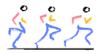


## Fondren Orthopedic Group L.L.P.

Patient Information	Provider #:	Account Number:	count Number:	
Patient's Name (First MI Last)	Gender DOB Age	DL#	SSN	
	M F			
Address	City State	Zip Code	Home Ph:	
	•		0.11.01	
Email Address	Race	Ethnicity	Cell Ph: Preferred Language	
Zilidii / Idali ooo	Naos		1 reierred Zuriguage	
Deticute Francisco	Business Phane	Marital Status	Referring / Primary MD	
Patient's Employer	Business Phone	Marital Status M S D W	Referring / Primary MD	
Employer Address		Employer #		
		_		
Spouse's Name	Spouse's Employer	DOB	SSN	
Guarantor Information (if patient is a minor)				
Guarantor's Name	Relationship to Patient	DOB	SSN	
	•			
Billing Address	City State	Zip Code	Emergency Phone	
billing Address	ony state	Zip code	Linergency i none	
Insurance Information				
Insurance Carrier Name-Primary	Identification Number	Group Number	Ins. Phone Number	
Name of Policy Holder	Employer	SSN DOB	Relationship	
Insurance Carrier Name - Secondary	Identification Number	Group Number	Ins. Phone Number	
misurance during name decondary	Tachtinoation Number	Croup Humber	ms. I none rumber	
Name of Policy Holder	Employer	SSN DOB	Relationship	
What other ways may we contact you? Please circle YES or	NO if you would like us to leave a messa	ge at the numbers you	ı provide:	
Harris # MEO and NO - Marke # MEO and NO - Oall	VEQ and NO Others #		V50 NO	
FAMILY AND FRIENDS: Please let us know what persons v	YES or NO Other #:		YES or NO	
		PHONE #	id list trieffi below.	
1	70 TO			
2.				
3.				
Please check one of the following: This IS	a work-related injury. This IS N	OT a work-related	injury	
MED	ICARE / MEDICAID - PATIENT'S ONLY			
I certify that the MEDICARE information given by me is corre	ect. As this office does accept assignment	with Medicare, this in	formation 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 covers		t, i illust illioilli tills oi	ilice. I flave feau allu	
Medicare is my <b>primary</b> coverage.	Medicaid is my <b>primary</b> covera	ge.		
Medicare is my <b>secondary</b> coverage.	Medicaid is my <b>secondary</b> cover			
I am not covered by Medicare or a Medicare HMO	I am not covered by Medicaid of			
ASSIGNMENT OF BENEFITS: I hereby authorize	RELEASE OF INFORMATION: I hereby au		T TO CARE: I authorize and	
Payment to the Fondren Orthopedic Group, L.L.P. for the	Fondren Orthopedic Group, L.L.P. to re		dren Orthopedic Group, L.L.P.	
surgical and/or medical benefits, if any, otherwise payable	any or all information acquired in the co		n upon me injections, draw  I / or any other procedure or	
to me for services I have received.  FINANCIALOBLIGATION: The undersigned Hereby	my examination and / or treatment. I understand that this may include the re		s the doctor may in his best	
unconditionally guarantees full and prompt payment of all	any medical or other information require		determine advisable for my	
personal balances incurred as a result of services rendered	processing of claims for payment. I also		•	
to me during the course of my medical treatment.	authorize the release of information to		,	
Payment is required today for all co-pays,	doctor or health care facility to which th			
deductibles, or co-insurance amounts that maybe due by	may be transferred or referred.			
the patient.				
X Signature of Patient/Parent/or Guardian Date	X	<sub>X</sub>		
	Julian Salar		Patient/Parent/or Guardian Date	

# ACKNOWLEDGEMENT OF NOTICES Fondren Orthopedic Group, L.L.P.

I acknowledge and agree that I ha <u>Notice of Privacy Practices</u> and	2.0		• •	
I acknowledge and agree that I ha  WELCOME TO OUR PRACTION at the time of check-in I also understand that I must I also understand that I must approved after normal busine Minor Children (under age o FMLA/Disability/Insurance I	CE and understand the have a referral if I have call the pharmacy to resess hours, weekends or 18 years) must be according.	nat I will be asle e an HMO or PC quest a prescrip holidays. ompanied by a pa	ked for copays/deductible  OS plan.  otion refill. Refills ARE NOT  arent during an office visit.	
Pursuant to the requirements of Se you that each of the physicians in the Cl entities listed below, and may, indirectly entities.	ear Lake Practice has	a financial ow	nership interest in the	n
Fondren Orthopedic Group-Clear Lake Phy 520 Blossom Webster, Tx. 77598		Fondren Orthop 520 Blossom Webster, Tx. 77	pedic Group-Clear Lake MI 598	R
Houston Physicians' Hospital 333 N. Texas Webster, Tx. 77598		Houston Physici 3810 Hughes Co Dickinson, Tx. 7		
You, as the patient of one of thes care facility, other than the entit			ng an alternative health	
Signature of Patient or Guardian	Relationship to Pa	atient	Date	
Clinic Use Only Fondren Orthopedic Group, L.L.P. mad referenced individual's written acknowl Practice and Patient Financial Disclosur	edgement of the Notic			
Signature of Employee				



