|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_  
Cell: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Primary Insurance]***

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claims Address

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: Group No: Effec. Date Copay

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Secondary Insurance]***

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Claims Address

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID: Group No: Effec. Date Copay

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***[Please complete only IF Workers Compensation is needed 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 #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Dr**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dr.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Consent Form Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

**Assignment of Benefits**: I authorize North Texas Hand Center, (NTHC) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that NTHC will collect payment for supplies and services provided at the time of service. I understand that I am financially responsible to the provider for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing. **Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Consent for treatment**. I consent for NTHC to administer treatments, tests and/or diagnostic tests to treat my/the patient’s injury/illness on an outpatient basis. Treatments may include but are not limited to: 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 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. **Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Durable Medical Equipment.** Should it be required that a brace, splint or other durable medical equipment is prescribed by the physician, I understand that due to sanitary reasons, the item is non-returnable. I also understand that these items may not be covered by my insurance company

**Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Phone Calls**. By providing contact information, I authorize NTHC, it assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

**Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Involvement of Others in Care.** I authorize NTHC to discuss my/the patient’s care and medical needs with the following person(s)

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Date of Birth  (for identification) | Relationship | Phone |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**May We Contact You by Phone and Leave a Message About Your Care?**

Primary Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** Leave message with contact number only **□** Leave message with contact number only

**□** Leave message with detailed information **□** Leave message with detailed information

**□** Do not leave message **□** Do not leave message

I understand that **Dr. Stuart M. Hilliard** may include consent at satellite offices under common ownership. **Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that I have been offered a copy of “Notice of Privacy Practices.” **Patient Initials**: \_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name of Patient or Responsible Party**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Responsible Party**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**MEDICAL HISTORY**

**DATE TODAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

LAST FIRST MI

**HEIGHT:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OCCUPATION**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT TODAY**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** □ Single □ Married □ Separated □ Divorced □ Significant Other

**Does your job require repetitive use of your hands?** □ YES □ NO

**Work Status:** □ FT □ PT □ Disabled □ Retired □ Self Employed □ Homemaker □ Unemployed

**PHARMACY** (List pharmacy most frequently used for prescriptions)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS** (Include prescription, over the counter, supplements and herbal medications. Attach extra sheet if necessary) or □ **NONE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dose (mg)** | **How often taken** | **Reason** | **Physician prescribing** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| 5. |  |  |  |  |

**SURGERIES** (Include all surgeries in your lifetime. Attach extra sheet if necessary) or □ **NONE**

|  |  |  |
| --- | --- | --- |
| **Type of Surgery** | **Date (approximate)** | **Hospital or city if known** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

**ALLERGIES** (Include medications, foods, x-ray, dyes) or □ **NONE KNOWN**

|  |  |  |
| --- | --- | --- |
| **Name of Allergen** | **Type of Reaction** | **Approximate Date** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |

**TOBACCO HISTORY**

Are you/have you been a smoker □ YES □ NO Yrs: \_\_\_\_\_\_\_\_ PPD: \_\_\_\_\_\_\_

Do you use other tobacco products? □ YES □ NO If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALCOHOL AND DRUG HISTORY**

Alcohol: □ Never □ Occasional □ Moderate □ Heavy

Have you ever used intravenous drugs? □ YES □ NO

**DO YOU HAVE A HISTORY OR FAMILY HISTORY OF MALIGNANT HYPOTHERMIA?** □ YES □ NO

**FAMILY HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Is there a history in your family of:** | **Yes** | **No** | **Affected relative(s)** |
| Heart attack |  |  |  |
| Diabetes |  |  |  |
| Prostate cancer |  |  |  |
| Kidney cancer |  |  |  |
| Kidney stones |  |  |  |
| Other significant disease |  |  |  |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_/ \_\_\_\_\_\_/\_\_\_\_\_\_

