FONDREN ORTHROPEDIC GROUP L.L.P.

Howard R. Epps. M.D., P.A.
Pediatric Orthopedic Surgery
Scoliosis and Pediatric Spinal Deformity
Board Certified

Dear Parent or Guardian:

Thank you for choosing Dr. Epps for your child's orthopedic specialty care.

Enclosed you will find our updated patient information forms. To enable our office to provide more timely service, please complete these forms prior to your visit and present them to our front desk, receptionist upon your arrival. Insurance company policies require proof of identity- patients/guardians or your representative must present a photo ID and your insurance/current medicaid card/documentation at the time of your clinic visit.

If a referral is required by your managed care plan, it MUST be received in our office by your appointment time. If you have any questions about your referral, you may call our referral dept. at 713-799-2300 ext. 3418 or ext. 3374. They can answer any of your referral questions that you may have.
You may fax your referral to 713-794-3313.

Patients who are not covered by insurance or self-pay patients are required to pay a cash or credit card deposit of $350 prior to seeing Dr. Epps.

All patients are seen in the order of scheduled appointments only. If you are unable to keep this appointment, please call 713-799-2300 ext 3023 or ext. 3257, so that we can help you to reschedule your appointment.

Sincerely yours,

Dr. Epps and Staff

7401 S. Main
Houston, Texas 77030-4509
Phone (713) 799-2300
Fax (713) 383-5201

HISTORY & PHYSICAL QUESTIONNAIRE

Name: ____Nickname:______________________________
Height: _____________ Weight: ___________________DOB:__________________________________
****

Previous Medical History

Surgery-Any previous surgeries/operation? __no __yes –if so, please list them
When? __________What hospital? ____________________Name of surgeon? ______________________
What type surgery was done? ____
When? __________What hospital? ____________________Name of surgeon? ______________________
What type of surgery was done? ____
Is the patient currently taking medications now? If so, please list: ____
____
____
Does the patient have any allergies? ____
____

Has the patient had any serious injuries (fractures, concussion)? ______________________________________
Does patient have any health problems? __NO __YES, please list____
____
____
Has the patient or anyone in the family had: (Please mark as many needed) __diabetes __liver disease
__bleeding problems __asthma __high blood pressure __ tumors/cysts __heart disease __kidney disease
__ bad reaction to general anesthetics __sickle cell anemia/trait __cancer __scoliosis __headaches
__fever __TB __change of appetite __wear glasses __fainting spells __difficulty hearing __ chest pain
__weight loss __ear infections __nausea or vomiting __eye problems __chills __belly pain __Others not listed: __
Does the patient have any hardware/metals in their body? ___no ___yes , if so, where?_______________________

For Newborns up to age 10:

Weight @ birth: ________lbs. _______ozs.
Was the patient a full term-pregnacy? __NO__YES if no, how many weeks was the mom? _______wks
How long was the patient in the hospital before going home? ___________months ________days
Any problems during delivery? __NO __YES, if so what, ____
____
What type of delivery? __ Vaginal __ C-Section
Was child breech? __NO __YES This is child# ________________

Immunizations:

Is the patient up to date? __YES __NO

Social History:

Is the patient in school? __NO __YES if so, what grade? ____
Does your child do well in school? ____
Is the patient employed? __NO __YES, if so, what type of job? ____
When was the last check up with your pediatric doctor?____
Is the patient on any special diet? ____

Please list any other concerns that you might want Dr.Epps to know? ______________________________________
____

Signature:____
Date:____

Thank you for choosing FONDREN ORTHROPEDIC GROUP LLP

FONDREN ORTHOPEDIC GROUP L.L.P

PEDIATRIC QUESTIONNAIRE

DR. HOWARD R. EPPS

All blanks <u>MUST</u> be filled in

Date:____________

Patient's Last Name__________________First Name___________________ Nick name:____________________________________

Date of Birth:_______________________________ Age______Male_______ Female_____ Social #:_______-_______-_______

Address:____City:____

State: ____ Zip Code:____

Mother's name: Mrs. or Ms.:____

Date of birth (mom):____ Social #________-_________-_______

Home phone #:____________________ Cell#___________________________ Tex Driver Lic#.___________________________

Work #:____ Emergency #____

Employer:__________________________Phone#:__________________________Address:____________________________

Address if different from above: ___________________________________Email Address:__________________________________

Father's name: ____

Date of birth (dad):____ Social # ____________-__________-____________

Home phone #_____________________ Cell #__________________ Tex Driver Lic#:___________________________________

Work #____ Emergency # ____

Employer:_______________________Phone#________________Address:____

Address if different from above: ___________________________Email address:____

<u>Emergency Contact :</u> Name:_______________________________Home Phone #_______________________________________

Relationship to patient____

Patient's Pediatrician Name: ____

Address:_____________________________ City:____________________Phone:____

Are you the legal guardian of the child?____

What are we seeing the patient for ____

Did you remember to bring your X-rays, MRI's, Medical Records, if any was done prior to scheduling your appointment? You will need to pick them up prior to your appointment. Dr. Epps requires the actual X-rays, MRI or CD.

