NORTH TEXAS HAND CENTER, P.A.

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: _____

NORTH TEXAS HAND CENTER, P.A.

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 # _____
□ Leave message with contact number only
□ Leave message with detailed information
□ Do not leave message

Secondary Phone # _____
□ Leave message with contact number only
□ Leave message with detailed information
□ 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.

NORTH TEXAS HAND CENTER, P.A.

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 ☐ Widowed

Does your job require repetitive use of your hands? ☐ YES ☐ NO

Work Status: ☐ FT ☐ PT ☐ Disabled ☐ Retired ☐ Self Employed ☐ Homemaker ☐ Unemployed

PHARMACY NAME: _____ **LOCATION:** _____

MEDICAL CONDITIONS *(Include conditions that may or may not require medications) Attach extra sheet if necessary.* ☐ **NONE**

Condition	Date Diagnosed
1.	
2.	
3.	

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

Name of Medication	Dose (mg)	How often taken	Reason	Physician prescribing
1.				
2.				
3.				

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

Type of Surgery	Date (approximate)	Hospital or city if known
1.		
2.		
3.		

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of Allergen	Type of Reaction	Approximate Date
1.		
2.		

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			

NORTH TEXAS HAND CENTER, P.A.

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
	Fever/Chills	□Yes	□No
	Weight Loss	□Yes	□No
	Weight Gain	□Yes	□No
	Other: _____		
Eyes	Difficulty Seeing	□Yes	□No
	Other: _____		
Head	Dry Mouth	□Yes	□No
Ears	Hearing Problems	□Yes	□No
Nose	Hoarseness	□Yes	□No
Throat	Lumps/Swelling in Neck	□Yes	□No
	Sore Throat	□Yes	□No
	Trouble Swallowing	□Yes	□No
	Other: _____		
Cardiac	Chest Pain	□Yes	□No
(Heart)	Irregular Heart Beat	□Yes	□No
	Pain with Walking	□Yes	□No
	Shortness of Breath	□Yes	□No
	Swelling in Feet/Ankles	□Yes	□No
	Other: _____		
Neuro	Dizziness	□Yes	□No
	Fainting	□Yes	□No
	Headache	□Yes	□No
	Memory Loss	□Yes	□No
	Numbness	□Yes	□No
	Weakness	□Yes	□No
	Other: _____		
Respiratory			
	Cough	□Yes	□No
	Shortness of Breath	□Yes	□No
	Use of Inhalers	□Yes	□No
	Wheezing	□Yes	□No
	Other: _____		

Musculo-	Wrist Pain	□L	□R	□Yes	□No
Skeletal	Hand Pain	□L	□R	□Yes	□No
	Finger Pain	□L	□R	□Yes	□No
	Elbow Pain	□L	□R	□Yes	□No
	Back Pain	□L	□R	□Yes	□No
	Joint Pain	□L	□R	□Yes	□No
	Joint Swelling	□L	□R	□Yes	□No
	Joint Warmth	□L	□R	□Yes	□No
	Muscle Pain	□L	□R	□Yes	□No
	Swelling	□L	□R	□Yes	□No
	Numbness	□L	□R	□Yes	□No
	Other: _____				
Skin	Bruising			□Yes	□No
Hair	Hair Loss			□Yes	□No
Nails	Nail Problems			□Yes	□No
	Rash			□Yes	□No
	Skin Changes			□Yes	□No
	Other: _____				
Mental	Anxiety			□Yes	□No
Health	Depression			□Yes	□No
	Difficulty Sleeping/Concentrating			□Yes	□No
	History of Physical/ Mental Abuse			□Yes	□No
	Mood Swings			□Yes	□No
	Stress			□Yes	□No
	Suicidal			□Yes	□No
	Other: _____				
Gastro-	Abdominal Pain			□Yes	□No
Intestinal	Blood in Stool			□Yes	□No
	Change in Bowel Habits			□Yes	□No
	Constipation			□Yes	□No
	Heartburn			□Yes	□No
	Loss of Appetite			□Yes	□No
	Nausea			□Yes	□No
	Vomiting			□Yes	□No
	Other: _____				

Most Recent Mammogram: _____ **Most Recent Colonoscopy:** _____

Most Recent Influenza Vaccine: _____ **Most Recent Pneumococcal Vaccine:** _____

NORTH TEXAS HAND CENTER, P.A.

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 Wise Health Surgical Hospital at Parkway and Wise Health Surgical Hospital at Argyle.

2. 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 Wise Health Surgical Hospital at Parkway or Wise Health Surgical Hospital at Argyle.

3. 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 Wise Health Surgical Hospital at Parkway or Wise Health Surgical Hospital at Argyle.

If you have any questions concerning this notice, please feel free to ask your physician or any representative of Baylor Surgicare – Denton, Wise Health Surgical Hospital at Parkway or Wise Health Surgical Hospital at Argyle. 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 Wise Health Surgical Hospital at Parkway and Wise Health Surgical Hospital at Argyle.

_____ _____

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

NORTH TEXAS HAND CENTER, P.A.

FOLLOW MY HEALTH PATIENT PORTAL

Welcome to the all-in-one personal health record and patient portal that lets you access your medical information in a secure online environment 24 hour a day, 7 days a week from any computer, laptop or smart phone!

What is It?

- Access Your Medical Information Online 24/7
- Take a More Active Role in Managing Your Health and Wellness

What Can I Do?

- Request prescription refills
- Send a message to the clinical staff regarding medications, complications or surgery
- Send a message to the clerical staff regarding an appointment, your account or any other question
- Receive test results electronically

Benefits

- SAVE TIME! No more waiting on hold to speak to staff or schedule appointments
- IT'S CONVENIENT! Anywhere anytime access lets you communicate on your time
- IT'S PRIVATE: Secure messaging ensures privacy between you and your physician

Medication List and Health History

These tabs are for your record keeping only. Information that you enter in these fields does not transfer to our office. It is a tracking tool for you.

How to Register for a Portal Account

Just follow these simple steps to get connected today!

Check your email. You will receive an email from "noreply@followmyhealth.com." Click the registration link and follow the onscreen prompts.

Click Sign Up and Connect. If you already have a portal account and want to add an additional provider, click **Sign in and add this connection.**

Create a username for your portal account. By default, your email address that your invitation was sent to will appear in the username box. It is recommended to use this email address as your username.

Next, **create a password** following the criteria noted on the right of the screen.

Reenter your password to continue.

Get Connected. Follow the on-screen prompts on the next four screens to complete your connection. These screens include accepting our **Terms of Service**, entering your **Invite Code** and accepting the **Release of Information.**

Registration and Connection is Now Complete. Your health record will now begin to upload. Please note this may take a few minutes.

View the First Time Walk-Through Video. