PLEASE PRINT

PATIENT INFORMATION (The Person Seeing the Physician)

PATIENT'S NAME - Last, First, Middle Initial		Email Address	Age	Birthdate / /
ADDRESS - Number and Street	City		State	Zip
Sex: ☐ Male ☐ Female	Marital Status: ☐ M - Married ☐ S - Single ☐ D - Divorced ☐ W - Widow/Widower	Spouse's Name	Patient's Driver's License No.	
Occupation or Student	Patient's Social Security No.	Home Phone (include area code) ( )	Business Phone (include area code) ( )	
Employer Name	Employer Address	City	State	Zip

IMPORTANT → **DO YOU HAVE ANY ALLERGIES?** ☐ NOT KNOWN ☐ NO ☐ YES What Kind?

Patient's Personal Physician or Primary Care Physician (PCP)	Referring Physician	Referred By

☐ ***Same as above***

RESPONSIBLE PARTY INFORMATION (The Person Who Is Financially Responsible)

RESPONSIBLE PARTY NAME - Last, First, Middle Initial		Address - Number and Street	
City	State	Zip	Home Phone (include area code) ( )
Resp. Party Social Security No.	Driver's License No.	Employer	Business Phone (include area code) ( )

EMERGENCY CONTACT

NAME - Last, First, Middle Initial	Relationship	Address - Number and Street	
City	State	Zip	Home Phone (include area code) ( )

INSURANCE INFORMATION (Please Present Insurance Card to Receptionist)

Do **NOT** indicate your Worker's Compensation Insurance Carrier here. This must be verified by your employer prior to seeing the Physician.

Type: ☐ Medicare ☐ Insurance Plan:	Subscriber's Name (The person who has the policy)	Subcriber's Social Security No.
Insurance Company Name	Insurance Co. Phone No. (include area code)	SUBSCRIBER DATE OF BIRTH
Insurance Company Address	Policy No.	Group No.
Employer, If Group Coverage		
Patient's Relationship to Subscriber: ☐ S - Self ☐ W - Wife ☐ H - Husband ☐ C - Child ☐ O - Other	METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ DEBIT CARD ☐ CREDIT CARD	

Please read before signing - **Assignment of Benefits, Medical Release, and Statement of Financial Responsibility**

I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A. to release medical information and/or records that may be necessary to request reimbursement from (including but not limited to): insurance companies, HMO's, PPO's, Managed Care Contracting agencies, contracted Independent Physician Associations (IPA's), Texas Department of Insurance Division of Workers Compensation, if injury is work related, Third Party Review organizations contracted by an insurance company to review insurance claims, and/or insurance adjusters, to whom a claim has been submitted. I also give my authorization to have medical records mailed, delivered or FAXed to my Primary Care Physician (PCP), "Gatekeeper" or any other physician responsible for my medical care under a managed care contract (if applicable). I also give my authorization to have my medical record mailed, delivered or FAXed to a consulting physician who may review my medical treatment plan with my Plano Orthopedic Physician. I assign all medical and surgical benefits, to include major medical benefits to which I am entitled, to the physician's Professional Associations of: Drs. Sutker, Barber, Smith, Lund, Troop, Courtney, Crates, Dauber, Carmody, Chaim, Montgomery et al. In the event that I receive a payment from my insurance carrier where my physician has filed the claim on my behalf, I will forward that payment to my physician to have it applied to my account. I understand that an insurance claim will be filed with my primary insurance carrier only (Plano Orthopedic will not file on "Secondary" insurance). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges (for non-work related injuries) whether or not paid by said insurance (less any mandated or contractual adjustments). I understand and agree that I am responsible for responding promptly to my insurance company if they request any additional information or accident report and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred. I understand that any overpayment on my account will be promptly refunded. If an account is established, I authorize Plano Orthopedic Sports Medicine & Spine Center, P.A., to obtain a credit report when necessary in regards to my account. Payments by insurance plans on my account must be made within 60 days of filing, and any co-pay or deductible amounts remaining are due by the responsible party and must be paid in full within 30 days after insurance has paid, or there may be a late fee assessed against my account of 1.5% each month on the unpaid balance. I understand that this form must be updated at least annually, may be updated at each visit, and that I will provide Plano Orthopedic with any changes of address or insurance coverage immediately. Failure to notify Plano Orthopedic of any insurance plan changes, could result in loss of insurance benefits and could make me liable for medical charges. Proof of identity is required (e.g., drivers license) for each patient and/or responsible party. I understand that I need to present my insurance card at each visit, and understand that I may be required by my insurance plan to pay my co-payment at each visit. My email address will be used to notify me of appointments or other medical related issues and will not be sold or delivered to any other entity.