Our Fax number is 713-383-5201 or 713-383-5221.

RELEASE OF MEDICAL RECORDS

The following information must be completed entirely to honor this request.
Fax: 713-383-5201

Patient name:____

Address:____

City:______________________________________State:_______________Zip:___________

Telephone home: (____)_______-_________   Work: (____)_______-____________

I _____________________________, patient of Dr.____
am authorizing FONDREN ORTHROPEDIC GROUP L.L.P. 7401 South Main, Houston, Texas to release records pertaining to the above, disclosure may include any and all medical and/or billing records including information regarding diagnosis, test results, and treatment of drugs, alcohol, substance abuse, AIDS or psychiatric disorders, and stamped materials prohibiting redisclosure.

These records are to be released to:

Name:____

Address:____

City:________________________________State:_____________________Zip:____________________

Telephone :(___) _________________________ Fax: (___)_______________________________________

Email address: ____

These records are being requested for the purpose of :____.

For the date(s) of treatment from: From:____________________through__________________________.

FONDREN ORTHROPEDIC GROUP L.L.P., its employees and officers and physicians are released from legal responsibility and liability for the release of the above information to the extent indicated and authorized herein.

This authorization will expire 180 days from the date signed. This authorization may be revoked at any time, but retroactive make in good faith. Please allow 3-4 days upon receiving request.

Signed:____ ___________________________________

Patient or Representative   Date

____ ___________________________________

Relationship to Patient   Witness (optional)

CONSENT TO MEDICAL, SURGICAL AND DENTAL TREATMENT

I, ______________________of ______________________ being the legal guardian of ____________________ (born on ________________________), a minor child , do hereby authorize, appoint and allow ________________________, DOB:____________ SS#, ____________________who is ____________________________ to ____________________________ (minor's name) to have full power and authority to consistent to medical and surgical treatment, including examination and diagnosis for our said minor child. This is a full and complete authorization to consent to MEDICAL, SURGICAL AND DENTAL treatment for our minor child, including blood transfusions. We give said attorney fact full power an authority to do any and all things necessary to obtain medical, surgical and dental treatment for our minor child. We hereby indemnify and hold harmless ____________________________ and _______________________________ from any and all liability as a result of either giving consent for such medical, surgical and dental treatment and we hold harmless any and all medical providers, physicians, dentists/oral surgeons, hospitals or medical clinic from their performing medical, surgical or dental treatment in reliance upon the consent given herein.

Our attorney hereunder is specifically authorized to indemnify and hold harmless any third party medical provider, physician, dentist/oral surgeon, hospital or medical clinic who accepts and acts pursuant to the Power of Attorney.

WITNESS OUR HANDS this the _______day of _______, 2006.

