ Part-time City _____ State _____ Zip _____Years Employed_____
SPOUSE (PARENT)	Name_____ Date of Birth _____SSN_____ Last Name First Name Initial Employer Name_____ Years Employed_____ Address_____ Phone_____ Occupation_____ City_____ State _____ Zip_____ ☐ Full-time ☐ Part-time
PATIENT INSURANCE INFORMATION	Please list patient's primary medical insurance and/or employee health care plan coverage. Insurance Company or Health Care Plan Name_____ Policy/Group #_____ Effective Date_____ Name of Insured_____ ID #_____ Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
SECONDARY INSURANCE INFORMATION	Please list any and all secondary health care plan coverage you may have. Insurance Company or Health Care Plan Name_____ Policy/Group #_____ Effective Date_____ Name of Insured_____ ID #_____ Insured's relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

Patient Information and Assignment of Benefits

PHARMACY INSURANCE INFORMATION

Current Pharmacy _____ Phone _____

Please list any pharmacy insurance plans you have

Pharmacy Insurance Company _____

RxBIN# _____ RXPCN# _____

ID #_____Group#_____

Name of Insured _____ Relation to patient_____

Do you prefer Easy Open Lids? ☐ Yes ☐ No Are Generics Ok? ☐ Yes ☐ No

LEGAL INFORMATION

Are your present symptoms of condition related to or the result of an auto accident, work-related injury, or other personal injury someone else might be legally liable for? ☐ Yes ☐ No Your Initials _____

An accurate medication history is very important to helping us treat you properly and to avoid potentially dangerous drug reactions. Do you grant SROSM permission to access the National Pharmacy Database to retrieve your prescription history? ☐ Yes ☐ No Your Initials _____

ASSIGNMENT OF BENEFITS AND ASSIGNMENT OF ERISA RIGHTS

Legal Assignment Of Benefits And Designation Of Authorized Representative

I, the undersigned, have insurance and/or employee health care benefits coverage with the above listed insurance carriers, and for good and valuable consideration I hereby appoint Sterling Ridge Orthopaedics & Sports Medicine (Provider) as my designated Authorized Representative(s) . In add I hereby assign and convey directly to the above named healthcare provider(s), all medical benefits and/or insurance reimbursements, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for the actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby grant the above named provider(s) authority under HIPAA to release all medical information necessary to process my health claims. I hereby authorize any plan administrator, plan fiduciary, and/or insurer and to release to such provider(s) any and all insurance plan documents and a copy of my health insurance policy upon request. If requested, I also authorize my attorney to furnish to provider all third party settlement information upon written request. I also hereby authorize my provider permission to use my signature on all health insurance and/or employee health benefits claim submissions.

To the full extent permissible under the law, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), I hereby assign and convey to the above named provider(s), my benefits in any applicable employee group health plan(s), individual health insurance policy, personal injury protection policy, medical payments policy, underinsured/underinsured motorist policy, third party tort recovery, in order to satisfy any and all medical expenses legally incurred by me for medical services I received from the above named provider(s). Furthermore, to the full extent permissible under the law, I grant to the provider a lien on such medical benefits, settlement, proceed and/or insurance reimbursements.

Lastly I grant the provider authority to: (1) obtain information about the claim to the same extent as the assignor; (2) submit evidence and information on my behalf; (3) make statements about facts or law, if know; (4) make, request, give, or receive any notice about appeal proceedings; and (5) take any administrative, legal and judicial action, including filing suit, in my name with derivative standing, which the provider deems necessary to obtain payment of my health insurance benefits. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.
The foregoing shall not be construed as an obligation of this medical provider to pursue any legal appeal or legal recovery.

_____ _____

Signature of Insured / Guardian Date

INJURY / PAIN QUESTIONNAIRE **DATE:_____**

NAME:_____ SEX: M ☐ F ☐ DOB:_____ Height_____Weight _____

REFERRING PHYSICIAN:_____ PRIMARY CARE PHYSICIAN_____

IS THIS WORK RELATED? Please explain:_____

OCCUPATION:_____ IF STUDENT, NAME OF SCHOOL:_____

PRESENT ORTHOPAEDIC PROBLEM:_____

PRESENT PAIN LEVEL on a scale of 0 (no pain) to 10 (highest pain level): _____/10.