SIGNATURE OF RESPONSIBLE PARTY ______________________ **DATE** __________

SIGNED BY ______________________ (NAME PRINTED) **RELATIONSHIP TO PATIENT IF MINOR:** ☐ PARENT ☐ GUARDIAN

Plano Orthopedic Sports Medicine & Spine Center, P.A.

Universal Injury, Condition and/or Accident Statement

Patient Name ___________________________________ Today's Date ___/___/___
Full Name

Please complete the following statement. Most Insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury or condition and sign In BOX 4. We must have Box 1 "Date of Injury or Condition" completed to file your claim.

1

Date of Injury or Condition: ___________________________ < (COMPLETE DATE ON OR ABOUT)
Month / Day / Year — THIS DATE IS REQUIRED FOR INSURANCE FILING

→ ***The following details are required IF this was an INJURY***:

Where did injury occur: ____
(e.g., Auto, home, parking lot, friend's house, etc.; if at work, complete Box 2)

How did injury occur (brief summary): ____

____

2

Was injury or condition work related? [ ] YES [ ] NO < (Required/Please Answer)
If YES then…

Name of Employer: ____
Phone

Employer contact or Supervisor: ____
Phone

Adjuster's Name (if known): ____
Phone

3

Is there a possible third party liability statement (e.g. Auto, Homeowners, Property): [ ] YES [ ] NO
If YES then…

Name of Employer: ____
Phone

Adjuster's Name (if known): ____
Phone

4

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury or condition and the nature of my treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

___________________________________ Date: ____________________
Patient's Signature (or Responsible party if patient is a minor)

Plano Orthopedics & Sports Medicine Center

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Plano Orthopedics & Sports Medicine Center has adopted the following privacy policies.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical records to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of Plano Orthopedics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government-mandated reporting.

Publice Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public heath department.

Other uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other that those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

SIGNATURE NEEDED ON THIRD PAGE

Individual Rights
You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your PHI.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your PHI.
4. The right to amend or submit corrections to your PHI.
5. The right of receive an accounting of how and to whom your PHI has been disclosed.
6. The right to receive a printed copy of this notice.

Plano Orthopedics Duties
We are required by law to maintain the privacy of your PHI and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you do so by sending a letter outlining your concerns.

Acknowledgment Form

I acknowledge receipt of this Notice of Privacy Rights, which I have reviewed, and give my permission to Plano Orthopedics & Sports Medicine Center to use and disclose my health information in accordance with it.

Name of Patient	Signature of Patient
Date	Signature of Parent or Guardian

If you would like to indicate a child or spouse to *Discuss* medical information with our Doctors or Physician Assistant please indicate below.

Name	Relationship
Name	Relationship
Name	Relationship

<u>This is not release of MEDICAL RECORDS</u>.
There is a separate form you will need to fill out. Please ask for one if you would like to release your PHI to any other doctor or facility. You will be asked to fill one out if you request your records. The form is available on our website. www.posmc.com.

This authorization will expire in two (2) years from the above date unless written revocation is received.

PLANO ORTHOPEDIC
Sports Medicine & Spine Center, P.A.

