

Abilene Bone & Joint, LLP
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, Xrays, 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 see you and helping you with your orthopedic concerns.

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

ABILENE BONE & JOINT, LLP

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 License # _____

**Emergency Contact (not living with you) _____ Phone (____) _____

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

Name of Responsible Party _____ Birthdate _____

Address _____ Home Phone (____) _____

Social Security # _____ Driver's License # _____

Employer _____ Address _____

Was this an injury? ___ On the job? ___ Automobile? ___ Other _____ Date of Injury _____

Referred by _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Medicare # _____ Medicare # _____

Medicaid # _____ Medicaid # _____

Insurance Co _____ Insurance Co _____

Address _____ Address _____

Policy Holder's Name _____ Policy Holder's Name _____

SS # _____ SS # _____

Policy # _____ Group # _____ Policy # _____ Group # _____

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

I authorize payment of medical benefits to Abilene Bone and Joint, 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 _____ Date _____

Acknowledgement of Notice of Privacy Practices

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

Signature _____ Date _____

ORTHOPAEDIC 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? _____

Date of injury _____

Has injury had Xray or MRI? _____ Where? _____

Current problem is the result of (check all that apply) ___ car accident ___ work injury ___ other _____

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	(explain any "yes" answers, please)	

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 _____

MEDICATIONS

Medication	Dose	Reason for Medication	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies _____

Are all immunizations up to date ___ No ___ Yes If no, which immunizations are due? _____

ORTHOPAEDIC HISTORY (page 2)

Name _____ Today's Date _____

FAMILY HISTORY

Member	Alive / Deceased	Age	Health / cause of death
Maternal Grandmother	A / D	_____	_____
Paternal Grandmother	A / D	_____	_____
Maternal Grandfather	A / D	_____	_____
Paternal Grandfather	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: (describe all "yes" responses)

Eyes	No	Yes	_____
Ears, Nose, Throat	No	Yes	_____
Heart problems	No	Yes	_____
Lungs, Breathing problems	No	Yes	_____
Digestion, Bowel problems	No	Yes	_____
Bowel movement	No	Yes	_____
Bladder problems	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 How many? _____ Live nearby? ____ 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/day for ____ years.
Quit smoking? ____ This year ____ > 1 year ____ > 5 years ____ > 10 years Previously smoked ____ packs/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 _____

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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 my protocol for pain management.

All narcotic medication prescriptions will come from me personally, and will be addressed during the following office hours:

Between 8:00am and 4:00pm Monday through Thursday
Between 8:00am and 12:30pm on Friday
NO REFILLS ON WEEKENDS.

Medications must be attained from only one (1) pharmacy. Multiple pharmacy use is unacceptable. Each patient's profile is verified with pharmacies. This profile is filed in your permanent medical record. If you are receiving pain medication from another doctor, I will not prescribe pain medications for you.

Medications WILL NOT be replaced if they are lost, stolen out of your car, eaten by pets, left at relatives, fall in the toilet, 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.

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

Each of my patients 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 further treatment.

Shannon E. Cooke, M.D.
David M. Stark, M.D.
Jeremy B. Britten, M.D.

Patient's Signature _____ Date _____