NORTH TEXAS HAND CENTER, PA

Patient Name: ______________________________ **Today's Date:** ____________
First Middle Last
Home Address: ______________________________
City: ______________ State: __________ Zip: __________
Telephone: ( ) ______________ Birth Date: __________ Age: ______
Cell: ( ) ______________ SSN: ______________
Employer: ______________ Work Phone: ( ) ______________
Employer's Address: ______________________________
City: ______________ State: __________ Zip: __________
Marital Status: M S D W **Hand Dominance**: R or L

Responsible Party if patient is a minor

Name: ______________________________ today's Date: ____________
First Middle Last
Home Address: ______________________________
City: ______________ State: __________ Zip: __________
Telephone: ( ) ______________ Birth Date: __________ Age: ______
Cell: ( ) ______________ SSN: ______________
Employer: ______________ Work Phone: ( ) ______________
Employer's Address: ______________________________
City: ______________ State: __________ Zip: __________

[Primary Insurance]
Name of Insurance Company: ______________________________
Insured's Name: ______________ SSN: ______________ DOB: __________
Employer: ______________ Work Phone: ( ) ______________

[Secondary Insurance]
Name of Insurance Company: ______________________________
Insured's Name: ______________ SSN: ______________ DOB: __________
Employer: ______________ Work Phone: ( ) ______________

[Please complete IF Workers Compensation for claims billing purposes]
Did your injury happen on the job? Yes No **if yes,** on what date did the injury occur? ______________
Did you report the accident to your employer? Yes No
Employer Contact Name ______________ Telephone: ______________
Name of Insurance Company: ______________________________
Adjusters Name: ______________ Telephone: ______________
SSN: ______________ Claim # ______________

In case of emergency contact: ______________ Relationship: ______________
Home Phone: ( ) ______________ Cell Phone: ( ) ______________
Release Medical Information to: ______________________________
Referring Dr. ______________________________
Primary Dr. ______________________________

NORTH TEXAS HAND CENTER, PA

Patient's Name: ____ **Today's Date:** ________________

First Middle Last

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts at the time services are rendered unless other payment arrangements have been made. Any outstanding balances that are turned over to our collections agency will have a 33% increase to cover any administrative costs. __________ (**initial**)

I understand that I will be charged a $25 fee for any administrative paperwork, disability forms, FMLA, copies of medical records, etc…___________ (**initial**)

I understand that I will be charged $25 for any appointments that I miss or do not reschedule 24 hours in advance. ______(**initial**)

Should it be decided that surgery is necessary I understand that I will be required to pay $300 prior to the procedure, depending on my insurance deductible and co-insurance ___________ (**initial**)

Should it be required that a brace, splint or other durable medical equipment is prescribe by the physician, I understand that due to sanitary reason the item is non-returnable. I also understand that these items may not be covered by my insurance company. __________ (**initial**)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I consent to release my medication history and to have the same information gathered from any other prescribing providers. I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Dr. Stuart M. Hilliard** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Dr. Stuart M. Hilliard** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I may request a full copy of the Notice of Privacy Practices should I desire to have one.

Signature of Patient or Responsible Party: ______________________________Date: _____________

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Dr. Stuart M. Hilliard.**

I acknowledge that I have been given, upon request, the **North Texas Hand Center, P.A.** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Responsible Party: ____________________________________ Date: _____________

A photocopy of this consent shall be considered as valid as the original.

PATIENT NAME:_______________________________ **DATE OF BIRTH**: ___________________________

HEIGHT:__________________ **WEIGHT**:____________________

NORTH TEXAS HAND CENTER, PA

CURRENT COMPLAINT: (Please list in order which problem bothers you the most)

1.____

2.____

3.____

MEDICAL HISTORY: (Please list all. Example- Diabetes, High blood pressure, Rheumatoid Arthritis, Ect.)

____

____

____

SURGICAL HISTORY: (Please list ALL surgeries)

____

____

____

____

CURRENT DAILY MEDICATIONS:

______________________	____________________	____________________	_________________
______________________	____________________	____________________	_________________
______________________	____________________	____________________	_________________
______________________	____________________	____________________	_________________
______________________	____________________	____________________	_________________

PREFERRED PHARMACY/LOCATION:_______________________________________

MEDICATION ALLERGIES: (Include reaction):

___________________________________ ______________________________

___________________________________ ______________________________

NORTH TEXAS HAND CENTER, PA

_______________________________________ _________________________________

_______________________________________ _________________________________

HAVE YOU EVER HAD AN ALLERGIC REACTION TO THE FOLLOWING: **YES OR NO**
(Include reaction)

FOODS:
SHELLFISH NUTS EGGS ______________________________________

ENVIRONMENTAL:
TOPICAL IODINE ADHESIVES LATEX TAPE _________________________

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

HEPATITIS A HEPATITIS B HEPATITIS C HIV/AIDS TUBERCULOSIS

TOBACCO USE:
CURRENT DAILY SMOKER FORMER SMOKER SMOKELESS TOBACCO USE

YEARS SMOKED:_________

PACKS PER DAY:_________

ALCOHOL USE:
NEVER OCCASIONAL/ SOCIAL MODERATELY HEAVY

MARITAL STATUS:
SINGLE MARRIED WIDOWED SIGNIFICANT OTHER

EMPLOYMENT:
UNEMPLOYED HOMEMAKER FULL- TIME PART- TIME RETIRED

DOES YOUR JOB REQUIRE REPETITIVE USE OF YOUR HANDS? YES OR NO

Review of Systems Checklist

Please circle ONLY the symptoms you have experienced in the past two weeks

General:

fatigue fever weakness headache (chronic) weight loss weight gain
sleep disturbance

Eyes:

drainage from eyes Blurred or double vision dry eyes
Glasses or contacts

Ear, Nose, Throat, and Neck:

hearing loss nasal congestion nasal drainage sore throat dizziness vertigo
sinus problems difficulty swallowing snoring

Cardiovascular:

chest pain/ angina cold extremity edema lightheadedness murmur palpitations
reduced exercise tolerance fainting

Respiratory:

cough dry cough chest tightness difficulty breathing wheezing
short of breath

Gastrointestinal:

abdominal pain nausea vomiting diarrhea jaundice rectal bleeding heartburn
ulcers constipation

Genitourinary:

bloody urine increased frequency incontinence difficulty urinating

Musculoskeletal:

arm pain back pain deformity elbow pain finger pain gait abnormality
hand pain joint crepitus joint redness joint swelling joint pain joint warmth
neck pain numbness shoulder pain stiffness weakness wrist pain

Skin:

bruising insect bites scarring brittle nails nail changes nail deformity
nail discoloration nail thickening new lesions itching rash skin changes

Neurological:

memory loss impaired balance weakness confusion dizziness
motor paralysis neurological symptoms seizure numbness

Psychiatric:

anxiety depression psychiatric or emotional difficulty
substance abuse trying to decrease substance abuse alcohol or drug addiction

Endocrine:

cold intolerance prolonged healing heat intolerance high blood sugar
low blood sugar increased thirst increased appetite increased urination

Hematologic/ Lymphatic:

easy bleeding prolonged bleeding blood clotting problems easy bruising

recurrent infections prolonged infection slow wound healing

Allergic/ Immunologic:

allergies (seasonal) eye itching eye redness eye swelling hives nasal congestion

nasal swelling