LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

First and foremost, we want to express our appreciation to you for selecting our practice. We want all of your experiences with us to be positive.

We know that filling out these forms can be difficult, but please complete them carefully. Your accurate responses will give us a better understanding of you and your problem. This enables us to provide you with the best possible medical care. Thank you for your cooperation!

Please bring your insurance card, driver's license or other picture ID, and all copies of medical records pertaining to your appointment including MRIs, X-rays, and CT scans. We do prefer that you have these on a CD. Please bring copies of the reports with the imaging.

Please confirm prior to your appointment which location you are scheduled at as we have multiple locations.

Again, thank you for selecting Lone Star Orthopaedic and Spine Specialists. Please feel free to call if you have any questions prior to your appointment.

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC

Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

NEW PATIENT REGISTRATION

Contact Information

Patient Name (Last, First, MI): _____ Today's Date: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Primary Care Physician: _____

How did you learn about our practice?

O Referred by a Physician: _____ O Internet / Website O Newspaper / Magazine

O Referred by a Patient: _____ O Other: _____

Care Plan

Do you have any of the following: O Advance Directive O Designated Power of Attorney O Other: _____

Demographic Information

Date of Birth: _____ Social Security #: __ __ __ - __ __ - __ __ __ __ Gender: O Male O Female O Other

Marital Status: O Single O Co-Habitating O Married O Divorced O Widow / Widower O Other

Ethnicity: _____ Preferred Language: _____

Employer or School: _____

Is todays visit: **Work Related** O Yes O No **3rd Party Liability** O Yes O No **Auto Accident** O Yes O No

Emergency Contact Information

Contact Name (Last, First, MI): _____ Phone #: _____

Address: _____
Street City State Zip Code

Preferred Pharmacy

Pharmacy Name: _____ Phone #: _____

Primary Insurance Information

Primary Insurance: _____ Phone #: _____

Insured's Name: _____ Relationship to Patient: O Self O Spouse O Child O Other

Insured's Date of Birth: _____ Insured's Social Security #: __ __ __ - __ __ - __ __ __ __

Employer/Group Name: _____ Group #: _____

ID #: _____

Secondary Insurance Information

Secondary Insurance: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Workers' Compensation Information

Insurance Company: _____ Phone #: _____ Date of Injury: _____

Adjuster's Name: _____ Phone #: _____ Claim #: _____

Patient Signature: _____ Date: _____

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM
Kirstin Webster, APRN, FNP-BC

Bone Health & Osteoporosis Clinic ▪ Fracture Liaison Service

Last Name: _____ **First Name**: _____

DOB: ____ / ____ / ____ **Age:** _____

Male □ **Female** □

Comprehensive Bone Health Screen

New Patient □ **Established Patient** □ **Visit Date: ____ / ____ / ____**

Please Circle

Yes **No** **1.** Have you ever fractured or broken a bone (after age 45)?

Age	Bone Involved	Describe Circumstance

Yes **No** **2.** Have you ever been told you have weak or fragile bones?

Yes **No** **3.** Have you been diagnosed with a bone health disease?
□ Low Bone density (Osteopenia) □ Osteoporosis

Yes **No** **4.** Has a family member been diagnosed with a bone health disease?
□ Low Bone density (Osteopenia) □ Osteoporosis

Yes **No** **5.** Have you had any loss of height (gotten shorter) since age 20?
If Yes, How much height loss? (estimate): _____ inches

6. How many falls have you had in the last 12 months? (Please check one)
□ No Falls, in the last 12 months
□ 1 fall in the last 12 months, without injury
□ 2 or more falls in the last 12 months
□ 1 or more falls resulting in injury in the last 12 months

7. How active have you been in the last 12 months? (Please check one)
□ Unable to walk
□ Not Very Active (Walking less than 1 mile per day)
□ Somewhat Active (Walking 1-2 miles per day)
□ Very Active (Walking 2 or more miles daily, formal exercise routine; weight lifting)

8. How many caffeinated beverages do you have each day? (Coffee, Tea, Cola, Energy drinks, etc.)
□ Less than 1 per Day □ 1 to 3 servings per day □ More than 3 servings per day

Medical Information

Yes No 9. Have you ever had high calcium level in your blood?

