PATIENT INFORMATION

CONTACT INFORMATION

LAST NAME	FIRST NAME	MI

ADDRESS	CITY	STATE	ZIP

HOME #:	CELL #:	EMPLOYED?	YES	NO

EMPLOYER'S NAME:	EMPLOYER'S #:

EMPLOYER'S ADDRESS (CITY/ST/ZIP)

DATE OF BIRTH:	LAST FOUR OF SOCIAL SECURITY #:	MARITAL STATUS:
	XXX-XX-	

EMERGENCY CONTACT:	PHONE #:

NEXT OF KIN:	PHONE #:

ADDRESS OF NEXT OF KIN:

RELEASE AUTHORIZATION

I hereby authorize Lone Star Orthopedics to release any and all medical information, acquired in the course of my examination and/or treatment, including, but not limited to, information pertaining to the following: Mental Health; Alcohol & Substances; HIV/AIDS to my insurance carrier; my employer; other doctors treating or evaluating me; and/or my attorney.

This authorization includes verbal communication to my employer regarding my condition and ability to work, as well as verbal communication with agents of the insurance carrier for purposes of getting treatments/diagnostics approved.

I authorize payment directly to Lone Star Orthopedics. I authorize use of this form on all my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies.

Signature _____ Date _____

Witness _____ Date _____

This authorization is valid for 12 months

PATIENT NAME:
NOMBRE DEL PACIENTE:

WHAT IS YOUR AGE? _____

PLEASE DESCRIBE THE SYMPTOMS WHICH BRING YOU TO THE OFFICE TODAY. PLEASE SPECIFY THE BODY PART INVOLVED AND WHETHER IT IS ON THE RIGHT OR LEFT.

IS THERE A DATE OF INJURY, IF SO WHEN?

WAS THIS WORK RELATED? Y N SCHOOL RELATED? Y N

WHEN WAS YOUR LAST DAY YOU WERE ABLE TO WORK/ATTEND SCHOOL?

PLEASE DESCRIBE YOUR JOB. IF YOU ARE NOT WORKING, WHAT ABOUT YOUR JOB AND INJURY PREVENT YOU FROM WORKING?

PLEASE GIVE THE DETAILS OF THE INJURY/ACCIDENT AND HOW IT OCCURRED, OR IF NO INJURY HOW DID YOU FIRST NOTICE YOUR SYMPTOMS:

HOW DO YOU THINK EACH OF THE BODY PARTS YOU MENTIONED EARLIER GOT HURT?

WHICH DOCTORS HAVE YOU SEEN SO FAR FOR THIS PROBLEM? PLEASE LIST THEM AND INDICATE IF THEY WERE SEEN FOR TREATMENT OR JUST AN OPINION:

DATE	DOCTOR'S NAME (PHONE # IF KNOWN)	
		TREATMENT / OPINION
		TREATMENT / OPINION
		TREATMENT / OPINION
		TREATMENT / OPINION

PLEASE DESCRIBE ANY TREATMENT YOU HAVE RECEIVED FOR THIS PARTICULAR PROBLEM. (TO MAKE THINGS EASIER, SOME TREATMENTS ARE LISTED FOR YOU)

- ☼ PHYSICAL THERAPY/MANIPULATIONS HOW MANY WEEKS? _____ DID THEY HELP AT ALL? A LITTLE / SOME / A LOT
- □ INJECTIONS WHAT BODY PARTS? _____ HOW MANY TIMES? ____ DID THEY HELP AT ALL? A LITTLE / SOME / A LOT
- □ SURGERIES WHAT TYPE OF SURGERY_____ DID IT HELP AT ALL? A LITTLE / SOME / A LOT
  WHAT TYPE OF SURGERY_____ DID IT HELP AT ALL? A LITTLE / SOME / A LOT
  WHAT TYPE OF SURGERY_____ DID IT HELP AT ALL? A LITTLE / SOME / A LOT
- □ HAVE YOU HAD PAIN MANAGEMENT? YES / NO
- □ HAVE YOU DONE WORK CONDITIONING/HARDENING? YES / NO
- □ ANY OTHER TREATMENTS?

WHAT DIAGNOSTIC STUDIES WERE DONE SO FAR AND WHEN? (INCLUDE CT SCANS, BONE SCANS, MRI, NERVE TESTS)

CONSENT FOR TREATMENT

I, as a patient or on the patient's behalf, voluntarily consent to medical care including diagnostic, examinations, or surgical treatment under the general and special direction of Kenneth G. Berliner, M.D. and such associates or assistants as he may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of any treatment rendered by Dr. Berliner and such associates and assistants.

