PEDIATRIC PATIENT REGISTRATION

Date:________

PATIENT INFORMATION: *Please use full legal name* ***Avoid Nicknames****

( )Jr. ( ) Other________

Last Name:____________________ **First Name:**____________________ **Middle Initial:**__________

Address:______________________________ **City/State/Zip**____________________

Date of Birth:______________ **Age:**______ **Sex:**________ **Social Security#:**______________

"I live with...... ( ) Both Parents ( )Father ( )Mother ( ) Other:____________"

PARENT/GUARDIAN INFORMATION: *Please fill out completely*

Father's Last Name:______________ **First Name:**______________ **DOB:**______ **SS:**__________

Home#:(______)______-______ Cell#:(______)______-______ Work#:(______)______-______

Mother's Last Name:______________ **First Name:**______________ **DOB:**______ **SS:**__________

Home#:(______)______-______ Cell#:(______)______-______ Work#:(______)______-______

Emergency Contact:______________________ **Emergency Contact Number:(______)______-______**

How did you hear about us!__________________ Referred by:__________

GUARANTOR INFORMATION: List the person responsible for the bill/or purchased the insurance)

Relationship of Guarantor to Patient: ______SELF (Please skip to the next section) ______Parent ______ Other

Last Name:______________ First Name:______________ MI:__________ DOB:__________

Address:______________________ City__________ State__________ Zip__________

Home Phone#:(______)__________ Cell Phone#(______)__________ Work Phone: (______)__________

Social Security#:______________ Age: ________ Sex: ( )Female ( )Male

Employer Name/Address:

____

INSURANCE I NFORMATION: Please present your insurance card/documentation and identification for photocopying

PRIMARY INSURANCE:

Insurance Plan Name:______________ Insured's Name:______________ DOB:______ Insured's SS#__________

Policy ID#______________ Group#__________ Effective Date:__________ Termination Date:__________

Claims Mailing Address:______________________ Claims Phone #:(______)______-______

SECONDARY INSURANCE:

Insurance Plan Name:______________ Insured's Name:______________ DOB:______ Insured's SS#__________

Policy ID#______________ Group#__________ Effective Date:__________ Termination Date:__________

Claims Mailing Address:______________________ Claims Phone #:(______)______-______

I agree that the information supplied on this form is current and accurate to the best of my knowledge. I hereby assign to **ELITE ORTHOPAEDICS**, any insurance or other third-party benefits available for healthcare services provided to me. I understand that **ELITE ORTHOPAEDICS** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **ELITE ORTHOPAEDICS**, I agree to forward any health insurance and other third-party payments to **ELITE ORTHOPAEDICS** that I received for services rendered to me immediately upon receipt.

Patient/Responsible Party Signature:______________________________ **Date:**__________

*****I acknowledge that I have received a copy of the HIPPA Privacy Polices and understand that if I have any questions or complaints, I should contact the Privacy Official__________(Patient/Responsible Party Initials)**

Elite Orthopaedics

Michael E. Muncy, D.O.
Stephanie R. Stephens, M.D.

Welcome to our Practice! Elite Orthopaedics believes that in the interest of good health care practices, it is best to establish practice guidelines/policies between our patients and ourselves in order to avoid any misunderstandings. Our primary goal and responsibility is to provide quality healthcare and a positive experience. Please read through and initial each line; by initialing and signing you are acknowledging that you understand our guidelines/policies.

Copays, Co-insurance, Deductibles

_____ We expect that all co-pays, co-insurance and deductibles are paid in full at each visit and prior to surgery. We accept cash, check, debit cards and credit cards.

Billing and Insurance Information

_____ As a courtesy, we do submit insurance claims for our patients. You must bring your insurance card with you to every visit and make us aware of any changes in coverage. Lack of notification in change of coverage, or presentation of incorrect coverage, will result in patient responsibility for all charges. We also require a driver's license to confirm identity.

