Abilene Bone & Joint
1749 Pine
Abilene, Texas 79601
(325) 672-4372
www.ab-jc.com

Dear New Patient:

Thank you for making an appointment with our office.

In order to expedite the registration process and try to minimize your waiting time in our office, we would like you to fill out the following paperwork and bring it with you for your first appointment. Please also bring your insurance card and driver's license.

If your insurance plan requires a referral from your primary care physician to our office, then we must have this prior to your visit. If this referral has not been sent, then you may be asked to call your primary care physician to arrange this prior to being seen. Your appointment may be delayed, or even rescheduled for another day, if the referral has not been sent. We will make every effort to notify you if we do not have this referral prior to your visit. However, the ultimate responsibility for these referrals rests with you, the patient, and your primary care physician.

If you are visiting our office about a problem which has previously been diagnosed or treated by other physicians (ie. the emergency room doctors), please bring all pertinent records with you. These records may include test results, X-rays, or MRI reports.

We realize that appointments must be canceled at times. Please give our office at least 24 hours notice if you need to make a cancellation.

We look forward to seeing you and helping you with your orthopedic concerns.

Shannon E. Cooke, M.D.
David M. Stark, M.D.
Jeremy B. Britten, M.D.
Derek T. Padon, M.D.
And the Abilene Bone & Joint Staff

ABILENE BONE & JOINT

Date:_________________________ Account #:_______________

PATIENT'S NAME:____ Age_____ Birthdate _________________Sex____

Address____
Street or P.O. Box City State Zip Code

Phone(____)____________________ Cell Phone (____)________________ Social Security #__________________________

Employer___________________________________ Address____

Occupation_________________________________ Business Phone(___)__________________________________

Marital Status - ☐ Single ☐ Married ☐ Divorced ☐ Widowed Driver's Lic#__________________________________

*Person not living with you to contact in an emergency____________________________ Phone_______________________

IF PATIENT IS UNDER 18 YEARS OF AGE OR RESIDING WITH PARENTS, PLEASE COMPLETE:

Name of Responsible Party ____Birthdate______________________

Address____
Street or P.O. Box City State Zip Code

Home phone(___)__________________Social Security #____________________Drivers' Lic# ______________________

Employer____________________________ Address_____________________Work phone(____)______________________

****

Was this an injury? Yes___ No___ Date of Injury______________

On the job?____ Automobile?_______ Other______________________________

Referred by:____

PRIMARY INSURANCE

Medicare #____

Medicaid #____

Insurance Co____

Address____

____

Policy Holder's Name_________________________________

" SS#__________________________DOB:__________

Policy #______________________Group #______________

SECONDARY INSURANCE

Medicare #____

Medicaid #____

Insurance Co____

Address____

____

Policy Holder's Name_________________________________

" SS#__________________________DOB:__________

Policy #______________________ Group #______________

If policy holder is other than the responsible party, please write policy holder's address and phone number:____________________

____

- -

I authorize payment of medical benefits to Abilene Bone and Joint Clinic, LLP, for any insurance filed by the Clinic. I also authorize the release of any necessary information to process any of the above insurance claims.

****I have disclosed all insurance policies and have no other health care coverage at this time.***

I understand that I am financially responsible for all charges even if insurance is pending.

Signature:____

Acknowledgement of Notice of Privacy Practices

I have been provided with and understand the Notice of Privacy Practices of the Abilene Bone and Joint Clinic, LLP, which describes details of uses and disclosures of my protected health information. I understand that the Abilene Bone and Joint Clinic, LLC, reserves the right to change their Notice of Privacy Practices, and will have the revised notice available for my review upon my request.