5228 W. Plano Parkway • Plano, Texas 75093

ALLAN N. SUTKER, M.D., P.A.*
Sports Medicine
Arthroscopic Surgery of the Knee and Shoulder
Orthopedic Surgery

F. ALAN BARBER, M.D., FACS, P.A.*
Arthroscopic Surgery of the Knee and Shoulder

PURCELL SMITH, III, M.D., P.A.*
Surgery of the Hand, Wrist, Elbow
Orthopedic Surgery

EARL R. LUND, M.D., P.A.*
Surgery of the Hand and Upper Extremity
Arthroscopic Wrist Surgery

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Orthopedic Surgery

JOHN M. CRATES, M.D., P.A.*
Orthopedic Surgery
Arthroscopic Surgery
Surgery of the Foot and Ankle

KENNETH S. DAUBER, M.D., P.A.**
Physical Medicine and Rehabilitation

CAMERON N. CARMODY, M.D., P.A.*
Reconstructive Surgery of the Neck and Back
Orthopedic Surgery

SOLOMON H. CHAIM, M.D., P.A.*
Surgery of the Foot and Ankle
Orthopaedic Surgery

WILLIAM K. MONTGOMERY, M.D., P.A.*
Total Joint Replacement

Physicians Board-Certified by
*The American Board of Orthopedic Surgery
** The American Board of Physical Medicine and Rehabilitation

In Memoriam
BRADLEY T. BRITT, M.D.
1954 - 1995

To Our New Patients....

We Need Your Assistance.

The attached forms are concerning your current spine condition, and your past and current medical history. It is extremely important that you answer all questions to the best of your ability. **PLEASE COMPLETE THIS FORM.**

You will need to obtain ALL prior spine x-rays, myelograms/CT scans, spine MRI scans, and a copy of their reports from the radiologist. Please bring these together with any medical records of pertinent examinations with you on the day of your appointment.

We feel your spine problem deserves this careful attention to obtain an accurate diagnosis and help initiate the appropriate treatment.

Please be informed that Dr. Courtney's policy is that he **DOES NOT** prescribe long term narcotics. They may be obtained from your family physician or we can refer you to a pain management specialist if you require long term pain management.

Thank you.

Tel: 972.250.5700 Fax: 972.250.5747
www.posmc.com

Name __________________________
Age ________ Date ____________
Occupation______________________

REFERRED BY:
Plano Profile__ Collin Quest __
D Magazine __ Allen Image __
Frisco Style __ McKinney Living __
Internet __ Plano Morning News __
PCP __________________________
Other _________________________

CHIEF COMPLAINT:

HISTORY OF PRESENT COMPLAINT:

Date of injury or onset of symptoms:

Describe in detail how the event occurred and the pain **IMMEDIATELY** (48 hours):

Describe the **INITIAL** treatment you received:

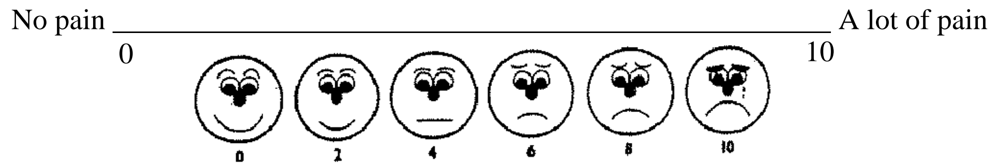
Names of physicians who have treated you for this injury/condition:

List all special tests (X-rays, MRI, CT scan, etc.) prior to this evaluation:

CURRENT SYMPTOMS:
Describe in **DETAIL THE PROGRESSION OF YOUR PAIN & PRESENT** complaints and symptoms:

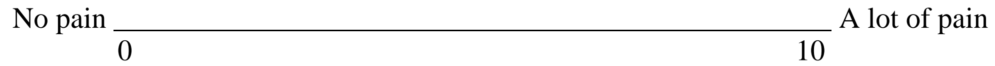
1. How bad is your back/neck pain now? (On a scale of 0-10, please mark the appropriate place on the graph.)