#### Fondren Orthopedic Group L.L.P.

#### 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, Guard signs this authorization on behalf of the patien	lian, Conservator, or Authorized Representative) t, complete the following:		
Legal Representative's Name			
Legal Representative's Signature	Date		

### **PATIENT QUESTIONNAIRE**

NAME:		DOB:	TODAY'S DAT	ΓE:
NAME:OCCUPATION:	HEIGHT:	WEIGHT:	DOMINANT HA	AND:R_L
CHIEF COMPLAINT:			_ DATE OF INJUR	Y:
AFFECTED SIDE? R or L				
DESCRIBE PROBLEM	I:			
INJURY LOCATION:		·		
INJ. RELIEVED:				
INJ. AGGRAVATED:				
PAST MEDICAL HISTORY (CI	HECK ALL THAT APPLY)	NONE Al	PPLY	
ANEMIA	CA OVARIAN	IRR. HEA		NUMBNESS/TINGLING
ANXIETY	CA PROSTATE	HIATAL		OSTEOPOROSIS
ASBESTOSIS	CA THYROID	HIGH CH	IOLESTEROL	OSTEOARTHRITIS
ASTHMA	CHEST PAIN	HIV		PNEUMONIA
BIPOLAR DISORDER	CHRONIC BACK PAIN	HYPERT	HYROIDISM	POOR CIRCULATION
BLEEDING DISORDER	COR. ARTERY DISEASE	HYPOTH	IYROIDISM	PULMONARY EMBOLIS
BLOOD CLOT	CON. HEART FAILURE		STONES	REFLUX
BRONCHITIS	DEPRESSION	LIVER P		RHEUMATOID ARTHRI
CANCER	DIABETES	LUNG PI	ROBLEMS	SEIZURE
CA BRAIN	EMPHYSEMA	LUPUS		SLEEP APNEA
CA BREAST	HEART ATTACK	MIGRAII		STROKE
CA CERVICAL	HEART MURMUR	NEUROL		TUBERCULOSIS
CA COLON	HYPERTENSION	DIS	ORDER	UTI
CA KIDNEY	HEART STENT	OFFICE		
CA LUNG	HEPATITIS A B C	OTHER_		_
PAST SURGICAL HISTORY (C	HECK ANY THAT APPLY)	NONE A	PPLY	
ABDOMINAL SURGERY	GALLBLADD	ER REMOVAL	PNEU	MONECTOMY
AMPUTATION	GASTRIC BYI	PASS	PROS	TATECTOMY
ANGIOPLASTY	HEART SURG	ERY	ROTA	ATOR CUFF REPAIR
APPENDECTOMY	HEMORRHOI	DECTOMY	SPINI	E SURGERY CERVICAL
ARTHROSCOPY KNEE	HIP REPLACI			E SURGERY THORACIC
ARTHROSCOPY SHOULDI			ESPINI	E SURGERY LUMBAR
BANDING		OMY PARTIAL	TONS	SILLECTOMY
BRONCHOSCOPY	INTERVENTION		T U R	P
CABG	PROCEDURI		VASE	CTOMY
CAROTID ENDARTERECT	OMYKNEE REPLA	CEMENT	VERT	EBROPLASTY
CARPAL TUNNEL REPAIR	KYPHOPLAS'	I'Y		ER SURGERY IN PAST 90 DAY
COLON RESECTION FEMORAL BYPASS	NEPHRECTO		ОТНІ	ER
FEMORAL BYPASSFRACTURE REPAIR	PACEMAKER PARATHYRO			
FRACTURE REPAIR	FARATHIRO	IDECTOMI		
FAMILY HISTORY (Use M f	or mother, F for father, o	or B for both)		
NONE APPLY	, <b>–</b>			
ANESTHESIA PROBLEMS	CA BREAST	CA OVA	RIAN	HYPERTENSION
ARTHRITIS	CA CERVICAL	CA PROS	STATE	OSTEOPOROSIS
ASTHMA	CA COLON/RECTAL	CA THYI	-	STROKE
BLEEDING DISORDER	CA KIDNEY	CANCER		TUBERCULOSIS
CA BRAIN	CA LUNG	DIABETI	ES	
OTHER				
SOCIAL HISTORY (CHECK A)	LL THAT APPLY)	NONE APPLY	Y	
SINGLECIGAR		<del></del>	SICAL WORK	REGULAR DUTY
MARRIED (smoke yea			ENTARY WORK	LIGHT DUTY
DIVORCEDPIPE S	MOKING	RET	IRED	OUT OF WORK
WIDOWEDCHEW	ING TOBACCO	HOM	IEMAKER	
ALCOI	HOL (drinks/day:	)STUI	DENT	
MEDICATIONS TAKEN DAILY	Y (NAME AND DOSAGE)	NONE		
	_			
PHARMACY USED:			PH#	
ALLERGIES TO MEDICINE: (1	LIST ALL) NO ALLERGI	IES		
	, <u></u> ::			

