SOUTH AUSTIN ORTHOPAEDIC CLINIC, PA
4534 Westgate Blvd., Suite 110
Austin, Texas 78745
(512) 892-1220 phone
(512) 892-2439 fax

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 have enclosed paperwork for you to fill out. If you can mail or fax this information back to us prior to your visit we can have your chart prepared and ready for your visit when you arrive. Please also include a photocopy of your insurance card (front and back sides) as well as a photocopy of your driver's license. This information allows us to verify your insurance eligibility ahead of time further reducing the time you spend in our office while these administrative tasks are performed.

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 is not present when you arrive then you may be asked to call your primary care physician to arrange this prior to being seen thus delaying your appointment.** 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 **please bring all pertinent records such as: physicians notes, test results, x-rays, and surgery reports if applicable.**

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

Thank you in advance for helping us to try and serve you better. We look forward to seeing you soon.

Sincerely,

Drs. Race, Savage, Blais, Westmoreland and Staff

SOUTH AUSTIN ORTHOPAEDIC CLINIC, PA

PLEASE FILL IN ALL OF THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME: ____________________ DATE OF BIRTH: ____________

ADDRESS: ____________________ CITY: ____________ ZIP:__________ PHONE:______________

PARENT'S NAME (IF CHILD) ______________________________

PATIENT'S SOCIAL SECURITY # ____________________ DRIVER'S LICENSE # ______________

NAME OF PERSON RESPONSIBLE FOR BILL: ______________________________
(IF OTHER THAN SELF)
ADDRESS: ______________________________

RELATIONSHIP: ____________________ PHONE: ______________

PATIENT'S EMPLOYER: ______________________________
(OR PARENT'S EMPLOYER, IF MINOR // IF RETIRED—FROM WHERE)

ADDRESS: ______________________________ PHONE: ______________

SPOUSE'S EMPLOYER: ______________ SPOUSE'S DOB: __________ SPOUSE'S NAME: ______________

ADDRESS: ______________________________ PHONE: ______________

NAME OF PERSON TO NOTIFY IN EMERGENCY:
OTHER THAN IMMEDIATE HOUSEHOLD____________________ PHONE: ______________

IS THIS A WORKERS COMPENSATION CLAIM YES__________ NO__________

HEALTH INSURANCE COMPANY: ______________________________

POLICY #______________________________ GROUP # ______________________________

INSURED NAME: ______________________________ DOB: ______________________

SPACE BELOW FOR OFFICE USE ONLY

VERIFIED BY:____________________ ADJUSTOR: ______________________________

INSURANCE CARRIER:____________________ POLICY/CLAIM # ______________________

ADDRESS: ______________________________

ATTENTION:______________________________

GENERAL RELEASE OF INFORMATION

I hereby authorize SOUTH AUSTIN ORTHOPAEDIC CLINIC, PA to release information regarding my care to my insurance company and to other physicians involved in my case. I hereby give permission to the physicians and staff of SOUTH AUSTIN ORTHOPAEDIC CLINIC, PA to examine and treat my medical condition.

____ ______________________________

SIGNATURE OF PATIENT DATE
(PARENT IF PATIENT IS A MINOR)

FINANCIAL RESPONSIBILITY AGREEMENT

Please be advised that it is the policy of this office to estimate and collect patient responsibility amounts at the time of your visit. This amount includes co-payments, deductibles, coinsurance and any items not covered by your insurance plan. Payment will be expected at the time of service unless **prior arrangements** have been made. Failure to do so may result in the rescheduling of your appointment.

I understand that not all services offered by my physician are covered by my insurance plan. I agree to be directly responsible for payment of charges, copayments, deductibles, and any other services which are not covered by my insurance plan. (example: Heel pads, Braces, Sling, Waterproof cast liners, and other Durable Medical Equipment).

I FULLY UNDERSTAND AND AGREE TO THE ABOVE POLICIES AND AUTHORIZATIONS

Patient/Guardian Signature:____ DATE:__________________________

METHOD OF PAYMENT:
CASH _____ CHECK _____
M/C _____ VISA _____
DISCOVER _____

OTHER INSURANCE INFORMATION

I certify, by my signature below, that I DO / DO NOT have secondary Health Insurance coverage. If you do have secondary coverage, please provide the name in the space below.

Secondary Insurance Name:____

Please allow the receptionist to make a copy of your card.