Yes No 10. Have you ever had low vitamin D in your blood?
If Yes, describe treatment: _____

Yes No 11. Have you ever been told you have hyperparathyroidism?

Yes No 12. Have you ever been told you have Paget's disease?

Yes No 13. Have you ever been told you have arthritis?
If Yes, (check 1 or both) □ Osteoarthritis □ Rheumatoid arthritis

Yes No 14. Have you ever been diagnosed with cancer?
If Yes, (please fill out table information)

Date	Location of Cancer?	Treatment
		□ Radiation □ Chemotherapy □ Combination
		□ Radiation □ Chemotherapy □ Combination
		□ Radiation □ Chemotherapy □ Combination

For Women only

Yes No 1a. Are you still having menstrual cycles?

Yes No 2a. Have you ever missed your period for 6 months or more (besides pregnancy)?

Yes No 3a. Are you currently going thru menopause (peri-menopause)?

Yes No 4a. Are you post-menopausal?
If Yes, at what age did you complete? _____

Yes No 5a. Did you have a hysterectomy?
If Yes, (please state age and type)
□ Age _____ □ partial (ovaries remain) □ complete (ovaries removed)

Yes No 6a. Have you ever had hormone replacement therapy (HRT)?
If Yes, duration: □ past (<less than 1 yr) □ past (> than 1 yr) □ current

Medications

Yes No 15. Are you currently taking or have you previously taken prednisone pills (Cortisone)?
If yes, duration: □ More than 3 month's □ Less than 3 months

Medications (con't)

Yes No 16. Are you currently getting, or have you previously gotten, steroid injections?
If Yes, number of injections □ less than 3 □ more than 3

Yes No 17. Have you taken any of the following medication that effect bone health?

Medication		Last Dose	Describe treatment duration
Digoxin	Lanoxin		
Fosamax	Alendronate		
Didronel	Etidronate		
Boniva	Ibandranate		
Aredia	Pamidronate		
Actonel	Risedronate		
Reclast	Zoledronate		
Xgeva	Denosumab		
Prolia	Denosumab		
Fortical	Calcitonin		
Evista	Raloxifene		
Estrogen			
Testosterone			
Forteo	Teriparatide		
Tymlos	Abaloparatide		

Please provide a current medication list including prescriptions, over the counter, vitamins and supplements

List Supplements:

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM
Kirstin Webster, APRN, FNP-BC

Risk for Falling (adapted from STEADI fall risk assessment)

Answer the following questions related to fall risk. Be honest.
Explanation for yes answers and their importance to your fall risk are provided with each question. If you answer yes to 4 or more please discuss with your bone health specialist and your Orthopaedic surgeon.

(Please Circle)

Yes No I have fallen in the past year
People who have fallen once are likely to fall again

Yes No I use (or have been advised to use) a cane or walker to get around safely
People who have been advised to use a cane or walker may already be more likely to fall

Yes No Sometimes I feel unsteady when I am walking
Unsteadiness or needing support while walking are signs of poor balance

Yes No I steady myself by holding onto furniture when walking around at home
Unsteadiness or needing support while walking are signs of poor balance

Yes No I am worried about falling
People who are worried about falling are more likely to fall

Yes No I need to push with my hands to stand up from a chair
This is a sign of weak leg muscles, a major reason for falling

Yes No I have some trouble stepping up and onto a curb
This is also a sign of weak leg muscles

Yes No I often have to rush to the toilet
Rushing to the bathroom, especially at night, increases your chance of falling

Yes No I have lost some feeling in one or both of my feet
Numbness in your feet can cause stumbles and lead to falls

Yes No I take medication that sometimes makes me feel lightheaded or more tired than usual
Side effects from medicines can sometimes increase your chance of falling

Yes No I take medication to help me sleep or improve my mood
These medicines can sometimes increase your chance of falling

Yes No I often feel sad or depressed
Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls

_____ Add up the number of Yes you have circled above in your answers
Yes Total If you scored 4 points or more, you may be at risk for falling.