WAS THIS RELATED TO AN AUTOMOBILE ACCIDENT? \_\_Y \_\_N

REVIEW OF SYSTEMS
(Please circle YES or NO if any currently apply to you)

PRINT PATIENT NAME:	,	,	PATIENT DOB:	DATE:	
Have you had any new symptoms?	Yes	No	Do you have diabete	s? Yes	No
GENERAL:			SKIN:		
Fever?	Yes	No	Sensation Disturbance	e? Yes	No
Chills?	Yes	No	Bruising?	Yes	No
Sweats?	Yes	No	Birthmark?	Yes	No
Weakness?	Yes	No	Rash?	Yes	No
Malaise?(discomfort)	Yes	No	Itching?	Yes	No
Abnormal Weight Loss?	Yes	No	Dryness?	Yes	No
Sleep Disturbance?	Yes	No	Suspicious Lesions?	Yes	No
EYES, EARS, NOSE, THROAT:			NEUROLOGICAL:		
Double Vision?	Yes	No	Headaches?	Yes	No
Blurred Vision?	Yes	No	Memory Loss?	Yes	No
Eye Irritation?	Yes	No	Confusion?	Yes	No
Eye Discharge?	Yes	No	Transient Paralysis?	Yes	No
Vision Loss?	Yes	No	Weakness?	Yes	No
Eye Pain?	Yes	No	Numbness?	Yes	No
Light Sensitivity?	Yes	No	Tingling?	Yes	No
Earache?	Yes	No	History of Seizures?	Yes	No
Ringing in Ears?	Yes	No			
			Syncope?(fainting)	Yes	No
Nasal Congestion?	Yes	No	Tremors?	Yes	No
Nosebleeds?	Yes	No	Vertigo?(dizzy)	Yes	No
Sore Throat?	Yes	No			
Difficulty Swallowing?	Yes	No	PSYCHIATRIC:		
Hearing Loss?	Yes	No	Depression?	Yes	No
			Anxiety?	Yes	No
<u>CARDIAC:</u>			Memory Loss?	Yes	No
Chest Discomfort?	Yes	No	Mental Disturbance?	Yes	No
Chest Pains?	Yes	No	Suicidal Thoughts?	Yes	No
Palpitations?	Yes	No	Mood Disorders?	Yes	No
Syncope?(fainting)	Yes	No	Paranoia?	Yes	No
Shortness of Breath?	Yes	No	Sleep Disturbances?	Yes	No
Numbness in Arms?	Yes	No	Eating Disorder?	Yes	No
Swelling of Limbs?	Yes	No	Duting Disorder:	103	110
Ononing of Dinios.	103	110	ENDOCRINE:		
RESPIRATORY:			Sensitivity to Cold?	V	NI.
Cough?	Yes	No		Yes	No
			Sensitivity to Heat?	Yes	No
Shortness of Breath?	Yes	No	Abnormal Weight Ga		No
Wheezing?	Yes	No	Excessive Thirst?	Yes	No
Chest Congestion?	Yes	No	Excessive Urination?	- **	No
			Excessive Hunger?	Yes	No
GASTROINTESTINAL:			Diabetes?	Yes	No
Nausea?	Yes	No	•		
Vomiting?	Yes	No	HEMATOLOGIC/LYMPHA	ΓIC:	
Diarrhea?	Yes	No	Chronic Infections?	Yes	No
Constipation?	Yes	No	Abnormal Bruising?	Yes	No
Abdominal Pain?	Yes	No	Bleeding?	Yes	No
Blood in Stool?	Yes	No	Enlarged Lymph Noc		No
Heartburn?	Yes	No			1.0
			ALLERGIC / IMMUNOLOGI	<u>C:</u>	
GENITOURINARY:	_		Hives?	Yes	No
Painful Urination?	Yes	No	Hay Fever?	Yes	No
Blood in Urine?	Yes	No	Persistent Infections?	Yes	No
Urinary Frequency?	Yes	No	HIV Exposure?	Yes	No
Urinary Hesitancy?	Yes	No	Runny Nose?	Yes	No
Incontinence?	Yes	No	Sinus Congestion?	Yes	No
MUSCULOSKELETAL:			EXTREMITIES:		
Back Pain?	Yes	No	Redness of a limb?	Yes	No
Joint Pain?	Yes	No	Swelling of a limb?	Yes	No
Joint Swelling?	Yes	No	Discoloration of a lin		
Muscle Soreness?	Yes	No	Discoloration of a lin	iv: 16S	No
Arthritis?	Yes	No No			
Altimus!	168	140			