_____ Please remember insurance coverage is a contract between the patient and the insurance company. Elite Orthopaedics will look to the patient for payment in full if insurance does not cover the services provided. **In the event your insurance carrier has not paid within 60 days you are responsible for the balance due and we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor.** Failure to promptly resolve this balance may result in third party collection and/or legal procedures be taken. We participate with most insurance plans; however, it is the patient's responsibility to ensure proper authorization and physician participation before making an appointment.

_____ **Please keep a close watch for the carrier Explanation of Benefits (EOB) to be sent to you from the carrier reflecting claim payment and amount you may possibly owe provider**. **As a courtesy, monthly statements are mailed to the patient's address on file. For patient balances not paid in full within 90 days, we reserve the right to formally transfer all associated liability for the claim to third party collection and/or legal action.**

_____ **We do not file any insurance with your Automobile Insurance Company, or any other third-party (attorney, business insurance company, employer, separated spouses, etc.) for the purpose of obtaining payment.** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e. receipt, patient ledger, medical reports). We do not accept letters of guarantee or other promises to pay when cases settle.

Physician Referrals

_____ It is the patient's responsibility to obtain referrals from your primary care physician and ensure we are in receipt of them. If the referral is NOT obtained before the visit, the patient is liable for payment in full on the date of service.

Wait Time

_____ At Elite Orthopaedics we understand your time is valuable and that every patient, and their condition, is unique with different needs which may require more time than planned. Therefore, we will make every effort to provide you with the highest quality care and to minimize your waiting time. As this is a surgical practice, there may be times that a surgery may arise or take longer than expected which may cause a delay or rescheduling of your appointment. Every effort will be made to accommodate for this, and in the event of a delay or emergency we will do our best to notify you as soon as possible.

Late Arrival

_____ We make every effort to stay on schedule, therefore it is the policy of Elite Orthopaedics that if you're 15 minutes LATE arriving to your scheduled appointment you may be rescheduled. If you're going to be late, please call the office to reschedule.

Telephone Calls and Medical Questions

_____ Each physician has a dedicated clinical team to assist in providing your care. When you call with a routine medical question or request, the front office staff will connect you with the clinical team. Except in emergencies, our physicians and/or clinical

teams do NOT accept calls while they are in clinic with patients. If you call when your team is in clinic, the front office staff will gladly take a message or forward you to the team's voicemail. The team will respond to your call either between patients (time permitted), by the end of the day, or within 24 hours.

Prescription Refill Guidelines

______ Think ahead! Our office requires **48-hour notice for prescription refills, no exceptions**.

- Medications will be refilled between **8 AM and 4 PM Monday-Friday**. No refills on the weekends or holidays. The "on-call" physician will NOT refill medications.
- Safety of your prescription is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED**. Lock up your prescription medications and keep them away from children.
- Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
- Be aware of the effect of other medications you may be taking. Ask your doctor or pharmacist whether you can take them along with pain medication.
- Do not drink alcohol while taking pain medication. Obey warnings regarding sedation of certain medicines.
- Follow the prescribed dose of the medication. Do not give your medications to other people and do not take medication from others.

Form Completion

_____ Effective July 1, 2010, there is a **$20 charge per occurrence** for the completion of the following forms:

- Disability
- FMLA
- AFLAC
- Supplemental Insurance
- Dictated Work Excuse
- Medical Hardships

Payment is due when forms are presented. Forms will not be processed without payment. **Please allow 5 to 7 working days for the completion of forms.**

Patient/Guardian Signature: ________________________ Date: _______

Notification

Elite Orthopaedics would like to contact you for various reasons, including **Protected Health Information (PHI)** related to Appointments, Appointment Reminders, Test Results, X-Ray Results, Medications, Medical Status, and Surgery Scheduling if applicable. Please check the following:

☐ **Yes** ☐ **No** PHI information left at the Telephone Number(s) and/or E-Mail address I provided.

☐ **Yes** ☐ **No** PHI Mailed to address I provided.