____ ______________________________

Patient / Parent / Guardian Signature Date

FOR WORKERS COMPENSATION PATIENTS ONLY:

This is to authorize SOUTH AUSTIN ORTHOPAEDIC CLINIC to release any information regarding my care in this case to my employer's insurance carrier and the TWCC. Also, I authorize payment of medical benefits to SOUTH AUSTIN ORTHOPAEDIC CLINIC.

____ ______________________________

SIGNATURE OF PATIENT DATE

SOUTH AUSTIN ORTHOPAEDIC CLINIC, PA

PATIENTS NAME: ____Date of Birth ____________________

MEDICAL HISTORY: Please check only **CURRENT** problems.

GENERAL

YES NO
___ ___ Fever
___ ___ Weight Loss
___ ___ Decreased Appetite
___ ___ Excessive Fatigue

EYES

YES NO
___ ___ Wear Glasses
Date of last exam ___________
___ ___ Glaucoma
___ ___ Cataracts
___ ___ Infections
___ ___ Injuries

EARS, NOSE, THROAT, MOUTH

YES NO
___ ___ Wear hearing aids
Date of last exam_______________
___ ___ Nose Bleeds
___ ___ Congestion
___ ___ Inability to Smell
___ ___ Sinus
___ ___ Sinus Headaches
___ ___ Sore Throat
___ ___ Mouth Sores
___ ___ Hoarseness
___ ___ Difficult swallowing

CARDIOVASCULAR

YES NO
___ ___ Chest pain/angina
Date of last EKG_________________
___ ___ High blood pressure
___ ___ Irregular pulse
___ ___ Heart murmur
___ ___ High Cholesterol
___ ___ Swelling Hands/feet
___ ___ Leg pain while walking
___ ___ Pacemaker

PSYCHIATRIC

YES NO
___ ___ Depression
___ ___ Anxiety
___ ___ Mental Illness
___ ___ Sleeping Difficulty

ENDOCRINE

YES NO
___ ___ Diabetes
___ ___ Thyroid Disease
___ ___ Hormone Problems
___ ___ Increased thirst/urination
___ ___ Increased Appetite

RESPIRATORY

YES NO
___ ___ Asthma
___ ___ Emphysema
___ ___ Bronchitis
___ ___ Chronic cough
___ ___ Shortness of breath
___ ___ Pneumonia
___ ___ Bloody Sputum
___ ___ Lung Cancer
___ ___ TB
Date of last chest x-ray_____________

GASTROINTESTINAL

YES NO
___ ___ Persistent nausea/vomiting
___ ___ Blood in vomit
___ ___ Heartburn
___ ___ Gallbladder problems
___ ___ Hernia
___ ___ Abdominal pain
___ ___ Ulcer / gastritis
___ ___ Change in bowel habits
___ ___ Liver disease
___ ___ Jaundice
___ ___ Diverticulitis
___ ___ IBS / Colitis
___ ___ Hemorrhoids
___ ___ Colon cancer

GENITOURINARY

YES NO
___ ___ Urinary tract infection
___ ___ Painful urination
___ ___ Blood in urine
___ ___ Loss of bladder control
___ ___ Kidney stones
___ ___ Sexually transmitted disease
MALES
___ ___ Prostate problems
FEMALES
___ ___ Menstrual problems
___ ___ Menopause
___ ___ Uterine / cervical cancer
___ ___ Breast pain
___ ___ Birth control
Method:_________________________
Date of last PAP __________________
Date of last mammogram_____________

ALLERGIC / IMMUNOLOGIC

YES NO
___ ___ Food Allergies
___ ___ Inhalant Allergies
___ ___ Immune Disorder

HEMATOLOGIC / LYMPHATIC

YES NO
___ ___ Anemia
___ ___ Bleeding tendencies
___ ___ Phlebitis
___ ___ Persistent swollen glands or lymph nodes
___ ___ Blood transfusion
When?___________________________

MUSCULOSKELETAL

YES NO
___ ___ Back / neck pain
___ ___ Arm / leg pain
___ ___ Joint pain / swelling
___ ___ Arthritis
___ ___ Broken Bones
___ ___ Osteoporosis

INTEGUMENTARY

YES NO
___ ___ Skin disease /
Type___________________________
___ ___ Rashes Where __________