PLEASE DESCRIBE HOW THIS INJURY OCCURRED: _____

_____

DATE OF INJURY / ONSET FOR THIS PROBLEM:_____

LIST OF ANY CURRENT JOB DUTIES AND/OR PHYSICAL/SOCIAL ACTIVITIES YOU HAVE LIMITED OR STOPPED DUE TO YOUR CURRENT SYMPTOMS:_____

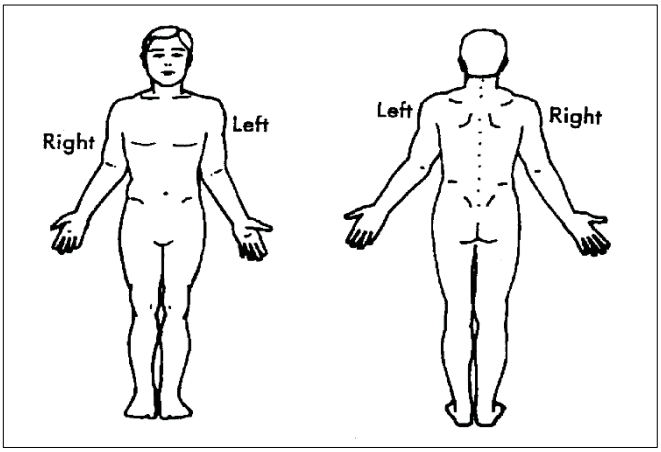
WHAT MAKES THE PROBLEM WORSE:_____

WHAT MAKES THE PROBLEM BETTER(including medications):_____

HOW ARE YOU TAKING CARE OF THE PROBLEM NOW:_____

WHAT ARE YOUR GOALS:_____

Please indicate on the chart below where you are injured and/or where your site of pain is located



Numbness & Tingling xxxxxxxxxx

Pain oooooooo

Please list any known ALLERGIES TO MEDICATIONS:

1._____

2._____

3._____

Please list any current medication(s) you are taking:

1._____

2._____

3._____

4._____

Are you latex sensitive? ☐Y ☐N

Have you ever had a reaction to anesthesia? ☐Y ☐ N

1. Were you seen in an Emergency Room? ☐Y ☐N

2. Were X-rays taken? ☐Y ☐N

3. Has this problem been evaluated by another physician? ☐Y ☐N

Name:_____ Date:_____

4. Is this a recurrent problem? ☐Y ☐N

5. Have you ever had surgery for this problem?

☐Y ☐N If yes, please explain:

Operation performed:_____

Doctor's Name:_____

Hospital Name:_____

6. Do you have a history of:

Diabetes	☐Y ☐N
Arthritis	☐Y ☐N
Heart Condition	☐Y ☐N
Elevated blood pressure	☐Y ☐N
Anxiety	☐Y ☐N
Depression	☐Y ☐N
ADD/ADHD	☐Y ☐N

7. Other medical problems:

_____

_____

_____

_____

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

PATIENT MEDICAL HISTORY

Patient Name:_____
Date:_____

Past Medical History

Have you ever had any medical problems	☐Yes ☐No
High Blood Pressure	☐Yes ☐No
Do you have a pacemaker?	☐Yes ☐No
Heart Disease	☐Yes ☐No
Stroke	☐Yes ☐No
Respiratory Disease (Asthma, COPD)	☐Yes ☐No
Sleep Apnea	☐Yes ☐No
Kidney Disease	☐Yes ☐No
Thyroid Disease	☐Yes ☐No
AIDS/HIV	☐Yes ☐No
Hepatitis	☐Yes ☐No
Rheumatoid Arthritis	☐Yes ☐No

Have you had surgery? ☐**Yes** ☐**No**

Surgeries Date

_____
_____
_____
_____

Social History:

Do you/have you ever use(d):

Tobacco	☐Yes ☐No
(If yes, how much?_____ no of years?_____)	
Alcohol	☐Yes ☐No
Do you or have you had a problem with chemical dependency?	☐Yes ☐No

For women only:

Are you pregnant?	☐Yes ☐No
Are you breastfeeding?	☐Yes ☐No
Are you using prescriptive birth control?	☐Yes ☐No

Family History:

Has anyone in your family had any of these conditions?

