Patient Registration
J. Michael Bennett, M.D.

NEW PATIENT ____
UPDATE: ____

DATE: ______________

PLEASE COMPLETE ENTIRE FORM **PATIENT INFORMATION**

NAME: ____
(Last Name) (First Name) (Middle Initial)

ADDRESS: ____

DOB: ____________ AGE: ______ MALE / FEMALE MARITAL STATUS: ________ SOCIAL SECURITY #: ________

DRIVER'S LICENSE #: ______________ HOME PHONE: ______________ CELL PHONE: ________

EMPLOYER: ______________ OCCUPATION: ______________ WORK PHONE: ________

EMPLOYER ADDRESS: ____

REFERRED TO THIS OFFICE BY : ______________________ Phone: ____________
(If by a physician please print physician's full name)

INSURANCE INFORMATION

***** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM *****

PRIMARY INSURANCE: ______________________ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? ______________ DOB: ________ SS#: ________

EMPLOYER NAME: ______________________ PHONE: ________

SECONDARY INSURANCE: ______________________ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? ______________ DOB: ________ SS#: ________

EMPLOYER NAME: ______________________ PHONE: ________

GUARANTOR INFORMATION (if different Patient)

☐ SPOUSE ☐ PARENT ☐ GUARDIAN NAME: ______________________

EMPLOYER: ______________________ PHONE: ________

BUSINESS ADDRESS: ______________________ CELL: ________

MEDICAL HISTORY (Please answer Yes or No)

ON THE JOB INJURY: YES NO IF YES, DATE OF INJURY: ____________ DATE LAST WORKED: ____________

MOTOR VEHICLE ACCIDENT: YES NO IF YES DATE IF ACCIDENT: ____________

IN CASE OF EMERGENCY

*****PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOU RESIDENCE*****

NAME : ______________ RELATIONSHIP: ______________ PHONE: ________

ADDRESS: ____

ASSISGNMENT AND RELEASE

This signature will authorize Fondren Orthopedic Group L.L.P. physicians to provide the indicated Medial/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Fondren Orthopedic Group L.L.P. all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medial information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: ______________________ Date: ____________

Signature of Patient (or parent): ______________________ Date: ____________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and it' not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any amount consistent with the contract or limits defined within your insurance plan.**

IN ORDER OT CONTROL COST OF BILLING, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF YOUR VISIT.

PATIENT HISTORY

NAME: ______________________________ AGE: ________ SEX: __________

PLEASE TELL US THE REASON FOR TODAYS VISIT INCLUDING BODY PART, RIGHT OR LEFT AND DATE SYMPTOMS BEGAN:

____

____

HAVE YOU SOUGHT PRIOR MEDIAL ATTENTION FOR THIS PROBLEM? YES NO

If YES, from whom: ______________________________ Date : __________

Were x-rays taken: YES NO If YES , what body part: ______________________________

PAST HISTORY

LIST CURRENT MEDICATIONS: ______________________________

____

____

LIST ALL ALLERGIES TO MEDICATIONS: ______________________________

____

Illnesses: ☐ None ☐ Diabetes ☐ Heart Trouble ☐ Hypertension ☐ Emphysema ☐ Asthma ☐ TB ☐ Ulcer ☐ Cancer ☐ Thyroid ☐ Hepatitis

☐ Other (explain) ______________________________

Surgeries: ☐ None ☐ Tonsillectomy ☐ Appendectomy ☐ Hernia Repair ☐ Hysterectomy ☐ Gallbladder

☐ Other (explain) ______________________________

Transfusions: ☐ No ☐ Yes (explain) ______________________________

Hospitalizations Other than Surgery: ☐ No ☐ Yes (explain) ______________________________

Family History	**Age**	**Living/Deceased**	**Illnesses/Cause of Death**
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			

Habits: Smoke Cigarettes: ☐ Yes ☐ No How much __________ Drink Alcohol: ☐ No ☐ Yes Use Drugs: ☐ No ☐ Yes

Review of Systems: (Check all that apply)

General
- ____ Weight Loss
- ____Weight Gain
- ____Poor appetite
- ____Chills
- ____Fevers
- ____Night sweats