No pain ____ A lot of pain
0 10



2. How bad is your leg/arm pain now?

No pain ____ A lot of pain
0 10



Back/neck pain % **versus** leg/arm pain % (i.e. 60% back vs. 40% leg)

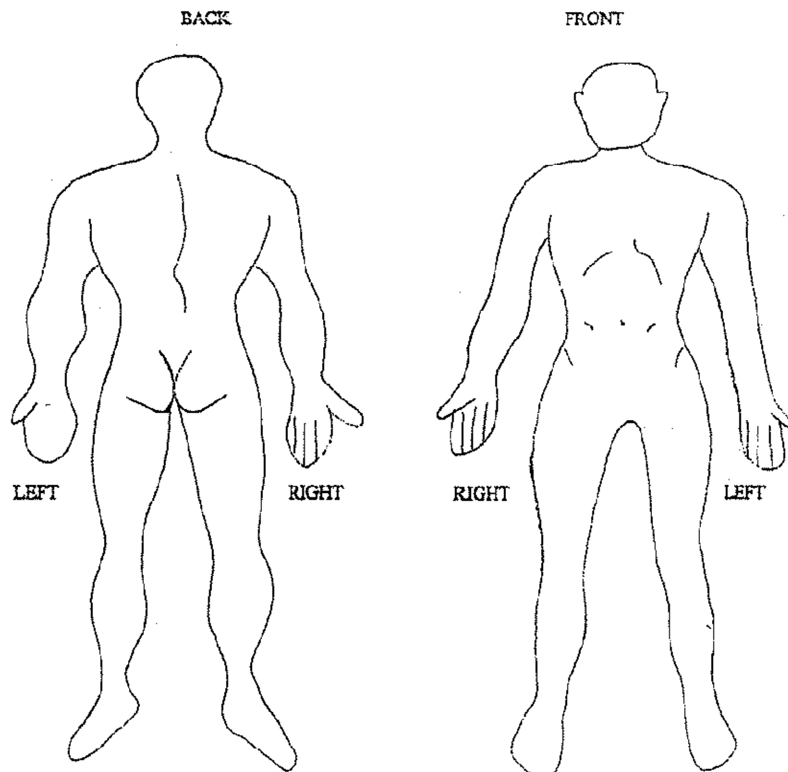
____________________ vs. ____________________

Where do you hurt most?

Patient Pain Drawing

Mark the area on your body where you feel the described sensations. Use appropriate symbol(s). Mark area where sensations travel, if any. Include **ALL** affected areas.
Just to complete the picture, please draw your face.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
>>>	===	000	XXX	///
>>>	===	000	XXX	///
>>>	===	000	XXX	///



CURRENT SYMPTOMS CONTINUED

Pain is: dull / sharp / achy / cramping / stabbing / throbbing / burning

Do you have numbness/tingling? **Yes** or **No** If yes, Where? ____________________________

Does the pain/numbness travel? **Yes** or **No** If yes, Where? ____________________________

Pain is: worse / better / same

# of hours you can sit ______ stand ______ walk ______

How far can you walk? # of blocks ______ # of miles ______

Recent changes in bowel or bladder habits: **Yes** or **No**

Do you have problems with sleep? **Yes** or **No**

My pain is:	**BETTER**	**WORSE**	**SAME**
- Sitting	_______	_______	_______
-Standing	_______	_______	_______
-Walking	_______	_______	_______
-Bending forward	_______	_______	_______
-Bending backward	_______	_______	_______
-Midday	_______	_______	_______
-Middle of the night	_______	_______	_______
-Lying flat on back	_______	_______	_______

CURRENT TREATMENT:

Anti-Inflammatories:

Muscle Relaxers:

Pain Killers:

Braces:

Physical Therapy (location/duration):

Injections (where and what type):

PAST MEDICAL HISTORY

A. Circle if you now have or have previously suffered from: high blood pressure / heart attack / lung problems / thyroid condition / liver disease / ulcers / diabetes / seizures / stroke / blood clots / depression / mental illness / drug dependency / narcotic abuse / blood transfusions / asthma / C.O.P.D. / cancer / other:

