PATIENT INFORMATION FORM

Patient Name: _____ <> D.O.B.: _____ <> SSN: _____

Age: _____ <> Sex: Male / Female <> Pregnant: ☐ Yes ☐ No <> Telephone: (Home) _____

Address: _____ <> Telephone: (Cell) _____

City & Zip _____ <> Email address: _____

Referring Physician: _____ <> Primary Care Physician: _____

Patient's Employer: _____ <> Patient's Occupation : _____

Patient's Work Phone:_____ <> Emergency Contact Name & Phone # :_____

Marital Status : _____ <> Preferred Language: _____

Federal Regulations require us to ask your Race/Ethnicity. ☐ Asian ☐ Caucasian ☐ African American ☐ American Indian ☐ Hispanic ☐ Other

Reason for Visit

Reason for visit or chief complaint: _____ How long: _____
Is the condition you are being seen for today in any way related to an on-the-job injury? _____

Medications / Allergies

Current Medications _____ _____ _____

_____ _____ _____ _____

Pharmacy: _____ Phone: _____

Drug Allergies, including antibiotics: ☐ None or _____

I am allergic to *Contrast Dye:* ☐ Yes ☐ No <> allergic to *Iodine:* ☐ Yes ☐ No <> Are you currently on blood thinner? ☐ Yes ☐ No

Name of Blood thinners: _____

PAST MEDICAL HISTORY

Please check where appropriate and explain when needed.

Nervous System
- ☐ Paralysis
- ☐ Seizures / Epilepsy
- ☐ Migraines
- ☐ Stroke

HEENT
- ☐ Glaucoma
- ☐ Blindness
- ☐ Blurry vision
- ☐ Difficulty swallowing
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Voice changes

Cardiovascular
- ☐ Heart disease
- ☐ Murmur
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Valve disease
- ☐ Heart attack
- ☐ Palpitation

Pulmonary
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis

Gastrointestinal
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Gallbladder disease
- ☐ Ulcers
- ☐ Colitis
- ☐ Diarrhea
- ☐ Constipation

Genito-Urinary
- ☐ Kidney problems
- ☐ Prostate problems
- ☐ Urinary problems
- ☐ Menopause

Endocrine
- ☐ Diabetes
- ☐ Hypo-thyroid
- ☐ Hyper-thyroid
- ☐ Pituitary
- ☐ Adrenal

Immune System **Type**
- ☐ Infectious diseases _____
- ☐ Immune diseases _____
- ☐ Skin disorders _____
- ☐ Arthritis

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Bipolar disorder
- ☐ Schizophrenia

Hematologic
- ☐ Anemia ☐ Lymphoma
- ☐ Leukemia ☐ Sickle cell disease

Cancers
- ☐ Brain ☐ Ovarian ☐ Lung ☐ Stomach ☐ Colon/Rectal
- ☐ Breast ☐ Prostate ☐ Liver ☐ Skin ☐ Other _____

Past Surgical History _____

_____

Pacemaker: ☐ Yes ☐ No **<> Stimulator:** ☐ Yes ☐ No

Previous surgery: *Neck*: ☐ Yes ☐ No **<>** *Back:* ☐ Yes ☐ No **Performed by: Dr**._____

Any difficulty with surgery or anesthesia _____

Family Medical History (List all conditions: for example - diabetes, high blood pressure, cancer, etc)

_____ _____ _____

_____ _____ _____

Social History

Tobacco: ☐ No-never ☐ Yes-currently How many packs/day? _____ ☐ Yes-in the past How many years did you smoke? _____ When did you quit? _____

Alcohol: ☐ No ☐ Yes: how many drinks/day? _____ History of Alcohol Abuse: ☐ No ☐ Yes: how long have you been sober? _____

Illicit Drug Abuse: ☐ No ☐ Yes: please check all that apply ☐ marijuana ☐ heroin ☐ cocaine ☐ amphetamines ☐ other: _____

Have you ever had a problem w/ prescription medications (ie: misuse, abuse, addiction)? ☐ No ☐ Yes: which drugs? _____

PAIN INFORMATION

IF you have pain please fill out the following, if not skip to following page

Least----------->Worst

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain at its **WORST**.

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain at its **LEAST.**

0 1 2 3 4 5 6 7 8 9 10

Please rate your pain by circling the number that best describes your pain on the **AVERAGE.**

How did the pain start?

☐ Suddenly ☐ Pulling ☐ Lifting ☐ Gradually ☐ Twisting ☐ Bending ☐ Hit from behind
☐ Injured at work ☐ Fall ☐ Sports Injury ☐ Auto accident ☐ No apparent cause
☐ Other: _____

What activities make the pain worse?

☐ Nothing ☐ Sitting for long periods ☐ Weather ☐ Driving ☐ Standing for long periods ☐ Sleeping
☐ Work ☐ Walking ☐ Exercise

What reduces the pain?

