

**Patient Registration
Fondren Orthopedic Group**

NEW PATIENT _____
UPDATE: _____

DATE: _____

PLEASE COMPLETE ENTIRE FORM **PATIENT INFORMATION**

NAME: _____
(Last Name) (First Name) (Middle Initial)

ADDRESS: _____
(City) (State) (Zip Code)

DOB: _____ AGE: _____ MALE / FEMALE MARITAL STATUS: _____ SOCIAL SECURITY #: _____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE: _____

DRIVER'S LICENSE #: _____ EMPLOYER: _____

HOME NUMBER: _____ CELL PHONE _____ WORK PHONE: _____

EMAIL ADDRESS: _____ @ _____

PRESCRIPTIONS ARE NOW COMPLETED ELECTRONICALLY. PLEASE PROVIDE YOUR PHARMACY INFORMATION BELOW:

NAME: _____ PHONE: _____ ADDRESS(CROSS STREETS): _____

HOW WERE YOU REFERRED TO OUR OFFICE? CIRCLE ONE: **Dr. BENNETTS' WEBSITE** **FRIEND** **INSURANCE**
PHYSICIAN: _____ **MAGAZINE:** _____
(If by a physician please print physician's full name and phone number)

INSURANCE INFORMATION

**** PLEASE COMPLETE THE INFORMATION BELOW SO WE MAY FILE YOUR INSURANCE CLAIM ****

PRIMARY INSURANCE: _____ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? _____ DOB: _____ SS#: _____

EMPLOYER NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ PATIENT HOLDS POLICY ? YES NO

IF NOT WHO IS THE POLICY HOLDER? _____ DOB: _____ SS#: _____

EMPLOYER NAME: _____ PHONE: _____ RELATIONSHIP TO PATIENT: _____

GUARANTOR INFORMATION (if different Patient)

SPOUSE PARENT GUARDIAN NAME: _____

EMPLOYER: _____ PHONE: _____

BUSINESS ADDRESS: _____ CELL: _____

MEDICAL HISTORY (Please answer Yes or No)

ON THE JOB INJURY: YES NO IF YES, DATE OF INJURY: _____ DATE LAST WORKED: _____

MOTOR VEHICLE ACCIDENT: YES NO IF YES DATE IF ACCIDENT: _____

IN CASE OF EMERGENCY

****PLEASE LIST SOMEONE OTHER THAN PERSONS LIVING AT YOU RESIDENCE****

NAME : _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____

ASSIGNMENT AND RELEASE

This signature will authorize Fondren Orthopedic Group L.L.P. physicians to provide the indicated Medial/Surgical care necessary for my treatment. Should it be necessary, I hereby authorize my insurance to pay directly to Fondren Orthopedic Group L.L.P. all benefits otherwise payable to me under the provisions of this policy. I also authorize the release of all medial information to the insurance company that is required to process all claims. I understand this authorization may be mailed or faxed to my insurance company.

Signature of Insured: _____ Date: _____

Signature of Patient (or parent): _____ Date: _____

PATIENT HISTORY

IN ORDER TO COMPLY WITH ELECTRONIC MEDICAL RECORD GUIDELINES PLEASE COMPLETE ENTIRELY.

NAME: _____ AGE: _____ Todays Date: _____

Occupation: _____ Height: _____ Weight: _____

FEMALES: Are you pregnant? _____ Last menstrual cycle _____

PLEASE TELL US THE REASON FOR TODAYS VISIT INCLUDING BODY PART _____ :

RIGHT OR LEFT SIDE: _____ DATE SYMPTOMS BEGAN: _____

HAVE YOU SOUGHT PRIOR MEDICAL ATTENTION FOR THIS PROBLEM? NO YES
If YES, from whom: _____ Date : _____

Were x-rays taken: NO YES If YES , what body part: _____

LIST ALL ALLERGIES TO MEDICATIONS or CHECK NONE _____

LIST CURRENT MEDICATIONS (PLEASE INCLUDE ANY SUPPLEMENTS) OR CHECK NONE _____

Illnesses: None Diabetes Heart Trouble Hypertension Emphysema Asthma TB Ulcer Cancer Thyroid Hepatitis
 Other (explain) _____

Surgeries: None Tonsillectomy Appendectomy Hernia Repair Hysterectomy Gallbladder
 Other (explain) _____

Transfusions: No Yes (explain) _____

Any problems with anesthesia ? No Yes (explain) _____

Hospitalizations Other than Surgery: No Yes (explain) _____

Habits: Tobacco: No Yes Type: _____ How much per day? _____ Previous - Year Quit? _____

Drink Alcohol?: No Yes _____ drinks per day Use Drugs?: No Yes

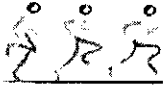
Family History **Age** **Living/Deceased** **Illnesses/Cause of Death**
Mother: _____
Father: _____
Brothers: _____
Sisters: _____
Children: _____