First Last MI

Please check “X” the complaint(s) that apply to you. If you are unsure, place a question mark (?)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **General** | Fatigue/Tired |  | □Yes □No |  | **Musculo-** | Wrist Pain | □L □R |  | □Yes □No |
|  | Fever/Chills |  | □Yes □No |  | **Skeletal** | Hand Pain | □L □R |  | □Yes □No | |
|  | Weight Loss |  | □Yes □No |  |  | Finger Pain | □L □R |  | □Yes □No | |
|  | Weight Gain |  | □Yes □No |  |  | Elbow Pain | □L □R |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | Back Pain | □L □R |  | □Yes □No | |
|  |  |  |  |  |  | Joint Pain | □L □R |  | □Yes □No | |  |  | □Yes □No |
| **Eyes** | Difficulty Seeing |  | □Yes □No |  |  | Joint Swelling | □L □R |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | Joint Warmth | □L □R |  | □Yes □No | |
|  |  | | |  |  | Muscle Pain | □L □R |  | □Yes □No | |
| **Head** | Dry Mouth |  | □Yes □No |  |  | Swelling | □L □R |  | □Yes □No | |
| **Ears** | Hearing Problems |  | □Yes □No |  |  | Numbness | □L □R |  | □Yes □No | |
| **Nose** | Hoarseness |  | □Yes □No |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **Throat** | Lumps/Swelling in Neck | | □Yes □No |  |  |  |  |  |  | |
|  | Sore Throat | | □Yes □No |  | **Skin** | Bruising |  |  | □Yes □No | |
|  | Trouble Swallowing |  | □Yes □No |  | **Hair** | Hair Loss |  |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | **Nails** | Nail Problems |  |  | □Yes □No | |
|  |  | | |  |  | Rash |  |  | □Yes □No | |
| **Cardiac** | Chest Pain |  | □Yes □No |  |  | Skin Changes |  |  | □Yes □No | |
| **(Heart)** | Irregular Heart Beat |  | □Yes □No |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | Pain with Walking |  | □Yes □No |  |  |  |  |  |  | |
|  | Shortness of Breath |  | □Yes □No |  | **Mental** | Anxiety |  |  | □Yes □No | |
|  | Swelling in Feet/Ankles | | □Yes □No |  | **Health** | Depression |  |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | Difficulty Sleeping/Concentrating | |  | □Yes □No | |
|  |  |  |  |  |  | History of Physical/ Mental Abuse | |  | □Yes □No | |
| **Neuro** | Dizziness |  | □Yes □No |  |  | Mood Swings |  |  | □Yes □No | |
|  | Fainting |  | □Yes □No |  |  | Stress |  |  | □Yes □No | |
|  | Headache |  | □Yes □No |  |  | Suicidal |  |  | □Yes □No | |
|  | Memory Loss |  | □Yes □No |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | Numbness |  | □Yes □No |  |  |  |  |  |  | |
|  | Weakness |  | □Yes □No |  | **Gastro-** | Abdominal Pain |  |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | **Intestinal** | Blood in Stool |  |  | □Yes □No | |
|  |  |  |  |  |  | Change in Bowel Habits |  |  | □Yes □No | |
| **Respiratory** | |  |  |  |  | Constipation |  |  | □Yes □No | |
|  | Cough |  | □Yes □No |  |  | Heartburn |  |  | □Yes □No | |
|  | Shortness of Breath |  | □Yes □No |  |  | Loss of Appetite |  |  | □Yes □No | |
|  | Use of Inhalers |  | □Yes □No |  |  | Nausea |  |  | □Yes □No | |
|  | Wheezing |  | □Yes □No |  |  | Vomiting |  |  | □Yes □No | |
|  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |  |  | | | | |

**Most Recent Mammogram:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Most Recent Colonoscopy:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Most Recent Influenza Vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Most Recent Pneumococcal Vaccine:** \_\_\_\_\_\_\_\_\_\_\_\_

DISCLOSURE OF PHYSICIAN OWNERSHIP

NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

1. Stuart M. Hilliard, M.D. is a partial owner of Baylor Surgicare - Denton and partial owner in the

management company of Parkway Surgical and Cardiovascular Hospital – Ft. Worth.

1. You have the right to choose the provider of your health care services. Therefore, you have the

option to use a health care facility other than Baylor Surgicare - Denton or Parkway Surgical and Cardiovascular Hospital- Ft. Worth.

1. You will not be treated differently by your physician if you choose to obtain health care services

at a facility other than Baylor Surgicare - Denton or Parkway Surgical and Cardiovascular Hospital- Ft. Worth.

If you have any questions concerning this notice, please feel free to ask your physician or any representative

of Baylor Surgicare - Denton or Parkway Surgical and Cardiovascular Hospital- Ft. Worth. We welcome

you as a patient and value our relationship with you.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has partial ownership interest in Baylor Surgicare - Denton and partial owner in the management company of Parkway Surgical and Cardiovascular Hospital – Ft. Worth.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Signature of Parent or Guardian (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type or Print Name of Patient Type or Print Name of Parent or Guardian

(if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date