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

PAST MEDICAL HISTORY

For each category, please indicate any conditions which you **currently have** or **have had in the past:**

No Medical Problems

O I do not have any current or previous medical conditions

Cardiovascular

O Hypertension O Heart Attack O Stroke O TIA (Transient Ischemic Attack)
O Atrial Fibrillation O Congestive Heart Failure

Pulmonary

O Asthma O COPD O Emphysema O Tuberculosis
O Frequent Pneumonia O Sleep Apnea O Supplemental Oxygen Requirement

Gastrointestinal

O Gastric Reflux (GERD) O Gastric Ulcer O Hepatitis O Cirrhosis
O Liver Disease O Gall Stones O Hernia O IBS / Crohn's Disease / Ulcerative Colitis

Renal

O Kidney Stones O Kidney Infection O Renal Insufficiency O Dialysis-Dependent

Genitourinary

O Enlarged Prostate (BPH) O Sexual Difficulty O Urinary Incontinence O Menstrual Problems
O Frequent or Chronic Urinary Tract Infection (UTI)

Musculoskeletal

O Degenerative Arthritis O Rheumatoid Arthritis O Gout O Fibromyalgia
O Osteoporosis / Osteopenia O History of Hip Fracture O Vertebral Fracture O Scoliosis

Endocrine

O Diabetes O Thyroid Disease O Addison's Disease O Polycystic Ovarian Syndrome (PCOS)

Neurologic / Psychologic

O Anxiety O Depression O Bipolar Disorder O Schizophrenia
O Peripheral Neuropathy O Carpal Tunnel Syndrome O Alzheimer's Disease O Parkinson's Disease
O Multiple Sclerosis O Spinal Cord Injury O Traumatic Brain Injury (TBI)

Hematologic

O Anemia O Clotting Disorder O Taking Anti-Coagulant Medications ("Blood Thinners")
O Deep Venous Thrombosis (DVT) O Pulmonary Embolism (PE)
O History of Blood Transfusion O Sickle-Cell Anemia

Immunologic

O Immune Disorder O Long-term Steroid Therapy (e.g. Prednisone) O Immuno-Suppressant Medication
O Organ Transplant O Eczema O Psoriasis O Lupus
O Sjogen's Syndrome O HIV/AIDS

Cancer

If you have been diagnosed with cancer, or have had cancer in the past, please select the appropriate bubble:

O Breast O Lung O Kidney O Thyroid
O Prostate O Bowel O Skin O Bone
O Leukemia O Lymphoma O Myeloma
O Other: _____

Please provide any additional details about type of cancer, when it was diagnosed (approximate year), any treatment (Including any Medications, Radiation, and/or Surgery), the name of your Oncologist, and the approximate date of your most recent Oncology follow-up appointment:

PAST MEDICAL HISTORY *(CONTINUED)*

Additional Medical Problems

If you have any additional medical problems not listed, or need to provide any additional information, please check the bubble marked "yes", and provide details below:

O Yes, I have the following medical conditions:

SURGICAL HISTORY

For each category, please indicate any surgeries which you have had:

Head & Neck

O Eye Surgery O Sinus Surgery O Facial Reconstructive / Plastic surgery
O Oral Surgery O Neck Surgery

Cardiothoracic

O Cardiac Bypass O Cardiac Stent O Angioplasty / Cardiac Catheterization
O Pacemaker / Defibrillator O Cardiac Valve Surgery O Lung Surgery O Mastectomy

Abdominal

O Hernia Repair O Appendectomy O Gastric Bypass O Cholecystectomy (Gallbladder)
O Esophageal Surgery O Stomach / Bowel Surgery O Organ Transplant O Kidney Surgery