Do you give our office permission to discuss your Protected Health Information with other parties and for these parties to be present during the examination if you so choose?

☐ **Yes** ☐ **No** If yes, please provide their names:

☐ **Spouse (List Name):** ____________________

☐ **Parent (List Name):** ____________________

☐ **Parent (List Name):** ____________________

☐ **OTHER (List Name):** ____________________

☐ **OTHER (List Name):** ____________________

I understand that as a part of my continuing healthcare, my physician maintains medical records in his/her office which contain my health history, symptoms, examination test results, diagnosis and treatment plans, to be used on a basis for planning my care and treatment, and that this information may be released to my other physicians/healthcare providers.

I understand that I have the right to request restrictions as to how my medical records may be used or disclosed.

I understand that this document is a part of my permanent medical record and that I may make changes regarding the disclosure of my health information at any time and that I must **notify the physician in writing of these changes.**

____________________ ____________________ ____________

Print Name **Signature** **Date**

MEDICAL QUESTIONNAIRE — Orthopaedic Surgery

Patient Name: ____________________

BP ____/____	Pulse _____
Temp. _______	Ht ______ Wt ______

Age: ______ ☐ F ☐ M   Dominant Hand: ☐ R ☐ L   Did you bring x-rays? ☐ Y ☐ N
Who requested that you visit this office? ______________________________
*What is the main reason for your this visit: ☐ Pain ☐ Numbness ☐ Weakness ☐ Swelling ☐ Stiffness
☐ Other________________________ (C.C.)

*What body part is involved? Please mark in the table below.

☐ Neck and radiates to ☐ R arm ☐ L arm ☐ Neither	Shoulder ☐ R ☐ L	Elbow ☐ R ☐ L	Hand ☐ R ☐ L	Pelvis ☐ R ☐ L	Knee ☐ R ☐ L	Foot ☐ R ☐ L
☐ Back and radiates to ☐ R leg ☐ L leg ☐ Neither	Arm ☐ R ☐ L	Wrist ☐ R ☐ L	Finger T 2 3 4 5 ☐ R ☐ L	Hip ☐ R ☐ L	Ankle ☐ R ☐ L	Toe B 2 3 4 5 ☐ R ☐ L

*How long ago did it start? ____Days ____Weeks ____ Months ____ Years.
Have you had a problem like this before? ☐ Yes ☐ No (Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

ANSWER: COMMENTS

☐ **NO INJURY (Onset was:** ☐ Gradual or ☐ Sudden
Why do you think it started? ______________________
☐ **INJURY (☐ Sport ☐ Accident - NOT Auto or Work)**
Date _______ Where and how did it happen? ______________________
What sport? ______________
☐ **INJURY AT WORK** Date _______
From a ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach ? ______________________
☐ **WORK-RELATED – (BUT NO INJURY)**
Date ________ How did your job cause this problem? ______________________
☐ **AUTO ACCIDENT** Date _______

On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)
What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning (Quality)

The pain is ☐ Constant ☐ Comes and goes. **Does your pain wake you from sleep?** ☐ Y ☐ N (Timing)

Do you have? ☐ Swelling ☐ Bruise ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel or bladder

Since my problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged (Context)

What makes your symptoms **worse**? ☐ Standing ☐ Walking ☐ Lifting ☐ Exercise ☐ Twisting
☐ Lying in bed ☐ Bending ☐ Squatting ☐ Kneeling ☐ Stairs ☐ Sitting ☐ Coughing ☐ Sneezing (Modify)

What takes your symptoms **better**? ☐ Rest ☐ Elevation ☐ Ice ☐ Heat ☐ Other______________ (Modify)

What medications are you taking now (or previously) for this problem? ______________________ (Modify)

Have you had any of these treatments? ☐ Injection ☐ Brace ☐ Physical Therapy ☐ Cane/Crutches (Modify)

What test/scans have you had for this problem? ☐X-rays ☐MRI ☐CT scan ☐Bone scan ☐Nerve test (EMG)

