LONGVIEW ORTHOPAEDIC CLINIC ASSOCIATION

Patient's Name	Date of Birth	Age	Social Security Number

Sex	Race	Marital Status
Male Female	White Black Hispanic Other	Single Married Widowed Divorced Separated

Physical Address	City, State, & Zip Code	Home Phone
		( )

Mailing Address	City, State, & Zip Code	Cell Phone
		( )

Email	Employer	Work Phone
		( )

Primary Physician	Pharmacy

Spouse's Name	Date of Birth	Social Security Number	Employer	Phone Number
				( )

RESPONSIBLE PARTY FOR MINOR OR STUDENT:

Father's Name	Address	Date of Birth	Phone Number
			( )

Father's Employer	Social Security Number	Work Phone
		( )

Mother's Name	Address	Date of Birth	Phone Number
			( )

Mother's Employer	Social Security Number	Work Phone
		( )

HOW DID YOU HEAR ABOUT US?

____ PHONEBOOK ____ FAMILY/FRIENDS

____ INTERNET ____ OTHER ____________________

AUTHORIZATION:

I hereby assign to my physician all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I hereby authorize my physician to furnish information to my insurance carrier concerning my illness and treatments.

Because of concerns that there may be a conflict of interest when a physician refers a patient to a health care facility in which the physician has financial interest, I disclose to my patients that I or one of my partners has a financial relationship with the following rehabilitation providers: Highland Pines Skilled Nursing Facility, Bethany Home Health, Haven Care Nursing Home, located in Longview, Texas and The Willows located in Kilgore, Texas
Longview Orthopaedic physicians have ownership in the GSASC where some procedures are performed. They also have ownership in the MRI at GSMC and the physical therapy department at LOCA.

SIGNATURE: ______________________________ DATE: ____________________

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Patient History

TELEPHONE 903-758-2746 • FAX 903-758-7127

Patient Name:________________________ Birthdate (MM/DD/YYYY): ____/____/______

To help us meet all of your healthcare needs, please fill out this entire form in ink. Let us know if you need assistance. This is a confidential record of your medical history and will be kept in this office. It will not be released unless authorized by you in writing.

Today's Date:

Occupation:

Previous Occupation:

Marital Status: Single Married Divorced Widow Sep

Hobbies / Exercise / Recreation:

HABITS

Tobacco:	Yes	No	Type, Amount, Length of Time
Quit?	Yes	No	When?
Alcohol:	Yes	No	Type, amount per day / week:

Recreational Drugs:

DRUG ALLERGIES and type of reaction:

Do you have a latex allergy? Yes No

Primary Doctor: City:

Who referred you to us?

PAST MEDICAL HISTORY:			Hepatitis	Y N
Hypertension	Y	N	Diabetes	Y N
Heart / Disease	Y	N	Thyroid	Y N
AIDS	Y	N	Sickle Cell	Y N
Gout	Y	N	Cancer (list type)	
Rheumatoid Arthritis	Y	N	Other:	

PAST SURGICAL HISTORY (give dates):

Reason for today's visit? (Present health concerns, symptoms, or problems. For example: "Sore left knee for six weeks after a fall"):

REVIEW OF SYSTEMS: Have you ever had any of the following? (Circle all that apply.).

General Constitutional:	Weight loss	Weight gain	Activity tolerance (Increased or Decreased)				
Skin/Breasts:	Rashes	Dry skin	Hair loss	Hair growth	Tenderness	Lump	
Eyes/Ears/Nose/ Mouth/Throat:	Headaches	Dizziness	Vision disturbance	Nose bleeding or discharge	Gum bleeding	Cavities	Neck pain
Cardiovascular:	Chest pain or tightness	Palpitations	Shortness of breath with exertion		Heart murmur		
Respiratory:	Shortness of breath	Wheezing	Cough	Tuberculosis	Fever	Night sweats	
Gastrointestinal:	Changes in appetite	Abdominal pain	Nausea	Vomiting	Changes in bowel habit		
Genitourinary:	Changes in Frequency	Bloody	Discharge	Infections	Painful period		
Musculoskeletal:	Pain	Swelling	Muscle weakness	Joint Pain	Cramps	Loss of motion	
Neurologic/Psychiatric:	Seizures	Tremor	Difficulty with memory		Anxiety	Depression	
Allergic/Immunologic/ Lymphatic/Endocrine:	Allergy to Shellfish	Anemia	Intolerance to (Cold or Heat)		Bleeding tendency		

FAMILY HISTORY Has blood relative had any of the following:

Cancer	Y	N	High Blood Pressure	Y	N	Disability? Please explain reason. Y/N
Sickle Cell	Y	N	Rheumatoid Arthritis	Y	N	
Diabetes	Y	N	Bleeding Disorder	Y	N	
Heart Disease	Y	N	Osteoporosis	Y	N	
Brittle bone Disease	Y	N	Scoliosis	Y	N	
Inherited joint disorders	Y	N	Hip Dysplasia	Y	N	
Lupus	Y	N	Ehlers - Danlos Syndrome	Y	N	

Patient Signature: Physician Review: Date: ____/____/______

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Medication Sheet

Date: ____________________

Patient Name: ______________________________ Date of Birth: ____________________

Daily Medications/Dosage

Drug Allergies & Reaction

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Today's Date: ______________________________

Patient's Name: ______________________________

Please fill out ALL of the following information below, if it does not apply then put N/A.

Was this the result of an accident? YES NO

Date of accident: ______________________________

Place of accident: ______________________________

Nature of accident: ______________________________

____

____

____

Was this work related: YES NO

Was this related to an automobile accident: YES NO

I hereby declare that the above information is complete and accurate to the best of my knowledge.

____

(Signature)

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Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Longview Orthopaedic Clinic to use and/or disclose certain protected health information (PHI) about me to ________________________. (e.g. spouse, family,etc…)
(name)

This authorization permits Longview Orthopaedic Clinic to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual.")

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on ____________________ (90 days).

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Longview Orthopaedic Clinic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Longview Orthopaedic Clinic will notify any patient of a potential breach of HIPAA privacy information as soon as the breach is identified.

Longview Orthopaedic Clinic

Signed by: ______________________________ ______________________
Signature of Patient or Legal Guardian — Relationship to Patient

______________________________ ______________________
Print Patient's Name — Date

____
Print Name of Patient or Legal Guardian, if applicable

Patient/guardian must be provided with a signed copy of this authorization form.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________________, acknowledge that I have received a copy of the Longview Orthopaedic Clinic Association (LOCA) Notice of Privacy Practices.

______________________________________ ____________________
Patient Signature Date

______________________________________ ____________________
Patient Legal Representative (if applicable) Date

______________________________________ ____________________
Print name of Legal Representative Relationship to patient

FOR LOCA USE ONLY

LOCA has made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts taken to obtain written acknowledgment, including reasons (if known) why written acknowledgement was not obtained)

____

____

____

Name of Office Representative: ________________________________

Date placed in Patient Chart: ________________________________

LONGVIEW ORTHOPAEDIC
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Express Written Consent

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I/WE have read this disclosure and agree that the Lender/Creditor may contact me/us as described above.

Signature:____

Date:____

I grant permission to speak with the following people concerning my financial account:

Name:____ DOB:_______________________

Name:____ DOB:_______________________

Name:____ DOB:_______________________

Signature:____ Date:______________________

#20160 9/2017