B. Have you had any recent cardiac work-up or history of cardiac problems? (stress test, EKG, echocardiogram) If yes, Name of Cardiologist:

C. Have you ever been treated or are being treated by a psychiatrist?

D. Previous Surgeries (Type/date/surgeon):

E. Allergies (list and describe their effect on you):

F. Current medications you are taking including dosage:

REVIEW OF SYSTEMS: Please check all that apply

NEUROLOGICAL
___Loss of consciousness
___Paralysis
___Tremors
___Gait disturbances
___Headaches

GASTORINTESTINAL
___ Heartburn
___ Ulcer
___ Jaundice/hepatitis
___ Blood in stool
___ Weight loss/gain

CARDIOVASCULAR
___Shortness of breath
___Palpitations
___Chest pain on exertion
___Resting chest pain

RESPIRATORY
___ Chronic Cough
___ Wheezing/asthma
___ Pain with breathing
___ Flu/pneumonia

MUSCULOSKELETAL
___Backache
___Neckache
___Fractures
___Leg pain with walking

GENITOURINARY
___ Urinary frequency/urgency
___ Inability to urinate
___ Dribbling
___ Increased amount of time

FAMILY HISTORY

	AGE	LIVING	DECEASED	CAUSE OF DEATH
Father				
Mother				
Brother (s)				
Sister (s)				

SOCIAL HISTORY

What is your occupation? ______________________________ Currently employed? **Yes** or **No**

Date you last worked: ______________________________________

Have you returned to modified work or changed jobs? **Yes** or **No**

Have you missed time from work because of pain? **Yes** or **No**

List dates:

Marital status: Single / Married / Divorced / Widowed

Number of Children: _____ Ages ________ # Living at home: _______

Education (years): 9 10 11 12 13 14 15 16 16+

Alcohol use: # of beers/drinks per day _____ per week ______

Tobacco use: ______ packs per day Number of years ______

Have you ever filed for or are you currently filing for disability? **Yes** or **No**

Do you have an attorney involved with your case? **Yes** or **No**

If yes, Name and address:

Are you now or have you ever sued a physician? **Yes** or **No**

If yes, please explain:

Name of your primary care/family physician: ____

Please sign below acknowledging that you have filled out this form to the best of your knowledge.

X____ _____________________

Patient or Guardian Signature *Date*

SPINE PHYSICAL EXAMINATION FORM
Stephen Courtney, M.D.

PATIENT_______________ DATE_______________ AGE__________
M F in NAD/A+OX3 with normal / flat / depressed mood / bizarre affect.

Normal tandem gait/antalgic steppage/ataxic/Trendelenburg gait and normal/listing (R/L) forward leaning station.

☑ Heel Walk ☑ Toe Walk

INSPECTION: ☑ No deformity noted. ☐ Kyphosis ☐ Scoliosis ☐ No scars ☐ Anterior scar ☐ Posterior scar
☐ Rash __________ ☐ Abrasion __________ ☐ Tattoo __________

PALPATION: The pt. has TTP/spasm/both
SI joint ___ Paravertebral ___ Mid scapular border ___ trapezius___
Greater troch bursitis ________ Ischial tuberosity_____ Facet _____ Spinous Process _____

Cervical ROM: Flexion: __________ Extension: __________ Lat. Bend: R ______ L ______
Rotation: R ______ L ______

Lumbar ROM: Flexion: __________ Extension: __________ Lat. Bend: R ______ L ______
Rotation: R ______ L ______

Motion	Root	R		L	Motion	Root	R		L
Shoulder Abd.	C5	+5	/	+5	Hip Flex	L1,2,3	+5	/	+5
Elbow Flex	C5	+5	/	+5	Hip Add.	L3,4	+5	/	+5
Wrist Ext.	C6	+5	/	+5	Hip Abd.	L5	+5	/	+5
Elbow Ext.	C7	+5	/	+5	Knee Ext.	L2,3,4	+5	/	+5
Wrist Flex	C7	+5	/	+5	Knee Flex	L5, S1	+5	/	+5
Finger Ext.	C7	+5	/	+5	Ankle Inv	L4	+5	/	+5
Finger Flex	C8	+5	/	+5	EHL	L5	+5	/	+5
Finger Abd.	T1	+5	/	+5	Ankle D flex	L4, L5	+5	/	+5
					Ankle P flex	S1	+5	/	+5

NEUROSENSORY: (If not checked - intact to light touch.)

