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.

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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: _____

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PODIATRY INFORMATION

Demographic Information

___ New Patient ___ Established Patient Visit Date: _____

Name: _____ DOB: _____ Sex: M/F Ht:_____ Weight:_____

Current Symptoms

What is your date of injury? _____ If this is not an injury, when did the pain start? _____

Is this injury related to: O A Workplace Injury O A Motor Vehicle Accident O A 3rd Party Claim

Please describe how you were injured: _____

Location of the injury/Pain (Body Part): Right / Left / Both _____

If this is not an injury, when did the pain start? _____

Intensity of the pain on a scale of 0-10 (10 being the worst): _____

What helps with the injury/pain? _____

What makes the injury/pain worse? _____

Previous Treatment

Tell us what you have **already** done or tried for this injury/pain? (meds, physical therapy, etc.):

_____

What studies have you had done for this injury/pain? (X-ray-MRI-CT Scan, etc.):

_____

Diabetes History

Who is your Primary Care Physician? _____ Date of Last visit? _____

Are you Diabetic? _____ Last Blood Sugar Reading: _____

Current Medications

Please list all medications you are taking, including Prescription, Over-the-counter, and Herbal Medications: O None

Medication	Dose & How Often Taken	Doctor (If Prescription)

(Additional Medications-list on reverse side of form)

Allergies

Please list any allergies to medications, latex, iodine, & tape, including the reaction you experience: O No Known Allergies

Medication	Reaction	Most recent exposure to this Medication

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

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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

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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

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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:** _____

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Kirstin Webster, APRN, FNP-BC

Bone Health & Osteoporosis Clinic ▪ Fracture Liaison Service

Date: ___ / ___ / ____

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

DOB: ____ / ____ / ____ **Age:** _____ **Male** □ **Female** □

Please Circle

Yes **No** 1. Are you over the age of 50?

Yes **No** 2. Have you ever fractured or broken a bone (after age 45)?

Age	Bone Involved	Describe Circumstance

Yes **No** 3. Did a parent or sibling have a hip or vertebral (spine) fracture after the age of 50?

Yes **No** 4. Do you currently smoke, vape, or use chewing tobacco?
If No, Are you a Former Smoker? □ No □ Yes, Quit date: _____

Yes **No** 5. Do you drink alcoholic beverages? □ 1-3 drinks per day □ 3+ drinks per day

Yes **No** 6. Have you ever had a weight loss procedure or gastric bypass?

Yes **No** 7. Have you ever taken any of these medications for 3 months or longer?
(Check all that apply)
□ Prednisone □ Methylprednisolone □ Dexamethasone □ Methotrexate
□ Chemotherapy

Yes **No** 8. Do you take any calcium supplements (including TUMS)
If Yes, How much do you take _____

Yes **No** 9. Do you take any Vitamin D supplements?
If Yes, How much do you take _____

Yes **No** 10. Have you ever taken (or has it been suggested you take) a medication for your bones? (Check all that apply)
□ Fosamax □ Boniva □ Actonel □ Reclast □ Evista □ Prolia
□ Forteo □ Tymlos □ Calcitonin □ Strontium □ Boron

Yes **No** 11. Have you had a bone mineral density test (DXA) within the past 2 yrs.?
If Yes, When _____ Where _____

Yes **No** 12. Have you had a barium x-ray in the past two weeks?

Yes **No** 13. Have you had a nuclear medical scan or injection of an x-ray dye in the past week?

Office use only: □ Reviewed- Appt. not needed Name: _____
□ Schedule