Pelvic

O C-Section O Hysterectomy O Bladder Suspension O Prostate Surgery

Vascular

O Varicose Vein Surgery O Aortic Aneurysm Repair O Vascular Bypass O Carotid Endarterectomy
O AV Fistula (Dialysis access)

Neurologic

O Brain Surgery O Ventricular Shunt O Cervical Spine Surgery O Lumbar Spine Surgery
O Scoliosis Surgery O Carpal Tunnel Release O Ulnar Nerve Decompression

Orthopaedic

O Fracture Repair O Knee Replacement O Hip Replacement O Shoulder Arthroplasty
O Arthroscopic Surgery

Other Surgeries

O If you have had any surgeries not present above, please list them here:

HOSPITALIZATION

Have you ever been hospitalized, for any reason?

O Never O None besides those listed in Surgical History O Yes

If you answered "Yes", please provide details including reason, approximate dates and length of hospital stay:

FAMILY HISTORY

Please indicate any medical conditions affecting your family members:

Mother

O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Scoliosis O Skeletal Dysplasia
O Genetic Abnormalities O Other O Unknown / Not Applicable

Father

O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Scoliosis O Skeletal Dysplasia
O Genetic Abnormalities O Other O Unknown / Not Applicable

Siblings

O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Scoliosis O Skeletal Dysplasia
O Genetic Abnormalities O Other O Unknown / Not Applicable

Children

O Diabetes O Hypertension O Heart Disease O Stroke
O Mental Illness O Cancer O Scoliosis O Skeletal Dysplasia
O Genetic Abnormalities O Other O Unknown / Not Applicable

If you answered "Other" to any of the above, please provide explanation below:

_____

_____

SOCIAL HISTORY

Marital Status

O Single O Co-Habitating O Married O Separated / Divorced
O Widow / Widower

Education

O Grammar School O High School O College O Post-Graduate

Employment

What is your current *(or most recent)* Occupation?

_____

Please describe your Current Work Status:

O Working - Full Time O Working - Part Time O Seeking Employment O Physically unable to work / Disabled
O Not working by choice (Retired - Homemaker - Student - etc.)

Habits

Tobacco & Nicotine Products

O Never used O Current / Occasional User O Former user – Quit Date (Approximate):_____

If you are *currently* using Tobacco or Nicotine products, please indicate the Type (select all that apply):

O Cigarettes O Cigars O Chewing Tobacco O Nicotine Vaporizer / "e-Cigarette"
O Nicotine Gum / Patch

If you are *currently* using Tobacco or Nicotine products, please indicate how often:

O Daily O At Least 1x per Week O At Least 1x per Month O Less than Once per Month

Alcohol

O Never O Less than 1 drink per Week O Weekly O Daily

Do you have a History of Heavy Drinking or Alcoholism?

O Never O In the Past O Current

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

REVIEW OF SYSTEMS

For each category, please indicate all problems which you **currently have**:

Constitutional

O None O Fever O Chills O Night Sweats
O Recent Unexplained weight Loss (More than 10 Pounds) O Recent Unexplained weight Gain (More than 10 Pounds)

General

O None O Muscle Weakness O Difficulty Standing O Difficulty Walking

Head, Eyes, Ears, Nose, & Throat

O None O Sinusitis O Congestion O Dentures
O Vision Problems O Eye Glasses O Hoarseness O Difficulty Swallowing

Cardiovascular

O None O Chest Pain O Shortness of Breath O Ankle / Feet Swelling
O Palpitations

Respiratory

O None O Cough O Wheezing

Gastrointestinal

O None O Constipation O Heartburn O Dark / Bloody Stools
O Nausea O Vomiting

Musculoskeletal

O None O Neck O Back O Shoulder
O Wrist / Hand O Hip O Knee O Ankle / Foot

Integumentary

O None O Rash O Itching O Open sores
O Poor healing O Acne O Skin infection

Neurology

O None O Memory Loss O Confusion O Dizziness
O Vertigo O Tremor O Frequent Headache O Balance Problems

