Chisholm Trail
Orthopedics & Sports Medicine, LLLP

Patient Medical History

Patient Name:____ **DOB:** __________________ **Today's Date:** _________________

Are you seeking treatment with this facility for a work-related injury? ❒ Yes ❒ No If yes, please stop here and see the receptionist.

Past Medical History: Ex: high blood pressure, diabetes, heart disease

____

____

____

Medications with Name, Strength, and How Often: (separate list works, as well)

____

____

____

Drug Allergies: ____

Surgical History – Date and Surgery Performed:

____

____

____

Hospitalizations in Last Two Years – Date and Reason:

____

____

____

Social History

Do you use tobacco? ❒ Yes ❒ No Type? ❒ Snuff ❒ Pipe ❒ Cigarettes | # Per Day ________ # of years ________

Do you drink alcohol? ❒ Yes ❒ No How often? ❒ Daily ❒ Weekly ❒ Monthly | # Per Sitting ___________________

Family History

Please check all that apply:

	LIVING	AGE	CANCER	DIABETES	HEART DISEASE	HIGH BLOOD PRESSURE	MENTAL ILLNESS	OSTEOPOROSIS	STROKE	OTHER (Specify)
Father										
Mother										
Siblings										

Assignment of Insurance Benefits

I hereby authorize direct payment of surgical/medical benefits to Chisholm Trail Orthopedics & Sports Medicine, LLLP and the physician that it employs for services rendered. I consent to disclosure of my medical information by Chisholm Trail Orthopedics & Sports Medicine, LLLP to my insurance company in order to obtain payment for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I request that the payment of authorized benefits by Medicare and/or Medicaid be made on my behalf. Any remaining balance after insurance payment must be received or payment plan established within 120 days of service. Any subsequent remaining balance may be turned over to a collection agency.

Initial____________ Date____________

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices is available at my request. I understand that if I have questions or complaints regarding my privacy rights that I may contact office management. I further understand that the practice will offer me updates to this notice should it be amended, modified, or changed in any way.

Initial____________ Date____________

Release of Private Healthcare Information

I authorize the release of all or any part of my medical history by paper or verbally to *only* the following persons:

____

____

Signature:____ Date____________

Physician Assistant & Nurse Practitioner Consent

This facility employs certified physician assistants and nurse practitioners to assist your doctor in your care. These providers do not replace the physician in your medical treatment; they assist the physician in the delivery of your medical care. I hereby consent to the services of physician assistants and nurse practitioners in conjunction with my physician for my health care needs.

Initial____________ Date____________

Medical Records Policy

I understand that the medical records created in this office, including x-ray images, are property of Chisholm Trail Orthopedics & Sports Medicine, LLLP. All medical records and original x-ray images generated as a result of my treatment with Chisholm Trail Orthopedics & Sports Medicine, LLLP shall remain property of this office. I further understand that I have a right to a copy of my personal medical record, and that if I request a copy of records, including x-ray images, there is a fee associated with creating such copies as set out in Chapter 165.1 of the Texas Medical Board rules pertaining to medical records.

Initial____________ Date____________

Disclosures

The Chisholm Trail Physicians and/or entities owned or controlled by them have a financial interest in the THR Cleburne Surgery Center, Monticello Imaging, and MedLeft Pharmacy.

Initial____________ Date____________