Current work status? ☐ Regular ☐ Light Duty (how long?_____) ☐ Not working due to this problem
☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

When is the last date you worked your regular job? ______________

ALLERGY Do you have **ALLERGIES** to any medications? ☐ Yes ☐ No **If yes, list below:**

MEDICATION	REACTION	MEDICATION	REACTION

(SEE PAGE 2)

REVIEW OF SYSTEMS:

CIRCLE ANY CONDITION BELOW THAT YOU HAVE/HAVE HAD: **NONE** **Describe**

				NONE	Describe
M/S	Osteo/Rheumatoid Arthritis	Gout	Back pain	☐	______
GI	Heartburn Ulcers	Nausea Vomiting	Blood in stool	☐	______
ENDO	Frequent thirst	Frequent urination	Always hot/cold	☐	______
CONST	Weight loss	Frequent fever	Loss of appetite	☐	______
EYE	Blurred vision	Double vision	Vision loss	☐	______
ENT	Hearing loss	Hoarseness	Trouble swallowing	☐	______
C-VASC	Chest pain	Palpitations		☐	______
RESP	Chronic cough	Shortness of breath	Sleep apnea	☐	______
GU	Painful urination	Blood in urine	Kidney problems	☐	______
SKIN	Frequent rashes	Skin ulcers	Psoriasis	☐	______
NEURO	Headaches	Dizziness	Seizures	☐	______
PSYCH	Drug/alcohol problem	Depression	Insomnia	☐	______
HEME	Easy bleeding	HIV/AIDS	Hemophilia	☐	______

***PAST MEDICAL HISTORY:**

WHAT MEDICATIONS DO YOU TAKE? ☐ **None** **Please list below with dosage.**

MEDICATION	DOSE	HOW OFTEN	MEDICATION	DOSE	HOW OFTEN

HAVE YOU EVER HAD/DO YOU HAVE? Circle any conditions below: ☐ I do not have any of the conditions listed below.

Asthma	Stroke	Heart attack (when?)______	High cholesterol
Ulcers	Kidney failure	**High blood pressure**	Cancer (location?)__________
Hepatitis	Heart failure	Liver disease	**Notes/Other:**
Seizures	Emphysema/COPD	Blood clots (DVT) or P.E.	__________
Thyroid problem	Bipolar disorder	**Diabetes**	__________

***PAST SURGICAL HISTORY:**

What operations have you had (for any reason)? When? ☐ None______________________________

____

***FAMILY HISTORY**: Have any direct relatives had any of the following disorders? If so, which relative?

☐ Heart Disease________ ☐ Lung cancer________ ☐ Breast cancer________ ☐ Diabetes________

☐ Rheumatoid arthritis________ ☐ Kidney disease________ ☐ Other________

***SOCIAL HISTORY**:

Do you use tobacco? ☐Y ☐N Packs/day____ Alcohol use? ☐None ☐Social ☐Daily ☐Frequently

Illegal Drug use? ☐Y ☐N What type?__________

Occupation: __________________ ☐ Student (What grade?)

PLEASE SIGN: The information on these 2 forms is accurate to the best of my knowledge.__________________

Elite Orthopaedics of Las Colinas
Michael E. Muncy, D.O. **Stephanie R. Stephens, M.D.**

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Irving, Texas 75039

4351 Booth Calloway Rd. Ste 303
N. Richland Hills, Texas 76180

O) 214-496-9700 F) 214-496-9707

Consent for Treatment of a Minor

I, ______________________________, Parent/Legal Guardian

Of ______________________________, a minor, date of birth

______________, do hereby authorize Elite Orthopaedics to provide treatment and care that is deemed advisable and rendered under the general or special supervision of a licensed physician. It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable.

I hereby indemnify and hold harmless Elite Orthopaedics and their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs, and assigns from any and all liability for acting in reliance on this authorization.

I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third party payors who may be responsible for part or all of the cost of the services provided.

______________________________ ______________________________
Signature of Parent or Legal Guardian Date