Psychiatric

O None O Sleep disturbances O Feelings of hopelessness

Genitourinary

O None O Urinary incontinence O Pain with Urination O Frequent Urination
O Incomplete voiding

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

PRACTICE POLICIES

Financial Obligations

I agree that in return for the services provided by Lone Star Orthopaedic and Spine Specialists I will pay my account at the time service is rendered, or will make financial arrangements satisfactory to Lone Star Orthopaedic and Spine Specialists for payment. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Lone Star Orthopaedic and Spine Specialists. All co-payments and past due balances are due and payable at the time of service. I understand and agree that if my account is delinquent, a collection agency may be authorized to recover the unpaid amount.

Patient Initials:_____

HMO Referrals

If your insurance has designated a primary care physician (PCP), a prior authorization from your PCP is required to see a specialist. It is your responsibility to work with your PCP and insurance carrier to obtain this authorization prior to your office visit with Lone Star Orthopaedic and Spine Specialists. If authorization is not provided, either by you the Patient, or through your Insurance Carrier or PCP, you will be asked to re-schedule your appointment until the authorization is available, or pay for the visit at the time of service and file with your insurance carrier for reimbursement.

Patient Initials:_____

Self-Pay Accounts

Patients without an insurance plan at the time of service, and/or patients who are covered by insurance carrier with whom the practice does not participate, are individually obligated to pay the full charges at the time of service

Patient Initials:_____

Non-Participating Insurance Accounts

Services provided to Patients who are insured by carriers with which the practice does not participate are considered “out-of-network.” It is the financial obligation of the patient with non-participating insurance carriers to pay the co-pay and/or visit in full at the time of service.

Patient Initials:_____

If You Require Surgery

If you require surgery, your surgeon and supporting staff will work with you to select a date that will accommodate both schedules. Our staff will review any anticipated financial responsibilities you may have. Keep in mind that these are estimates only, and are subject to change once the surgery has been billed and insurance has paid. You may be asked to make a pre-payment to cover the amount of your deductible/percentage for surgical care. This payment will be due before surgery is performed.

Please feel free to talk to our staff about a payment plan if you have a special financial situation. Our office will work with you to ensure that you receive the highest quality of care. Lone Star Orthopaedic & Spine Specialists will require that all balances being placed on a payment schedule be paid in full within 6 months – as such, payment plans are structured on a 6-month time frame.

Patient Initials:_____

Returned Checks

All returned checks will be assessed a $35.00 fee.

Patient Initials:_____

Signature: _____ **Date:** _____

Patient or Authorized Party Signature

LONE STAR
ORTHOPAEDIC AND SPINE SPECIALISTS, PLLC
Gurpreet S. Bajaj, MD Von L. Evans, MD Jeffrey J. Ratusznik, MD John A. Thomas, MD Christopher P. Werner, DPM

PRACTICE CONSENT FORM

Consent to Treat

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventative health exams, immunizations, screening test, detailed phone consultations, copies of medical records, or preparation of reports, forms, and summaries.

Patient Initials:_____

Privacy Notification

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by the physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to a copy of this document.

Patient Initials:_____

Release of Information

I authorize Gurpreet S. Bajaj, M.D., Von L. Evans, M.D., John A. Thomas, M.D., Christopher Werner, D.P.M., and Jeffrey J. Ratusznik, M.D. to discuss information with the following:

___ Family Members

___ Coaching/Training Staff at my school. School Name: _____

____ I restrict release of information to only the following:

Name: _____ Relation: _____

Name: _____ Relation: _____

Patient Initials:_____

Medical Record Authorization

I authorize Lone Star Orthopaedic and Spine Specialists to obtain outside medical records including but not limited to Primary Care Physicians, Hospitals, Imaging Centers, and Pharmacies:

Patient Initials:_____

I have read and fully understand the above consent for treatment, financial responsibility, release of medical records information, and insurance authorization. These authorizations shall remain until written notice is given by me revoking said authorization.

Patient Signature: _____ **Date:** _____