NEUROLOGICAL

YES NO
___ ___ fainting / blackout spells
___ ___ Seizures
___ ___ Headaches
___ ___ Stroke
___ ___ Muscle weakness
___ ___ Numbness / tingling
___ ___ Tremors / hand shaking

PATIENT HISTORY

Name: ____ Age __________ Sex (M or F) Hand Dominance R / L

Date: ______________ Occupation: ____

Referring MD or Hospital: _______________________________________Work Related: YES or NO

Primary Care Physician Name: ____

SECTION A. HISTORY OF PRESENT ILLNESS OR INJURY

1. Chief Complaint and location of pain? ____
2. When did this begin?: ____
3. How did it occur? ____
4. When is it painful? ____
5. What makes it worse? ____
6. What makes it better? ____
7. Have you seen another physician for this complaint? YES or NO
8. If yes, who was the physician and what was the treatment? ____________________________________

   ____
9. Have you had any tests (x-rays, nerve studies, MRI other) for this problem? YES or NO

   If yes, List date and place: ____
10. Have you missed work? YES or NO If yes, Last date worked: ____________________________

SECTION B. PAST MEDICAL HISTORY

1. Do you have/had any of the following medical conditions? (circle)

Diabetes	Epilepsy/Seizure	Thyroid Problems	Depression	Fibromyalgia
Cancer	Lung Problems	Abnormal Bleeding	Ulcers	High Blood Pressure
Gout	Hepatitis	HIV Positive		

   Others (list) ____
2. List previous surgery ____
3. List past injuries ____
4. List current medication(s) and dosage ____

   ____
5. List ***DRUG*** allergies ____
6. Do you smoke? YES or NO How much? ____
7. Do you drink Alcoholic Beverages? YES or NO

OFFICE USE ONLY

B.P.______________________ Height ______________________ Weight _________________

“ACCIDENT DETAILS”

PLEASE FILL IN *ONLY* THE SECTIONS THAT APPLY AND SIGN THE BOTTOM.

SECTION NUMBER 7 MUST BE FILLED IN COMPLETELY IF THIS WAS NOT DUE TO AN ACCIDENT.

1.A. **DESCRIBE HOW YOUR *INJURY* OCCURRED:**____

____

____

B. The accident location was:____

C. Date of Accident:____

2. **COMPLETE THIS SECTION IF YOUR INJURY WAS WORK RELATED:**

A. Were you on the job or was it related to work? Yes________________ No _____________________

B. If Yes, Employers Name:________________________________ Telephone #___________________

C. If yes, Did you report it to your employer? Yes ___________________ No___________________

3. **COMPLETE THIS SECTION IF THERE WAS AN AUTO ACCIDENT:**

A. I was: __________ a driver __________ a passenger ____________ a pedestrian

B. **MY** auto insurance company is:____

Adjustors Name:____

Insurance Company Phone #______________________Claim/Policy #_______________________

C. Information on the *OTHER DRIVERS*:

Name:______________________________________ Telephone #_______________________

Insurance Company:________________________________ Claim # ______________________

Adjuster Name:_________________________________ Telephone #_______________________

4. **IF YOU WERE NOT IN AN AUTO ACCIDENT, COMPLETE THIS SECTION:**

A. Did your injury occur on someone else’s property? Yes___________________ No ________________

B. Name and telephone # of property owner:____

Owners Insurance Company:______________________________Claim # __________________

Adjusters Name:________________________________ Telephone #_______________________

5. **HAVE YOU RECEIVED ANY SETTLEMENT OR INSURANCE MONEY BECAUSE OF YOUR INJURY?** Yes_____ No _____ IF YES, Amount paid:___________ Who Paid___________________

6. **DO YOU INTEND TO MAKE ANY CLAIMS** Yes____________________ No __________________

A. Have you hired an attorney because of the accident? Yes_________________ No _________________

7. **IF NONE OF THE ABOVE APPLY, PLEASE EXPLAIN:** ___________________________________

____

____

____

***THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE*.**

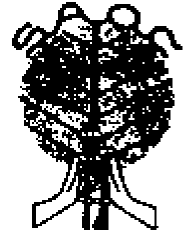
NAME:____________________________________ SIGNATURE______________________________

ADDRESS:_____________________________C____________S_____________Z___________________

HOME PHONE #__________________ WORK PHONE #_____________________ DATE_____________

SOUTH AUSTIN ORTHOPAEDIC CLINIC, P.A.