CERVICAL:			LUMBAR:			DTR:	R		L
C5	R____	L____	L1	R____	L____	C5 Biceps	+1	/	+1
C6	R____	L____	L2	R____	L____	C6 Brachiradialis	+1	/	+1
C7	R____	L____	L3	R____	L____	C7 Triceps	+1	/	+1
C8	R____	L____	L4	R____	L____	L4 Patellar	+1	/	+1
T1	R____	L____	L5	R____	L____	S1 Achilles	+1	/	+1
			S1	R____	L____				

PROVOCATIVE:

	R	L
Supine SLR	R___	L___
Sitting SLR	R___	L___
Femoral Stretch	R__	L__
Faber's	R___	L___
Tinel's Elbow / Wrist	R___	L___
Axial Comp. / Axial Dist	R___	L___
Phalens	R___	L___
Spurling's	________	

Waddell Signs:

Superficial/Nonanatomic TTP	0 / 5
Simulated Axial Loading/Rotation	0 / 5
Distraction SLR	0 / 5
Regional Weakness/Sensory	0 / 5
Overreaction	0 / 5

PATHOLOGIC:

	R	L
Babinski	—	—
Clonus	—	—
Hoffman's	—	—

X-RAYS:

PLAN:

Initials: ________
Date: ________

Plano Orthopedic
Sports Medicine & Spine Center
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Plano, TX 75093
972.250.5700

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Arthroscopic Surgery
Surgery of the Foot and Ankle

Kenneth S. Dauber, M.D., P.A.
Physical Medicine and Rehabilitation

Cameron N. Carmody, M.D., P.A.
Reconstructive Surgery of the Neck and Back
Orthopedic Surgery

Solomon H. Chaim, M.D., P.A.
Surgery of the Foot and Ankle
Orthopedic Surgery

William K. Montgomery, M.D., P.A.
Total Joint Replacement

Disclosure

The Plano Orthopedic physician you are seeing may have a financial interest in the following facilities:

Baylor Medical Center at Frisco
5601 Warren Parkway
Frisco, TX 75034
(214) 407.5000

Surgery Center of Plano
1620 Coit Road
Plano, TX 75075
(972) 519.1100

Texas Health Center for Diagnostics & Surgery
6020 West Parker Rd
Plano, TX 75093
(972) 403-2700

Preston Plaza Surgery Center
17950 Preston Rd, Ste 75
Dallas, TX 75252
(972) 267.5400

Plano Therapy Center
3405 Midway, Ste 500
Plano, TX 75093
(972) 473.0229

Allen Therapy Center
1223 W McDermott, Ste 50
Allen, TX 75013
(972) 359.1288

North Star MRI (Frisco)
8501 Wade Blvd., Ste 220
Frisco, TX 75034
(214) 618.3420

North Star MRI (Allen)
997 Raintree Circle, Ste 110
Allen, TX 75013
(972) 954.8001

North Star MRI (Plano)
3700 W 15th St Bldg D #200
Plano, TX 75075
(972) 758.9000

The facilities and our physicians are committed to providing clinical excellence in a safe and attractive environment for you and your family members. Their financial interest in these facilities enables them to have a voice in administration and their policies. This involvement helps to ensure the highest quality care for you.

Should you have any questions or concerns regarding this notice, please ask your physician or a member of his staff.

This verifies that I have read and understood the above statement.

Signature: ________________________________ Date: ________________