Heart Disease	☐Yes ☐No
Stroke	☐Yes ☐No
Cancer	☐Yes ☐No
Bleeding Disorder	☐Yes ☐No

Review of Systems:

Do you have any of these symptoms? Please check either Yes or No for each condition.

Constitutional:

Depression	☐Yes ☐No
Fever	☐Yes ☐No
Weight loss/gain	☐Yes ☐No

Heart:

Chest pain	☐Yes ☐No
Irregular heartbeat	☐Yes ☐No
Poor circulation	☐Yes ☐No

Genitourinary:

Bloody urine	☐Yes ☐No
Painful urination	☐Yes ☐No
Unable to urinate	☐Yes ☐No

Neurological:

Paralysis	☐Yes ☐No
Headaches	☐Yes ☐No

Blood:

Bleeding Problems	☐Yes ☐No
Blood Transfusion	☐Yes ☐No

Eyes:

Decreased vision	☐Yes ☐No
Cataracts	☐Yes ☐No

Lungs:

Short of breath	☐Yes ☐No
Wheezing	☐Yes ☐No
Persistent cough	☐Yes ☐No

Musculoskeletal:

Joint swelling	☐Yes ☐No
Muscle aches	☐Yes ☐No
Joint pain	☐Yes ☐No

Psychiatric:

Depression	☐Yes ☐No
Bipolar Disease	☐Yes ☐No
ADHD/ADD	☐Yes ☐No
PTSD	☐Yes ☐No
Anxiety	☐Yes ☐No

Ears, Nose & Throat:

Loss of hearing	☐Yes ☐No
Sinus problems	☐Yes ☐No

Gastrointestinal:

Stomach pain	☐Yes ☐No
Diarrhea	☐Yes ☐No
Vomiting	☐Yes ☐No

Skin:

Rash	☐Yes ☐No
Dryness of skin	☐Yes ☐No

Endocrine:

Thyroid Problems	☐Yes ☐No
Diabetes	☐Yes ☐No

Allergies:

Allergies to food	☐Yes ☐No
Allergies to things other than food?	☐Yes ☐No

Are you currently being treated for these conditions? Yes / No Explain:_____

_____

STERLING RIDGE ORTHOPAEDICS & SPORTS MEDICINE

PATIENT CONSENTS

Our "Notice of Privacy Practices for Protected Health Information" describes how medical information about you may be used and disclosed and how you can get access to this information. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review at the front desk.

☐ I,_____, acknowledge that I was provided access to a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

*** You may refuse to sign this acknowledgment***

☐ I refuse to sign this acknowledgement

CONSENT FOR RELEASE OF PHOTOS/RADIOGRAPHS/VIDEOS FOR WEBSITE PUBLICATION:

☐ I hereby give permission to Sterling Ridge Orthopaedics and Sports Medicine to photograph, televise, or otherwise illustrate as deemed advisable for diagnostic, educational, or research purposes and to enhance the medical record. I further authorize the use of such audio-visual material (video tape, audio tape, photographs, motion pictures, and other resulting records) for teaching purposes or to illustrate scientific papers or lectures at any time hereafter without inspection or approval, on my part, of the finished product or the specific use to which this material may be applied.

☐ I understand that no identifying information will be used

☐ I **DO NOT consent** to the use of any pictures/videos/radiographs obtained during my treatment

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

☐ I hereby **authorize** the release of medical information (by telephone, mail or otherwise) by physicians and staff of Sterling Ridge Orthopaedics and Sports Medicine to (please list name and relationship)

Name/Relationship	**Address/Phone Number**
_____	_____
_____	_____
_____	_____

☐ I **DO NOT** authorize the release of medical information to my family members.