Review of Systems: (Check all that apply)

- | | | | |
|--|---|---|---|
| General
___ Weight Loss
___ Weight Gain
___ Poor appetite
___ Chills
___ Fevers
___ Night sweats | Respiratory
___ Shortness of breath
___ Wheezing
___ Coughing
___ Coughing up blood | Psychiatry
___ Anxiety
___ Depression
___ Other _____ | Renal
___ Frequent urination
___ Urgent urination
___ Painful urination
___ Need to awaken to urinate
___ Blood in urine
___ Penile or vaginal discharge |
| Cardiovascular
___ Chest Pain(angina)
___ Palpitations
___ Irregular heartbeat
___ Rheumatic Fever
___ Swollen ankles
___ Shortness of breath on exertion
___ Shortness of breath at night | Neurological
___ Loss of consciousness
___ Headaches
___ Dizziness
___ Seizures
___ Fainting spells | Gastrointestinal
___ Indigestion
___ Gas
___ Nausea
___ Vomiting
___ Yellow skin
___ Abdominal pain
___ Constipation
___ Diarrhea
___ Black Stools
___ Rectal bleeding | Endocrine
___ Lymph node swelling
___ Node tenderness
___ Excessive appetite
___ Heat intolerance
___ Cold intolerance |
| Dermatology
___ Rash
___ Hives
___ Lesions | Infectious Disease
___ Hepatitis
___ HIV
___ Other _____ | | |

Signature: _____ Date: _____

I certify that the information provided above is correct and true



Fondren Orthopedic Group L.L.P.

Patient Name: _____

Clinic ID#: _____

Insurance Company: _____

SS#: _____

Provider Number: 716

Statement Group: _____

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and/or treatment.

I understand this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

MEDICARE – PATIENT’S CERTIFICATION: I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS’ COMPENSATION, or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE coverage.

I have Medicare Part B coverage: Yes No

If yes, the type of coverage:

Traditional Medicare OR Medicare Replacement Policy (HMO)

Medicare is my primary or secondary coverage:

I have Medicaid coverage: Yes No

If yes, the type of coverage is:

Traditional Medicaid OR Medicaid HMO Policy

Medicaid is my primary or secondary coverage:

I am seeing the doctor for a work-related injury: Yes No

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and/or medical benefits, if any, otherwise payable to me for services I have received.

Payment is required today for all copays, deductibles, or co-insurance amounts that may be due by the patient.

FINANCIAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

Signature of Insured/Guardian _____ Date _____

Witness _____ Date _____



Fondren Orthopedic Group L.L.P.

7401 South Main Street
Houston, TX 77030-4509
281-633-8600

Authorization for the Use and Disclosure of Information to the U.S. Dept of Labor

I understand that my health insurance benefit plan may be governed under the federal rules of the Employee Retirement Income Security Act (ERISA) even though I may not be a retired person. ERISA requires that employers/insurance carriers subject to those rules respond to appeals regarding benefits only from a plan member or a plan member's authorized representative. By signing this form it will allow **Fondren Orthopedic Group, L.L.P.**, your medical provider, to : (1) submit any and all appeals on your behalf when your insurance company denies benefits to which we believe you are entitled, (2) submit a request for benefit information from your insurance company, and (3) initiate formal complaints to the appropriate state or federal agency that has jurisdiction over your plan.

I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential Protected Health Information (PHI), as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I hereby authorize release of my confidential PHI by my medical provider, for the purposes stated herein. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is prohibited from redisclosure by state or federal law.

This authorization must be dated and signed by the patient or a person authorized by law to give this authorization. A copy, electronic or a facsimile transmission of this form shall be deemed the same as the signed original.

Patient's Name

Fondren Account Number

Patient's Signature

Date

If a Legal Representative (or Parent, Guardian, Conservator, or Authorized Representative) signs this authorization on behalf of the patient, complete the following:

Legal Representative's Name

Legal Representative's Signature

Date

**Fondren Orthopedic Group L.L.P.
J. Michael Bennett, M.D.
4690 Sweetwater Blvd., Suite 240
Sugar Land, Texas 77479**

Patient Financial Disclosure Notice

Pursuant to the requirements of Section 105.002 of the Texas Occupations Code, this is to inform you that Dr. J. Michael Bennett has a financial ownership interest in **Texas Sports Medicine Institute, 7830 West Grand Parkway, Richmond, TX 77406**
Sugar Land Surgical Hospital, 1211 Highway 6, Sugar Land, TX 77479
and PLEX 99, 7830 West Grand Parkway, Richmond, TX 77406
and may, indirectly, receive compensation for services you receive at the Facility.

You, as the patient of Dr. J. Michael Bennett, have the option of using an alternative health care facility, other than the ones listed above, if you so desire.
By signing below, you are attesting that you have read and understand the information provided above.

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE

DATE SIGNED