☐ Nothing ☐ Lying down ☐ Medication ☐ Exercise ☐ Sleeping ☐ Massage ☐ Standing ☐ Heat
☐ Sitting ☐ Ice ☐ Walking ☐ Other: _____

Previous Tests

☐ MRI: *Neck / Back / Other* *Facility* _____ ☐ Pain Management: *Facility*_____

☐ CT Scan: *Neck / Back / Other* *Facility* _____ ☐ X-Rays: *Facility* _____

☐ Bone Scan: *Facility* _____ ☐ EMG: *Facility* _____

PREVIOUS TREATMENTS

Please indicate all the following measures you have tried

Medicines Tried:

☐aspirin
☐acetaminophen
☐motrin (ibuprofen)
☐aleve (naproxen)
☐advil (ibuprofen)
☐naprosyn (naproxen)
☐celebrex
☐cymbalta
☐tramadol (ultram)
☐mobic (meloxicam)
☐soma (carisoprodol)
☐norflex (orphenadrine)
☐lyrica (pregabalin)
☐zanaflex (orphenadrine)
☐flexeril (cyclobenzaprine)
☐toradol (ketorolac)
☐nortryptiline
☐elavil (amitriptyline)
☐zoloft (sertraline)
☐prozac (fluoxetine)
☐vicodin (hydrocodone)

Physical Therapy for this pain:

☐Physical Therapy *within the last 6 months* at:

☐None
☐Meske Sports & Physical Therapy ☐Bosque River Physical Therapy
☐Select Physical Therapy ☐Goodall Witcher Physical Therapy
☐Providence Physical Therapy ☐Scott & White Physical Therapy
☐Hillcrest Physical Therapy
☐Other: _____

Epidural Steroid Injection for this pain:

☐Injection *within the last 6 months* at:

☐None
☐Advanced Pain Care ☐Pain Clinic (Dr. Hurley)
☐Providence Hospital ☐Hillcrest Hospital
☐Other:_____

Other Treatments for this pain:

☐None
☐TENS Unit ☐Heat ☐Psychotherapy
☐Acupuncture ☐Ice ☐Traction
☐Chiropractic
☐Other_____

In the last 6 months, I have seen the following doctors for this pain:

_____

SYSTEM REVIEW

Check those symptoms that you have experienced in the last year.

General
- Fevers
- Chills
- Sweats
- Anorexia
- Fatigue
- Malaise
- Weight loss
- Weight gain
- Aches

Eyes
- Blurring
- Double Vision
- Irritation
- Discharge
- Vision Loss
- Eye pain
- Light Sensitivity

Ears/Nose/Throat
- Earache
- Ear Discharge
- Tinnitus
- Decreased Hearing
- Nasal Congestion
- Nosebleeds
- Sore Throat
- Hoarseness
- Difficulty swallowing
- Voice Changes

Cardiovascular
- Chest pain
- Palpitations
- Fainting
- Shortness of breath
- Peripheral edema

Respiratory
- Cough
- Pneumonia
- Excessive Sputum
- Bloody cough
- Wheezing

Gastrointestinal
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Black Stool
- Bloody Stool
- Jaundice

Male Genito-Urinary
- Painful urination
- Blood in urine
- Discharge
- Urinary Frequency
- Urinary Hesitancy
- Night urination
- Incontinence
- Genital sores
- Decrease Libido

Female Genito-Urinary
- Vaginal discharge
- Incontinence
- Painful urination
- Blood in urine
- Urinary Frequency
- Absence of menstruation
- Heavy menstruation
- Abnormal vaginal bleeding
- Pelvic pain

Musculoskeletal
- Back pain
- Neck pain
- Arm pain
- Leg pain
- Joint pain
- Joint swelling
- Muscle cramps
- Muscle weakness
- Stiffness
- Arthritis
- Difficulty walking

Skin
- Rash
- Itching
- Dryness
- Suspicious lesions
- Hair Changes

Neurologic
- Transient paralysis
- Weakness
- Tingling
- Seizures
- Tremors
- Vertigo
- Headache
- Numbness
- Speech difficulties

Psychiatric
- Depression
- Anxiety
- Memory loss
- Suicidal thoughts
- Hallucinations
- Paranoia

Endocrine
- Cold Intolerance
- Heat Intolerance
- Increased thirst
- Increased appetite
- Increased urination
- Weight Change

Heme/Lymphatic
- Abnormal bruising
- Bleeding
- Enlarged lymph nodes
- Anemia

Allergic/Immunologic
- Itching
- Hay fever
- Persistent Infections
- HIV Exposure
- Urinary tract infection
- Skin Infections
- History of Staph

WORKER'S COMPENSATION (required)

Is the condition you are being seen for today in any way related to an on-the-job injury? _____
If yes, have you filed a claim with your employer? _____
Type of Injury _____
Employer name and phone number _____
Has this condition ever been considered a work-related injury in the past? _____
I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered. If my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. I understand that Dr. Hamilton has elected to not participate in the Texas State Worker's Compensation Program. **Initial**: _____ **Today's Date**: _____

POLICY STATEMENTS

Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, the patient, not your insurance carrier. All charges are the responsibility of the patient whether the insurance carrier pays or not. If the insurance company does not pay your claim in full within 30 days, we ask that you contact the carrier to request prompt payment and to inform our office of their response. We accept payments in the form of MasterCard, Visa, money orders, cash (limited to maximum of $5000) and cashable personal checks.

