

**Patient Registration  
Fondren Orthopedic Group**

NEW PATIENT \_\_\_\_\_  
UPDATE: \_\_\_\_\_

DATE: \_\_\_\_\_

**PLEASE COMPLETE ENTIRE FORM PATIENT INFORMATION**

NAME: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

ADDRESS: \_\_\_\_\_  
(City) (State) (Zip Code)

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ MALE / FEMALE MARITAL STATUS: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

RACE \_\_\_\_\_ ETHNICITY \_\_\_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ @ \_\_\_\_\_

**PRESCRIPTIONS ARE NOW COMPLETED ELECTRONICALLY. PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW:**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ ADDRESS(CROSS STREETS): \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE? CIRCLE ONE: **Dr. BENNETTS' WEBSITE** **FRIEND** **INSURANCE**

PHYSICIAN: \_\_\_\_\_ **MAGAZINE:** \_\_\_\_\_  
(If by a physician please print physician's full name and phone number)

**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: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

**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: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

This signature will authorize Fondren Orthopedic Group L.L.P. physicians to provide the indicated Medical/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: \_\_\_\_\_

**PATIENT HISTORY**

IN ORDER TO COMPLY WITH ELECTRONIC MEDICAL RECORD GUIDELINES PLEASE COMPLETE ENTIRELY.

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ Todays Date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

FEMALES: Are you pregnant? \_\_\_\_\_ Last menstrual cycle \_\_\_\_\_

**PLEASE TELL US THE REASON FOR TODAYS VISIT INCLUDING BODY PART :**

\_\_\_\_\_

**RIGHT OR LEFT SIDE: \_\_\_\_\_ DATE SYMPTOMS BEGAN: \_\_\_\_\_**

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

If YES, from whom: \_\_\_\_\_ Date : \_\_\_\_\_

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

**LIST ALL ALLERGIES TO MEDICATIONS or CHECK  NONE**

**LIST CURRENT MEDICATIONS (PLEASE INCLUDE ANY SUPPLEMENTS) OR CHECK  NONE**

\_\_\_\_\_

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) \_\_\_\_\_

Any problems with anesthesia ?  No  Yes (explain) \_\_\_\_\_

Hospitalizations Other than Surgery:  No  Yes (explain) \_\_\_\_\_

Habits: Tobacco:  No  Yes Type: \_\_\_\_\_ How much per day? \_\_\_\_\_  Previous - Year Quit? \_\_\_\_\_

Drink Alcohol?:  No  Yes \_\_\_\_\_ drinks per day Use Drugs?:  No  Yes

**Family History**                      **Age**                      **Living/Deceased**                      **Illnesses/Cause of Death**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Children: \_\_\_\_\_

**Review of Systems:** (Check all that apply)

- |  |  |  |   |
|--|--|--|---|
| <p><b>General</b></p> <p><input type="checkbox"/> Weight Loss</p> <p><input type="checkbox"/> Weight Gain</p> <p><input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> Night sweats</p> <p><b>Cardiovascular</b></p> <p><input type="checkbox"/> Chest Pain(angina)</p> <p><input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> Irregular heartbeat</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Swollen ankles</p> <p><input type="checkbox"/> Shortness of breath on exertion</p> <p><input type="checkbox"/> Shortness of breath at night</p> <p><b>Dermatology</b></p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Lesions</p> | <p><b>Respiratory</b></p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> Coughing up blood</p> <p><b>Neurological</b></p> <p><input type="checkbox"/> Loss of consciousness</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Fainting spells</p> <p><b>Infectious Disease</b></p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Other _____</p> | <p><b>Psychiatry</b></p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Other _____</p> <p><b>Gastrointestinal</b></p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Yellow skin</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Black Stools</p> <p><input type="checkbox"/> Rectal bleeding</p> | <p><b>Renal</b></p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Urgent urination</p> <p><input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> Need to awaken to urinate</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Penile or vaginal discharge</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Lymph node swelling</p> <p><input type="checkbox"/> Node tenderness</p> <p><input type="checkbox"/> Excessive appetite</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Cold intolerance</p> |
|--|--|--|---|

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: 716

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





**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

**Fondren Orthopedic Group L.L.P.  
J. Michael Bennett, M.D.  
4690 Sweetwater Blvd., Suite 240  
Sugar Land, Texas 77479**

**Patient Financial Disclosure Notice**

Pursuant to the requirements of Section 105.002 of the Texas Occupations Code, this is to inform you that Dr. J. Michael Bennett has a financial ownership interest in **Texas Sports Medicine Institute, 7830 West Grand Parkway, Richmond, TX 77406**  
**Sugar Land Surgical Hospital, 1211 Highway 6, Sugar Land, TX 77479**  
and **PLEX 99, 7830 West Grand Parkway, Richmond, TX 77406**  
and may, indirectly, receive compensation for services you receive at the Facility.

You, as the patient of Dr. J. Michael Bennett, have the option of using an alternative health care facility, other than the ones listed above, if you so desire.  
By signing below, you are attesting that you have read and understand the information provided above.

\_\_\_\_\_  
PATIENT'S PRINTED NAME

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE SIGNED