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**2010 Katherine P. Raines Road, Suite 300 • Cleburne, Texas 76033 • (817) 556-3212**

## **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

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

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**Drug Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History** – Date and Surgery Performed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Hospitalizations** in Last Two Years – Date and Reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## **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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 copyof 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\_\_\_\_\_\_\_\_\_\_\_\_