TOP OF TEXAS ORTHOPEDICS

DR. TYLER N. COOPER MD **DR. TYLER A. BRITTEN MD**

(BLACK INK ONLY PLEASE)

Patient Information

Full Name:_____SUFFIX: (JR, SR, III)_____

Date of Birth:_____ SSN:_____

Phone Number:_____ Type: (CELL, HOME, MESSAGE)

Secondary Phone Number:_____Type: (CELL, HOME, MESSAGE)

Mailing Address:_____Apt.#_____

City:_____ State:_____ Zip Code:_____

Marital Status:_____Name of Spouse:_____

Email Address:_____

Emergency Contact

Name:_____ Relationship:_____

Phone Number:_____ Type: (CELL, HOME, MESSAGE)

Responsible Party Information

(Person Responsible for receiving bills; If patient, write self)

Name:_____SUFFIX: (JR, SR, III)_____

Date of Birth:_____ Age:_____ SSN:_____

Mailing Address:_____Apt.#_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Type: (CELL, HOME, MESSAGE)

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Insurance Information

Primary

Name of Insurance Company:_____

Subscriber Name (person who holds the insurance):_____

Subscriber DOB:_____ Subscriber SSN:_____

Policy # (ID #, Member #, etc.):_____ Group #:_____

Secondary

Name of Insurance Company:_____

Subscriber Name (person who holds the insurance):_____

Subscriber DOB:_____ Subscriber SSN:_____

Policy # (ID #, Member #, etc.):_____ Group #:_____

Additional information we may need to know regarding insurance:

_____

_____

By signing, you certify that the information provided is complete and correct. The information will be used to manage account and process insurance claims.

Patient/Guardian signature:_____ Date:_____

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Medical Information

Patient Name:_____ DOB:_____

Age:_____ Height:_____ Weight:_____ Sex: (circle) MALE or FEMALE

Primary Physician:_____Referring Physician:_____

Preferred Pharmacy:_____

Please list **ALL ALLERGIES** **DO NOT LEAVE BLANK**:_____

Please list **CURRENT MEDICATIONS**, *including* dosage and frequency:

History: (circle all that apply)

HEART DISEASE	HIGH BLOOD PRESSURE	HYPOTENSION	HIGH CHOLESTEROL	HEART ARRHYTHMIA
HEART ATTACK	STROKE	DIABETES	CANCER:	MAJOR INFECTIONS:_____
ASTHMA	LUNG DISEASE	KIDNEY DISEASE	THYROID DISEASE	HEPATITIS
PERIPHERVAL VASCULAR DZ	BLOOD CLOT, DVT, EMBOLISM	COLITIS	ULCERS	BACK PAIN
LIVER DISEASE	ARTHRITIS	ANEMIA	RHEUMATOLOGICAL DISEASE	HIV/AIDS
DEPRESSION	ANXIETY	GOUT	MIGRAINES	MENTAL ILLNESS

Others not listed:_____

Surgical History: (include procedure and date)

Family History: Are there any family members with any of the following? If so, list below:

|Diabetes | Hypertension | Heart Disease | Stroke | Cancer | Auto-Immune | Other:_____

Father: Alive or Deceased?	Daughter: Alive or Deceased?	Son: Alive or Deceased?
Mother: Alive or Deceased?	Sister: Alive or Deceased?	Brother: Alive or Deceased?

Social History: (circle all that apply)

Tobacco use? Y or N How much?	Alcohol? Y or N How much?	Recreational Drugs? Y or N, How much?

What is your occupation?_____

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Reason for Visit Today: **LEFT** or **RIGHT** _____

_____

How long has this been occurring?_____

Date of onset/injury?_____Pain level: (0-10)_____

Symptoms Associated with this problem:

INSTABILITY	LOSS OF MOTION	SWELLING	STIFFNESS	POPPING
WEAKNESS	DIFFUCULTY WALKING	"LOCKING UP"	"CATCHING"	"RADIATES"

Worsens with/when:_____

Improves with/when:_____

Previously Evaluated by:_____ When? _____

What was the recommended treatment at that time?_____

Attempted medications: (circle any that apply)

ALEVE ADVIL TYLENOL ASPIRIN MUSCLE RELAXANTS NARCOTICS
OTHER:_____

Other symptoms you are currently experiencing: (circle any that apply)

Fever	RUNNY NOSE	ABDOMINAL PAIN	DIFFICULTY URINATING/PAIN
CHILLS	SORE THROAT	CONSTIPATION	PALPITATIONS
FATIGUE	SHORTNESS OF BREATH	DIARRHEA	VISION CHANGES
DIZZINESS	COUGHING	NAUSEA	SKIN CHANGES
SYNCOPE	WHEEZING	VOMITING	RASHES/LUMPS
HEADACHES	CHEST PAIN	INCONTINENCE	NUMBNESS

By signing, you certify that the information provided is complete and correct.

Patient/Guardian signature:_____ Date:_____

Notice of Privacy Practices

Top of Texas Orthopedics PLLC is committed to maintaining the privacy of our client's Protected Health Information (PHI), while providing the highest quality service. In accordance with HIPAA regulations, all patients will receive a full written notice of our privacy practices effective February 1, 2019 *upon request*. This notice will explain your rights regarding your PHI and our obligations concerning the use and disclosure of your PHI.

Top of Texas Orthopedics PLLC may use and disclose your PHI for treatment, payment, and health care operations as well as other times in order to provide you with quality services.

You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of your PHI.

You have the right to complain about alleged violation to our practice and the U.S. Department of Health and Human Services.

Please indicate below all individuals authorized to discuss your PHI with our office or those who are authorized to receive copies of your medical records.

Name	**Relationship**	**Start/End Date**

Financial Policies

I understand that Top of Texas Orthopedics PLLC will bill my insurance company and I authorize payment of benefits by my insurance company directly to Top of Texas Orthopedics PLLC. I acknowledge that I will be responsible for any charges incurred. I understand that any balance left unpaid is subject to be sent to a collection agency and may be reported to the credit bureaus by such agency. I acknowledge that for any returned payments there will be a $30 fee assessed and I may be restricted from certain payment methods at our discretion.

I understand that copays and payments are due at time of service. If there is no insurance coverage, the full balance may be due at time of service. If surgery is necessary and/or agreed upon, we may require a down payment prior to the procedures being performed.

I authorize my insurance company, organization, employer, hospital, and any health care providers to release any information requested regarding the processing of my claim.

By signing, you agree to terms and conditions listed above and that all information you provided is correct.

Signature:_____ **Date:**_____

STUDENT ATHLETE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any medical provider associated with the school, organization, and team, including Top of Texas Orthopedics PLLC, to release the student's Protected Health Information(PHI), and related information regarding medical status, medical condition, injuries, illness, prognosis, diagnosis, rehabilitation, athletic participation status, and emergency medical treatment. The PHI information may be released to the student's parents/legal guardian, other health care providers, hospital, medical clinics, laboratories, physical therapists, athletic trainers, athletic coaches, athletic directors, and other medical personnel of the student's school, organization, or team.

By signing, you agree to terms of the Student Athlete Agreement.

Signature:_____ **Date:**_____

Athlete's Printed Name:_____