Signature _____ Date _____

PATIENT NAME:
NOMBRE DEL PACIENTE:

PLEASE LIST YOUR CURRENT MEDICATIONS

MEDICATION NAME	DOSE/STRENGTH	FREQUENCY	PRESCRIBING DOCTOR
		1X/DAY 2X/DAY 3X/DAY 4X/DAY MORE	
		1X/DAY 2X/DAY 3X/DAY 4X/DAY MORE	
		1X/DAY 2X/DAY 3X/DAY 4X/DAY MORE	
		1X/DAY 2X/DAY 3X/DAY 4X/DAY MORE	
		1X/DAY 2X/DAY 3X/DAY 4X/DAY MORE	

PLEASE LIST ANY MEDICATION OR MEDICAL TREATMENT YOU HAVE HAD A BAD REACTION TO:

PLEASE CHECK NEXT TO ANY HEALTH PROBLEMS YOU MIGHT HAVE HAD:

DIABETES ☐ YES ☐ NO
HEART ATTACK ☐ YES ☐ NO
STROKE ☐ YES ☐ NO
HIGH BLOOD PRESSURE ☐ YES ☐ NO
ASTHMA ☐ YES ☐ NO
ULCERS ☐ YES ☐ NO
SEIZURES ☐ YES ☐ NO
TUBERCULOSIS ☐ YES ☐ NO
HEPATITIS ☐ YES ☐ NO IF YES, WHAT TYPE? A / B / C

HAS ANYONE IN YOUR FAMILY HAD THOSE PROBLEMS? IF SO WHICH FAMILY MEMBER AND WHICH PROBLEM?

DID YOU EVER SMOKE? YES NO IF SO, HOW MANY PACKS PER DAY? ___
DO YOU EVER DRINK ALCOHOL? YES NO IF SO, HOW MUCH PER DAY? _____
HAVE YOU HAD ANY OTHER UNRELATED BONE OR JOINT INJURIES?
ANY MOTOR VEHICLE ACCIDENTS IN YOUR PAST?

YEAR	BODY PARTS INJURED	MRI DONE?	FULL RECOVERY?
		☐ NO ☐ YES _____	☐ NO ☐ YES SINCE_____
		☐ NO ☐ YES _____	☐ NO ☐ YES SINCE_____

HAVE YOU HAD ANY RECENT FEVER? ☐ NO ☐ YES
HAVE YOU HAD ANY RECENT WEIGHT LOSS? ☐ NO ☐ YES
HAVE YOU HAD ANY RECENT CHANGE IN VISION? ☐ NO ☐ YES
HAVE YOU HAD ANY RECENT COLDS OR FLU? ☐ NO ☐ YES
HAVE YOU EVER BEEN TOLD YOU HAVE A HEART MURMUR? ☐ NO ☐ YES
DO YOU GET SHORT OF BREATH EASILY? ☐ NO ☐ YES
DO YOU EVER GET CRUSHING CHEST PAINS? ☐ NO ☐ YES
DO YOU HAVE WHEEZING? ☐ NO ☐ YES
DO YOU HAVE A COUGH? ☐ NO ☐ YES
HAVE YOU EVER THROWN-UP BLOOD? ☐ NO ☐ YES
HAVE YOU RECENTLY HAD BLACK TARRY STOOLS? ☐ NO ☐ YES
DO YOU FEEL NAUSEOUS OR HAVE THROWN-UP RECENTLY? ☐ NO ☐ YES
DO YOU HAVE CONSTIPATION OR DIARRHEA? ☐ NO ☐ YES
DO YOU URINATING MORE OFTEN THAN USUAL? ☐ NO ☐ YES
DO YOU WAKE UP TO URINATE? ☐ NO ☐ YES
DOES IT HURT TO URINATE? ☐ NO ☐ YES
HAVE YOU NOTICED ANY RECENT RASHES? ☐ NO ☐ YES
HAVE YOU NOTICED ANY BREAST MASSES? ☐ NO ☐ YES
HAVE YOU HAD RECENT HEAD ACHES? ☐ NO ☐ YES
DO YOU HAVE A BLEEDING DISORDER? ☐ NO ☐ YES
HAVE YOU EVER TESTED POSITIVE FOR HIV? ☐ NO ☐ YES

COMPLIANCE AGREEMENT

I realize that Dr. Berliner and such associates or assistants are making medical decisions based on the assumption that the information given to him is truthful and accurate. I agree to be a truthful and accurate as is reasonably possible. I, also, understand that the outcome of treatment is partially based on my cooperation with Dr. Berliner's and such associates or assistants prescribed treatment plan. I agree to be as compliant as can reasonably be expected.

Signature _____ Date _____