A PROFESSIONAL CORPORATION



MICHAELJ. ELLIOTT, M.D., F.A.A.O.S. 1945-1998
CLARK RACE, M.D., F.A.A.O.S.
DAVID C. SAVAGE, M.D., F.A.A.O.S
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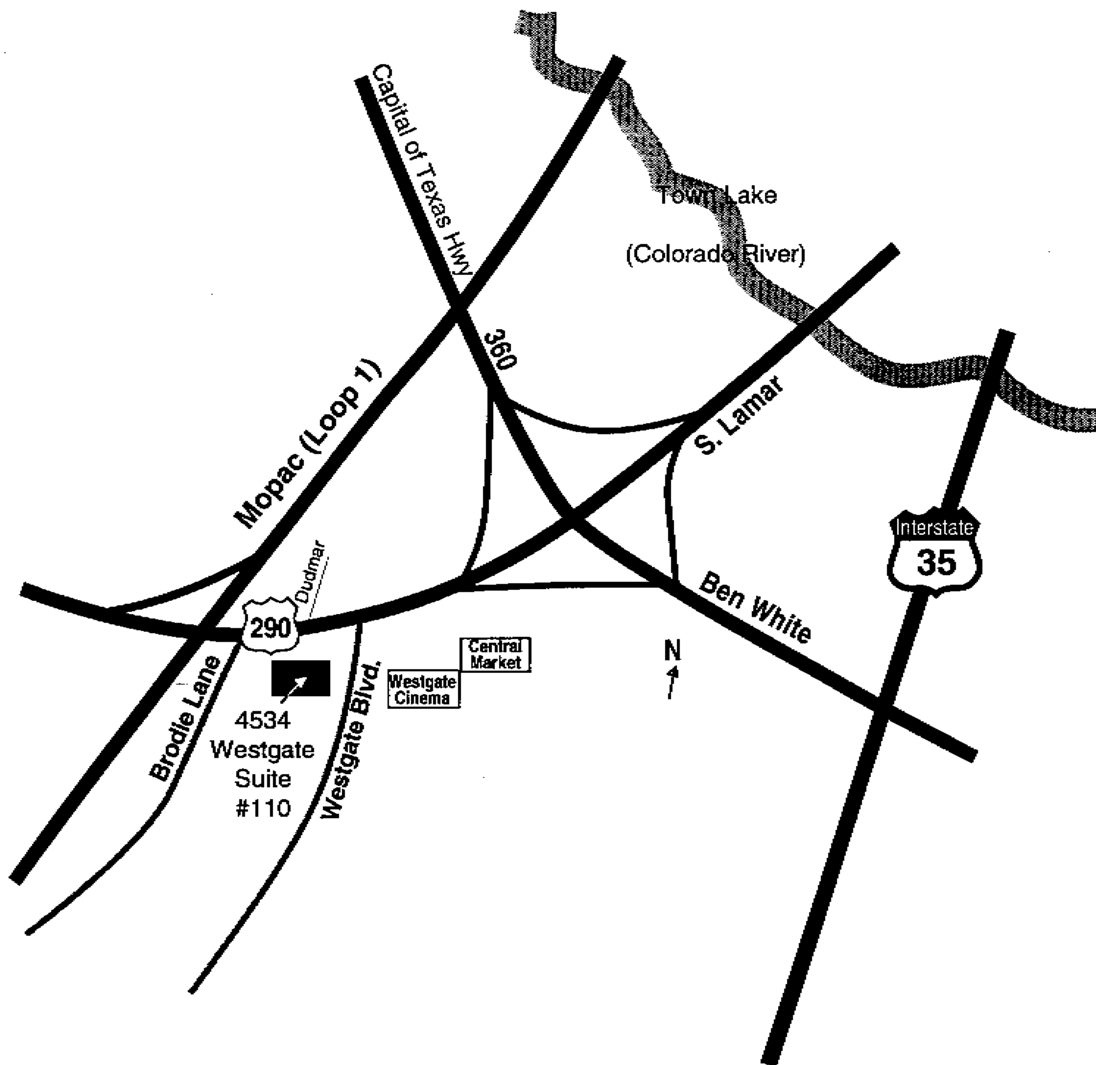

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Signature of Patient or Personal Representative

____

Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority