LITTLE RIVER HEALTHCARE

GEORGETOWN ORTHOPEDICS
MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Pharmacy Name/Location: _____

Height _____ Weight _____ Home phone _____ Other phone_____

1. Who is your primary care physician?_____
2. Reason for visit: _____
   _____
3. When, where and how did the problem begin? _____
   _____
4. Is your injury/conditions job-related? Yes/No. If yes, Date of injury: _____ (If your injury is to be covered by workman's compensation insurance, please make sure you provide all the required information before your appointment. Failure to do so may invalidate your claim and cause charges to be your responsibility)
5. Have you received any care elsewhere for this problem? If so, please explain: _____
   _____
6. Were any X-rays, MRI's, CT scans, Bone scans or other diagnostic tests taken for this problem? If so, where can these be located? _____
   _____
7. Please list any allergies that you have to medications and the symptoms that you experience.
   _____
   _____
8. Do you have allergies to latex_____tape_____any other over-the-counter medication_____

Social History:

Do you smoke cigarettes? Yes/No Packs per day? _____
Do you drink alcohol? (circle) Never Occasional Moderate Heavy
Do you exercise? Yes No

9. What is your occupation? _____What type of physical activity do you normally perform at work?
   _____

Past Medical History:

10. Do you currently have or have you had in the past any trouble with? (circle all that apply)

Cardiovascular Disease	Lung Disease	Diabetes Type I or Type II	Hepatitis	Renal Failure
High blood pressure	Blood Clots or DVT	Anemia	Stomach Ulcers	HIV

Family Medical History

11. Has anyone in your immediate family had trouble with any of the following? (circle all that apply)

Cardiovascular Disease	Lung Disease	Diabetes Type I or Type II	Hepatitis	Renal Failure
High blood pressure	Anemia	Stomach Ulcers	HIV	

MR#_____

12. Please list any major medical conditions not listed above:_____

_____

_____

_____

_____

13. Please list past Orthopedic surgical procedures and dates:_____

_____

_____

_____

_____

Female Patients Only: Reproductive History

Are you pregnant? Yes No

Age you began menstruating?_____ When was your most recent menstrual period?_____

Have you experienced menopause or had a hysterectomy? Yes No
If yes, what & when? _____

Review of Symptoms:

Please check any of the following that apply to you:

- ☐ Recent weight change
- ☐ Fatigue/weakness
- ☐ Fever, chills
- ☐ Skin rash
- ☐ Joint Stiffness, pain or swelling
- ☐ Muscle weakness
- ☐ Swollen legs or feet
- ☐ Stomach pain/heartburn
- ☐ Easy bleeding or bruising
- ☐ Frequent Illnesses
- ☐ Double Vision
- ☐ Headaches
- ☐ Chest Pain
- ☐ Coughing Up Blood
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in Urine
- ☐ Speech Difficulties
- ☐ Excessive Thirst

14. Please list your medications on the medication sheet.

_____ _____

Patient/Guardian Signature Reviewed by

MR#_____

LITTLE RIVER HEALTHCARE

Georgetown Orthopedics
1904 Railroad St.
Georgetown, TX 78626
512.863.4563

Patient Name (Please Print):_____

Acknowledgement of Services

Your Physician may order additional testing/services such as radiological imaging, outpatient physical therapy, or durable medical equipment for you today. It is your right, as a patient, to choose which company/facility provides that service for you. Listed below are a few local facilities, in addition to our office, in this area that are able to provide those services for you. If you need additional assistance with different locations, our staff can assist you with locating a facility in your area.

Radiology Facilities:

Little River Healthcare Georgetown Orthopedics
Little River Healthcare Georgetown Imaging
Austin Radiology Associates
St. David's Healthcare
Seton Medical Center- Williamson
River Ranch Radiology

Out Patient Physical Therapy

Little River Healthcare Georgetown Orthopedics
St. David's Rehabilitation
Seton Medical Center – Williamson
Hutto Physical Therapy
Georgetown Therapy (IH35 & Williams)

Durable Medical Equipment

Little River Healthcare Georgetown Orthopedics
Hanger
Med Express
Georgetown Medical Equipment

Patient Signature:_____ **Date:**_____

MR#_____

Medications

Medication	Dosage	Times per Day	For What Condition

**** Please list your current medications. ****

**** If you do not currently take any medications, please write "NONE". ****

Patient:_____ **Date of Birth:**_____

Date:_____ **Account #:**_____

LITTLE RIVER HEALTHCARE

Patient Information

Name (Last, First, MI) _____ Age: _____ Drivers License _____

Address: _____ City/State/Zip: _____

Home Phone #: _____ Cell Phone#: _____ Social Security #: _____

Date of Birth: _____ Male ☐ Female ☐ Marital Status: _____

Advanced Directive: (check one) ☐ Yes ☐ No ☐ I would like information about advanced directives; Organ Donor: ☐ Yes ☐ No