____

____

THE STATE OF TEXAS

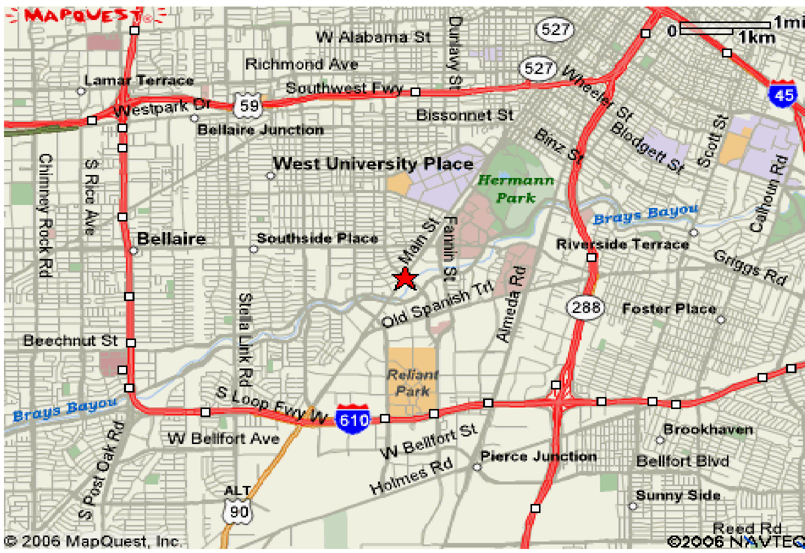
COUNTY OF HARRIS

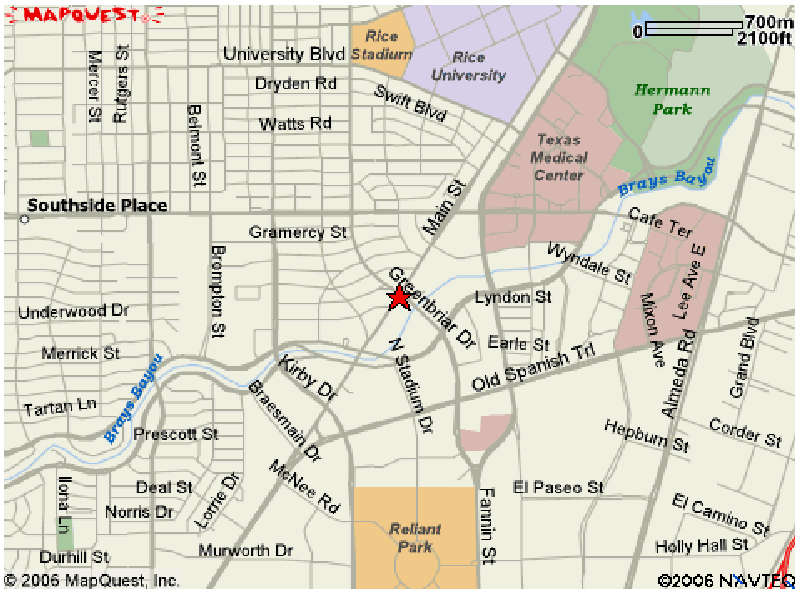
This instrument was acknowledged before me on this date _______________ day of _____________, 2007, by ____________________________ and ________________________________.

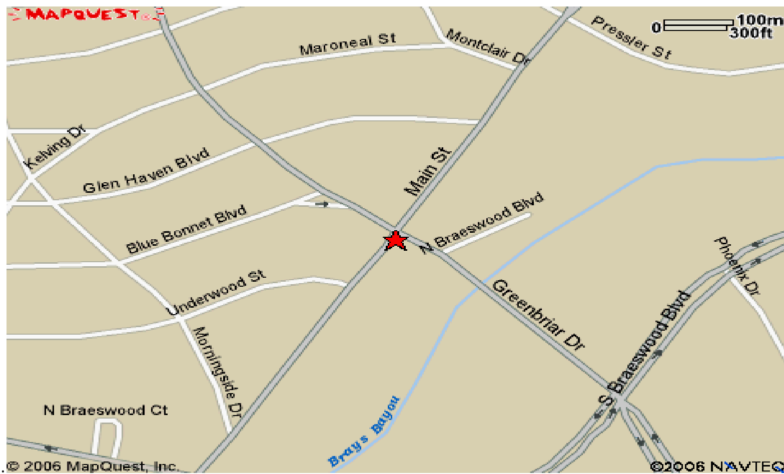
____

NOTARY PUBLIC, STATE OF TEXAS

Maps of Location: Ordered by level of magnification from Least to Greatest







Physical Address: **Texas Orthopedic Hospital**
Fondren Orthopedic Group L.L.P
2nd Floor to the left
7401 S. Main
Houston, TX 77030
713-799-2300 ext. 3023 or 3257

Driving Directions:

From I-10 East/Beaumont:
From I-10 E, exit 59 South. Take 59 South to 288/Lake Jackson exit. Exit Old Spanish Trail (OST) and turn right. Turn right at Greenbriar until you reach South Main and turn left on South Main. The first driveway on the left is the entrance to Texas Orthopedic Hospital. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From I-10 West/San Antonio:
From I-10 E take 610 South to the South Main exit and turn left. Travel north on S. Main and cross over Braes Bayou. Texas Orthopedic Hospital is located on the corner of S. Main and Greenbriar on the right. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From 59 South/Sugarland:
From 59 N, take 610 South to the South Main exit and turn left. Travel north on S. Main and cross over Braes Bayou. Texas Orthopedic Hospital is located on the corner of S. Main and Greenbriar on the right. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From 225/La Porte:
From 225 E take 610 West to the South Main exit and turn right. Travel north on S. Main and cross over Braes Bayou. Texas Orthopedic Hospital is located on the corner of S. Main and Greenbriar on the right. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From 45 N/Dallas:
Travel south on IH 45 to the 288/Lake Jackson exit. Exit Old Spanish Trail (OST) and turn right. Turn right at Greenbriar until you reach South Main and turn left on South Main. The first driveway on the left is the entrance to Texas Orthopedic Hospital. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From 45 S/Galveston:
Travel north on IH 45 and take 610 West to the South Main exit. Turn right on the South Main exit. Travel north on S. Main and cross over Braes Bayou. Texas Orthopedic Hospital is located on the corner of S. Main and Greenbriar on the right. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

From 288 S./Bay City:
From 288 take 610 West to the South Main exit and turn right. Travel north on S. Main and cross over Braes Bayou. Texas Orthopedic Hospital is located on the corner of S. Main and Greenbriar on the right. Our office is located inside Texas Orthopedic Hospital on the 2nd floor.

If you have any questions, please feel free to call our office at **713-799-2300-ext. 3023 or ext. 3257**