OUCH – Orthopedic Urgent Care Home

David S. Brown, M.D. (800) 682-4220

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____ Male ☐ Female ☐

Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: _____ Alternate: _____

Patient Date of Birth: _____ (MM/DD/YYYY)

Pharmacy: _____ Pharmacy Phone Number: _____

Pharmacy Address/Intersection: _____

Referring Physician: _____ Phone Number: _____
(First and Last Name)

Primary Care Physician: _____ Phone Number: _____
(First and Last Name)

CONTACT INFORMATION

Mother's/Guardian's Name: _____ Phone Number: _____

Father's/Guardian's Name: _____ Phone Number: _____

INSURANCE INFORMATION

1. Primary Insurance: _____

Member/Subscriber ID No: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ (MM/DD/YYYY)

Address (if different than patient): _____

2. Secondary Insurance: _____

Member/Subscriber ID No: _____ Group Number: _____

Name of Policy Holder: _____ DOB: _____ (MM/DD/YYYY)

Address (if different than patient): _____

GUARANTOR INFORMATION (Person responsible for billing/payments)

☐ Check if Guarantor is same as Primary Insurance Policy Holder

Name: _____ DOB: _____ (MM/DD/YYYY)

Phone Number: _____

Address (if different than patient): _____

PAYING INSURANCE BENEFITS:

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health plans to Orthopedic Urgent Care Home, PLLC. ("OUCH"). This assignment is for services rendered to me by "OUCH". This assignment will remain in effect until revoked by myself in writing. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify "OUCH" of any changes of insurance coverage will result in the financial obligation to rest fully on me regardless of any contract between the insurance company and "OUCH".

PATIENT NAME (Please Print): _____ Date of Birth: _____/_____/_____

SIGNATURE OF PATIENT/GUARDIAN: _____ Date Signed: _____/_____/_____

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Patient History Form

This is a confidential record and information contained here will not be released without your consent.

Today's Date: _____ Date of Birth: _____

Patient's Name (First, Middle Last): _____

Who referred you to us? _____ **Primary Care Physician**:_____

Chief Complaint: What is the main reason for your visit today? Describe problem in detail. (Ex. What hurts?)

_____

Where did this injury occur? (i.e. home, playground, school, work) _____

Sports related? Yes ☐ No ☐ Motor vehicle accident? Yes ☐ No☐

When did you first notice this problem? _____ Date if injured: _____

What makes the problem worse? _____

What makes the problem better? _____

How long does the problem usually last? Constant: _____ Occasional: _____

Does the pain interfere with your normal functions? (Explain) _____

Have you seen another physician for the problem? (Explain) _____

Have you had any diagnostic studies or treatments for this problem? (X-rays, MRI, EMG, Bone Scan, Bone Density)

If so, when and where? _____

Pain Level: _____0-3 (mild) _____4-6 (moderate) _____7-10 (severe)

Developmental History

☐ Full Term ☐Premature at _____ wks. gestation. Complications/Developmental Delays? _____

If premature, was patient in the NICU? _____ Age when first walked? _____

Female Patients: Date when menses began (mo/yr): _____ Regular or Irregular? _____

Medical Diagnoses: _____

_____

Previous Surgeries: _____

_____

Family History: _____

Social History (who does the patient live with?): _____

Patient History of: Smoking: Yes ☐ No ☐ Alcohol Use: Yes ☐ No ☐ Drug Use: Yes ☐ No ☐

Current Medications: _____

_____

Drug Allergies: _____

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Patient Name: _____ DOB: _____

REVIEW OF SYSTEMS:

	Yes	No	Comments
Constitutional:			
A. Recent weight change?	☐	☐	_____
B. Weakness, fatigue, or chills?	☐	☐	_____
Eyes:			
A. Difficulty seeing?	☐	☐	_____
B. Temporary loss of vision?	☐	☐	_____
Ears, Nose, Throat:			
A. Problems with hearing?	☐	☐	_____
B. Hoarseness, sore throat?	☐	☐	_____
Cardiovascular:			
A. Chest pain/discomfort?	☐	☐	_____
B. Palpitations?	☐	☐	_____
Respiratory:			
A. Shortness of breath?	☐	☐	_____
B. Cough?	☐	☐	_____
C. Wheezing?	☐	☐	_____
Gastrointestinal:			
A. Constipation?	☐	☐	_____
B. Frequent Heartburn or indigestion?	☐	☐	_____
C. Abdominal Pain?	☐	☐	_____
D. Blood in stool?	☐	☐	_____
E. Difficulty swallowing?	☐	☐	_____
Gentourinary:			
A. Blood in urine?	☐	☐	_____
B. Urinary frequency/urgency?	☐	☐	_____
C. Pain when urinating?	☐	☐	_____
D. Urethral discharge?	☐	☐	_____
Endocrine:			
A. History of high or low blood sugar?	☐	☐	_____
B. Thyroid problems?	☐	☐	_____
Musculoskeletal:			
A. Joint pain?	☐	☐	_____
B. Joint swelling?	☐	☐	_____
Neurological:			
A. Fainting?	☐	☐	_____
B. Problems with concentration?	☐	☐	_____
C. Sense of smell and taste?	☐	☐	_____
D. Coordination?	☐	☐	_____
Psychiatric:			
A. Depression?	☐	☐	_____
B. Anxiety?	☐	☐	_____
C. Other psychiatric problems?	☐	☐	_____
Skin:			
A. Rashes?	☐	☐	_____
B. Skin cancers?	☐	☐	_____
C. Other major skin problems?	☐	☐	_____
Heme/lymph:			
A. Bleeding tendencies/bruising?	☐	☐	_____
B. Any history of anemia?	☐	☐	_____
C. Do you have sickle cell disease?	☐	☐	_____

Patient signature/Legal Guardian: _____ Date: _____

Provider Signature: _____ Date: _____

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431 E State Highway 114, Ste 120
Southlake, TX 76092

fax: (817) 812-2868
phone: (800) 682-4220

HIPAA DISCLOSURE

I authorize OUCH Orthopedics to disclose my, or my minor child's, medical information pertaining to the diagnosis and/or treatment, laboratory results, medical history, or any related information to these listed below (physician, family member). The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with the care of myself or my child to facilitate further health care treatment. I further understand that requests for medical information from persons not listed below will require specific authorization prior to the disclosure of the medical information.

_____ _____
Name (please print) Relationship Name (please print) Relationship

_____ _____
Name (please print) Relationship Name (please print) Relationship

I hereby give permission to OUCH Orthopedics to notify me via the following:

☐ Yes ☐ No Appointment reminder, either by personal message or recorded messages.

☐ Yes ☐ No A message to call the office for test results.

_____ _____/_____/_____
Signature of Patient (if >18 years old) or Legal Guardian Date

_____
Printed Name

This authorization remains valid and effective from the date of signing until revoked in writing.