Cardiovascular
- ____Chest Pain(angina)
- ____Palpitations
- ____ Irregular heartbeat
- ____Rheumatic Fever
- ____Swollen ankles
- ____Shortness of breath on exertion
- ____Shortness of breath at night

Dermatology
- ____Rash
- ____Hives
- ____Lesions

Respiratory
- ____Shortness of breath
- ____Wheezing
- ____Coughing
- ____Coughing up blood

Neurological
- ____Loss of consciousness
- ____Headaches
- ____Dizziness
- ____Seizures
- ____Fainting spells

Infectious Disease
- ____Hepatitis
- ____HIV
- ____Other __________

Psychiatry
- ____Anxiety
- ____Depression
- ____Other __________

Gastrointestinal
- ____Indigestion
- ____Gas
- ____Nausea
- ____Vomiting
- ____Yellow skin
- ____Abdominal pain
- ____Constipation
- ____Diarrhea
- ____Black Stools
- ____Rectal bleeding

Renal
- ____Frequent urination
- ____Urgent urination
- ____Painful urination
- ____Need to awaken to urinate
- ____Blood in urine
- ____Penile or vaginal discharge

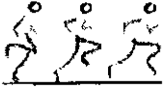
Endocrine
- ____Lymph node swelling
- ____Node tenderness
- ____Excessive appetite
- ____Heat intolerance
- ____Cold intolerance

FEMALES: Are you pregnant __________ Last menstrual cycle __________

Height __________ Weight __________ Dominant Hand ____Right ____Left

Signature: ______________________________ Date: __________

I certify that the information provided above is correct and true



Fondren Orthopedic Group L.L.P.

Patient Name: ______________________________ Clinic ID#: ______________

Insurance Company: ______________________________ SS#: ________________

Provider Number: ______________ Statement Group: __________

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment.

I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

MEDICARE – PATIENT'S CERTIFICATION: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

I have **Medicare Part B** coverage: ☐ Yes ☐ No

If yes, the type of coverage:
☐ Traditional Medicare OR ☐ Medicare Replacement Policy (HMO)

Medicare is my primary or secondary coverage: [-]

I have **Medicaid** coverage: ☐ Yes ☐ No

If yes, the type of coverage is:
☐ Traditional Medicaid OR ☐ Medicaid HMO Policy

Medicaid is my primary or secondary coverage: [-]

I am seeing the doctor for a work-related injury: ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

☑ Payment is required today for all copays, deductibles, or co-insurance amounts that may be due by the patient.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

________________________ ________ ________________________ ________
Signature of Insured/Guardian Date Witness Date

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

Fondren Orthopedic Group LLP

I, (name of patient) ____ , acknowledge and agree that I have reviewed a copy of Fondren Orthopedic Group's Notice of Privacy Practices and have completed the form below to the best of my knowledge.

______________________________	______________________________	______________
Signature of Patient or Guardian	Relationship to Patient	Date

Clinic Use Only

Fondren Orthopedic Group, L.L.P. made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of the Notice of Privacy Practices:

______________________________	______________
Signature of Employee	Date

FAMILY AND FRIENDS

Persons who are involved in your care (family "spouses", friends, other doctors "PCP" etc.) may inquire about your treatment, lab results, prescriptions, etc. IF THEY ARE NOT ON THIS LIST, WE CANNOT SPEAK WITH THEM REGARDING YOU. Please let us know what person(s) we may share information with and list them below.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

What other ways may we contact you? From time to time we will need to leave a message for you (as stated in our Notice of Privacy Practices) on answering machine, voice mail, or another individual in your absence. Is it OK to leave a message that includes details (such as diagnosis and medication information) at the numbers you have provided below:

Home Number: ______________________________ YES or NO

Work Number: ______________________________ YES or NO

Cell Number: ______________________________ YES or NO

Other Number: ______________________________ YES or NO

Fondren Orthopedic Group L.L.P.
7401 South Main Street
Houston, TX 77030-4509
(281) 633-8600

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to : (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

______________________________ ______________________________
Patient's Name Fondren Account Number

______________________________ ______________________________
Patient's Signature Date

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

____
Legal Representative's Name

______________________________ ______________________________
Legal Representative's Signature Date