Co pays: The patient is expected to present an insurance card at each visit to determine any changes in eligibility or copay assignments. All copayments and past due balances are due and payable at the time of service. NSF checks are assessed a $30 processing fee. Small Balance Refunds (<$150) may be available upon request with proof of overpayment and all visit balances paid. Refund checks are voided after 6 months.

Prepays: The patient portion of financial responsibility is due prior to the scheduling of surgery. This includes deductibles, coinsurance, or any services exempted from your insurance coverage. We recognize that determining expected out-of-pocket expenses can be complicated in some insurance coverage packages and have personnel to assist you. Based on the information provided by your insurance carrier(s), we will determine the payment expectations. Once the carrier's responsibility has been determined to be satisfied, any credit on your account will be refunded within 30 days from the carrier's final payment.

Referrals: If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your clinic visit. We will work to obtain these authorizations prior to your visit but request your participation and cooperation with your PCP as necessary.

Medical Records: All copies of your medical records & X-ray disk require a nominal fee of $25. Medical records sent to third party require a $25 charge for the first 20 pages and 50 cents/page for additional pages thereafter, plus postage. A Medical Records Release Form must be signed for any release of information. Please allow 14 days for medical records to be printed out and mailed. Please refer to our Notice of Privacy Practices in compliance with HIPAA regulations for guidelines on how your personal health information is protected. All patient encounters may be monitored and recorded for quality control purposes, including telephone calls and office visits.

Disability/FMLA Forms: The filing of Disability or FMLA forms follows receipt of a $50 Disability Form Fee. We will address Disability Paperwork for post-surgical patients for recovery time, as appropriate. Submit at pre-op, post-op, or scheduled visit. Please allow 14 days for forms to be completed, signed, and mailed after payment has been received. Each additional form request is treated and billed separately. Extension requests may be referred to Disability Physicians for impairment or functional capacity determination and evaluation.

Prescription Refills: Please remember to ask the doctor about your medications or refills during your visit with him. Refill authorizations must be requested by dispensing pharmacy. Prescription calls will be addressed the next business day. Pain medications will be managed for 90 days postoperatively. If further pain management is required, appropriate referrals will be made to either Pain Management or primary care physician.

Nonparticipating Insurance Plans: While most major medical insurance carriers are accepted, we DO NOT accept Texas Worker's Compensation Program, McLennan County Indigent Card, automobile insurance coverage, attorney letters of protection or letters of assignment.

Collection Agency: We may retain the services of an outside Collection Agency for recovery of delinquent balances. We reserve the right to attach collection fees associated with recovery of an individual account to that account balance.

Billing Questions: Patient statements are sent monthly and provide detail about dates of services and balances due. We are always happy to answer any questions or concerns about your statements. Please call our Business Office at 254-776-9775.

Recordings: All telephone calls are recorded. All office Visits are audio and video recorded.

This financial policy helps us provide quality consistent care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

PATIENT CONSENT AND RELEASE

I give H Bruce Hamilton, MD PA permission to examine and treat my condition. I understand all telephone calls are recorded. I understand all office visits are audio and video recorded. If any insurance claim or Workers Compensation claim is filed, I agree that clinical and all other necessary information concerning my condition and treatment may be released to my insurance company, employer, or Workers Compensation Carrier. I authorize payment to H Bruce Hamilton, MD, PA. I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. In consideration of services rendered, I hereby assign and transfer to H Bruce Hamilton, MD PA all rights, title and interest in the benefits payable for services rendered by all of my insurers and/or employee benefit plans, as well as all claims and/or causes of action (including but not limited to breach of fiduciary duty) that I have now and may have in the future related to the failure or refusal of any such insurer/employee benefit plan to properly pay benefits when due. I hereby authorize and instruct the insurers and/or employee benefit plans to pay directly to H Bruce Hamilton, MD PA all benefits due under the terms of my insurance policy or policies and/or employee benefit plans. I will pay H Bruce Hamilton, MD PA for all charges incurred or for all charges in excess of whatever sums may be paid for my insurers and/or employee benefit plans.
I have read and understood the above policy statements.

_____ _____
Signature Date