214.265.5050

www.OSSMDallas.com

Which Doctor are you seeing?

□ Newton □ Tucker

Name: _____

Address: _____

City/State/Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Would you like access to our web portal? Yes No

Social Security Number: _____Date of Birth: _____Age: _____ Sex: _____

Marital Status: _____ Spouse's Name: _____

Insurance: _____ Policy Holder's Name:_____ DOB:_____

Employer: _____ Employer's Telephone: _____

Address: _____

Occupation: _____

Emergency Contact: _____ Telephone: _____

Relationship to Patient: _____

Pharmacy: _____ Telephone: _____

How did you hear about us? _____

Please list any physicians that you see, or that would need a copy of today's visit note. _____
_____

We will need copies of your Driver's License/Photo ID and insurance cards at the time of service.

Payment is expected at the time of service. Payments should be made payable to:
William F. Tucker, Jr., MD, PA/W. Garner R. Newton, MD

I understand that I am responsible for payment of all charges incurred on my behalf and/or family members, regardless of insurance benefits.

Signature: _____ Date: _____

Orthopaedic Surgery and Sports Medicine of Dallas, PLLC
OSSMDallas.com
Phone 214.265.5050

PATIENT CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as part of the provision of healthcare services, Orthopaedic Surgery and Sports Medicine of Dallas, PLLC creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must agree to any restrictions in writhing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S NAME PRINTED	DATE
PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S SIGNATURE	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
WITNESS	DATE

214.265.5050

www.OSSMDallas.com

CONSENT FOR TREATMENT

I, knowing that I am suffering from a condition requiring diagnostic, medical or surgical treatment, do hereby voluntarily consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of W. Garner R. Newton, MD/William F. Tucker, Jr., MD., PA/ Orthopaedic Surgery and Sports Medicine of Dallas, PLLC, his assistants or his designee as is necessary in his judgment.

I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatments or examination by W. Garner R. Newton, MD/ William F. Tucker, Jr., MD, PA/ Orthopaedic Surgery and Sports Medicine of Dallas, PLLC.

Patient Signature: _____
Date: _____

If patient is a minor or unable to sign:

Signature: _____
Relationship to Patient: _____
Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign to W. Garner R. Newton, MD/ William F. Tucker, Jr, MD., PA all right, title and interest in any payment due me for services as provided in any policy or policies of insurance. I understand that I am responsible for providing to William F. Tucker, Jr., MD, PA/ W. Garner R. Newton, M.D., all insurance information at the time of my service, admission or during my hospital stay to allow for verification prior to my discharge, and that regardless of my assigned insurance benefits, I am responsible for the total charges for the services rendered. I understand that if my account is turned over to a collection agency for nonpayment, I will be assessed a 40% charge on the outstanding balance to cover the additional costs incurred recovering the balance which was not paid in a timely fashion.

Signed: _____ Date: _____

Signature of Spouse or Guardian: _____

Health History

Patient Name: _____

Reason for today's visit: _____ right/left_____

Is this a work injury (Workers Comp)_____

Notes:

PROBLEMS

MEDICATIONS

ALLERGIES

SOCIAL HISTORY

No Yes Do you smoke? (If yes, what and how much)

No Yes Do you drink alcohol? (If yes, how much and how often)

No Yes Do you use (or have you ever used) any addictive or illegal drugs (if yes what and when)?

Right/Left Dominant hand?

No Yes Do you have any tattoos? If so where:

FAMILY HISTORY

SURGICAL HISTORY

Patient Name: _____

PAST MEDICAL HISTORY

No Yes Arthritis (if so, what type): _____
No Yes Anemia
No Yes Anxiety Disorder
No Yes Asthma
No Yes Atrial Fibrillation
No Yes Bleeding Disorder:
No Yes Blood Clots:
No Yes Bronchitis/Pneumonia
No Yes Cancer:
No Yes Coronary Artery Disease/Other Heart Disease:
No Yes Depression
No Yes Diabetes:
No Yes Epilepsy/Seizures
No Yes GERD/Reflux
No Yes Gout
No Yes HIV or AIDS
No Yes Chest Pain/Heart Attack (MI)
No Yes Hepatitis/Other Liver Disease:
No Yes Hernia:
No Yes Hypercholesterolemia
No Yes Hypertension (High blood pressure)
No Yes Hypothyroidism/Other Thyroid problems:
No Yes Kidney Disease:
No Yes Lung Disease:
No Yes Lupus
No Yes Migraines
No Yes Osteopenia
No Yes Osteoporosis
No Yes Pacemaker/Defibrillator
No Yes Parkinson's Disease
No Yes Peripheral Vascular Disease
No Yes Pulmonary Embolism
No Yes Sciatica/Back pain or injury
No Yes Stroke/Paralysis/Polio/Menegitis:
No Yes Tuberculosis
No Yes Ulcers:
No Yes Urinary Tract Infection (UTI):
No Yes Use of blood thinners (if yes, which one(s)):
No Yes Any problems with Anesthesia?
No Yes Any loose teeth/ dentures?
No Yes Could you be pregnant?
No Yes Have you ever had a blood transfusion?

No Yes Are there any other medical problems that you feel we need to know about?

_____

_____