Date: _______________________ ***Signature:*** ____

Orthopedic History (page 1)

Name:_______________________________________ Today's Date: ___________________________________

SS#: _____________________________ Age: _________ Height _____________ Weight______________

Family Doctor: ________________________________ Referring Doctor: ________________________________

CHIEF COMPLAINT

Why are you seeing the doctor today? (   ) right   (   ) left ____

When did this problem begin? ____________________ How did this problem begin? ___________________

____

Current problem is the result of: (Check all that apply)

□ Car Accident □ Work Injury □ Other injury □ Other Date of Injury: ____________________

PAST MEDICAL HISTORY

Heart disease	No	Yes	Arthritis	No	Yes
High Blood pressure	No	Yes	Gout	No	Yes
Diabetes	No	Yes	Tuberculosis	No	Yes
Emphysema	No	Yes	Ulcers	No	Yes
Asthma	No	Yes	Seizures	No	Yes
AIDS	No	Yes	Thyroid disorders	No	Yes
Cancer	No	Yes	Bleeding disorders	No	Yes
Hepatitis A B C (circle one)	No	Yes	(if yes, explain)		

PAST SURGICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? □ No □ Yes

Did you have any problems with anesthesia? □ No □ Yes Describe: ____________________________________

Medication	Dose	Reason for Medication	Side Effects

Drug allergies:

Are all immunizations up to date? □ Yes □ No If no, which immunizations are due? ____________________

PLEASE COMPLETE OTHER SIDE

Orthopedic History (page 2)

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or cause of death
Grandmother (mom's)	A	D		
" (dad's)	A	D		
Grandfather (mom's)	A	D		
" (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	(Circle one)		Describe all Yes responses
Eyes	No	Yes	______________________________
Ears, Nose, Throat	No	Yes	______________________________
Heart Problems	No	Yes	______________________________
Lungs, Breathing	No	Yes	______________________________
Digestion/Bowel Problems	No	Yes	______________________________
Bowel movement	No	Yes	______________________________
Bladder problem	No	Yes	______________________________
Gynecological Problems	No	Yes	______________________________
Bleeding problems	No	Yes	______________________________
Balance problems	No	Yes	______________________________
Numbness/tingling	No	Yes	______________________________
Blackout/fainting	No	Yes	______________________________
Psychological problems	No	Yes	______________________________

SOCIAL HISTORY

□ Work in the home □ Employed (occupation________________________________) □ Student □ Daycare □ Retired

□ Single □ Married □ Divorced □ Separated □Widowed

Children? □ No □ Yes #_____________________

Do you live alone? □ No □ Yes

Exercise? □ Daily □ Weekly □ Monthly □ Rarely □ Never

What type of exercise? ____

History of substance abuse? □ No □ Yes What? ____

Smoke currently? □ No □ Yes _____Packs per day for ______years.

Quit smoking? □ This year □ > 1 year □ >5 years □ > 10 years

Previously smoked _____ packs per day for ______ years.

Drink alcohol? □ Daily □ 1-2 x/week □1-2 x/month □ 1-2 x/year □ None

Signature: _______________________________________ Date: ______________________________________

Reviewed by: ____________________________________, MD Date: ______________________________________

ABILENE BONE & JOINT
PAIN MANAGEMENT PROTOCOL

Because of the subjective nature of pain, and because pain management is somewhat controversial, it has become necessary to explain to patients the protocol for pain management.

1. All narcotic medication prescriptions will come from the physician personally and will be addressed during the following hours:
   MONDAY-THURSDAY, Between 8:00am and 3:00pm
   FRIDAY, Between 8:00am and 11:00am
   NO WEEKEND REFILLS

2. It may take 1-3 business days to refill your prescription. We must review your medical records, check for expiration dates, verify the number of refills, and ensure refill eligibility.

3. Medications must be attained from <u>only</u> one (1) pharmacy. Multiple pharmacy use is unacceptable. Each patient's profile is verified with pharmacies. This profile is filed in your permanent medical file. If you are receiving pain medication from another doctor, we will not prescribe pain medications to you.

4. Medications WILL NOT be replaced if they are lost, stolen out of your car, fell in the toilet, eaten by pets, left at relatives, or for any other reason. If you do not take your medication as directed and you utilize your medication before the refill date, there will be no refills – regardless.

5. If it is evidenced that these pain medications are being used inappropriately and against physician instructions, the authorities will be notified.

Each patient receives individualized treatment with the development of an appropriate pain management plan. The normal course of pain management is six (6) weeks post injury. Chronic pain patients will be evaluated and referred to a Pain Treatment Clinic for evaluation and treatment.

Shannon E. Cooke, MD
David M. Stark, MD
Jeremy B. Britten, MD
Derek T. Padon, MD

______________________________ __________
Patient's Signature Date