Patient's Employer: _____ Occupation: _____

Address: _____ City / State / Zip: _____

Work Phone #: _____ E-Mail Address: _____

Guarantor Information

Responsible Party: _____ Social Security #: _____ Relationship: _____

Address: _____ City / State / Zip: _____

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

Guarantor's Employer: _____ City State / Zip: _____

Emergency Contact Information

Nearest Relative: _____ Relationship: _____ Social Security # _____

Address: _____ City / State / Zip: _____

Home Phone #: _____ Employer: _____

Employer's Address: _____ City / State / Zip: _____ Work Phone # _____

Notify in Case of Emergency: _____ Relationship: _____

Address: _____ City / State / Zip: _____ Phone #: _____

Financial / Insurance Information

MUST PRESENT INSURANCE CARD/FORMS, DRIVERS LICENSE AND SOCIAL SECURITY CARD

METHOD OF PAYMENT: (Check one) ☐ Cash ☐ Worker's Comp ☐ Commercial Insurance ☐ Medicare ☐ Medicaid

Primary Insurance Carrier: _____ Type of insurance (circle one) HMO PPO POS Other

Policy Number: _____ Group Number or Name: _____ Effective Date: _____

Policy Holder Name: _____ Date of Birth: _____

Employer: _____ Policy Holder's Social Security Number: _____

Relationship to Patient: Self / Spouse / Parent / Other (please explain) _____

Medicare Lifetime Authorization: I authorize any holder of medical of other information about me to release to the Social Security Administration and Health Care Financing Administration of the intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and requested payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I further understand that I will assume full responsibility for any Medical costs not covered by Medicare.

_____ _____ _____

Patient Signature Medicare Number Date

Little River Healthcare Consent / Authorization Form **Form to be completed by the responsible party**

Previous Medical Care:

Have you been in the hospital in the last 60 days?	□ Yes	□ No
Is there a possibility that you could be pregnant?	□ Yes	□ No
Are you an Organ Donor?	□ Yes	□ No
Do you have an Advanced Directive?	□ Yes	□ No

Current Medical Care: Is this visit the result of an accident? □ Yes □ No □ Auto □ Other_____

Authorization for Care: I grant permission to the employees of Little River Healthcare to examine, treat, and perform diagnostic tests and procedures that my provider deems necessary.

_____ Initials

Authorization of Care by ANP/PA: I understand that my care may be provided by an Advanced Nurse Practitioner or Physician Assistant in consultation with a physician. Arrangements will be made for referral to a physician if medically indicated or at my request. My signature on this form constitutes my consent to treatment by this professional.

_____ Initials

Assignment of Benefit: Insurance Assignment: In consideration of services rendered or to be rendered, I hereby assign and transfer to Little River Healthcare any benefits payable for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical, for the payment of services rendered. This assignment includes insurance benefits accruing to me from uninsured motorist coverage.

_____ Initials

Financial Agreement & Responsibility: I understand that, regardless of my assigned benefits, I am responsible for all charges. I understand that Little River Healthcare may file a claim for benefits on my behalf but, whatever my coverage, it is a personal contract between me and my insurance company. If benefits are not paid, I will be billed for the entire balance which I must pay in full upon receipt of the statement. I understand that I am responsible for charges not covered by this assignment and / or not paid by said companies and payors.

_____ Initials

Non-Smoking Facility: I understand this is a non-smoking facility and I will abide by this policy.

_____ Initials

Valuables: I understand that Little River Healthcare is not responsible for personal items (dental items, eye wear, jewelry, clothing, etc.) electively kept in my room or designated area while I am a patient. I further understand that patient care items left in the room following discharge will be disposed of and not replace by Little River Healthcare.

_____ Initials

Photography/Imaging: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that Little River Healthcare will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Little River Healthcare's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

_____ Initials

HIV, HBV and HCV Testing After an Accidental Exposure: Texas law authorizes a hospital or physician to require that a patient be tested for possible exposure to the Human Immunodeficiency Virus, Hepatitis B virus and Hepatitis C virus in the following situations: (1)if donation of blood, blood products, organs or tissues is contemplated; (2) if a health care worker is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick; or (3) if a medical surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested if any of these situations occur during your hospitalization. I consent to HIV, HBV & HCV testing under any of the above situations.

_____ Initials

Privacy Practices Little River Healthcare is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individuals with a notice of our legal duties and privacy practices, if requested, with respect to protected health information. I have been given the opportunity to review the notice of privacy practices.

_____ Initials

Please indicate the appropriate response as it pertains to how we may contact and leave messages for you:

Home telephone, answering machine or voice mail	□ Yes	□ No
Cell Phone and/or Voice Mail	□ Yes	□ No
Work Phone, answering machine or voice mail	□ Yes	□ No

Authorization to Release Information: I authorize Little River Healthcare to release information requested by insurance companies, review agencies or other third party payers for payment of claims arising out of this visit.

_____ Initials

Please list the names of authorized individuals that can receive protected health information: _____

_____ Signature of Patient:

_____ Date & Time

_____ Signature of Patient's Representative (if applicable)

_____ Relationship to Patient:

_____ Reason patient unable to sign

Place Sticker Here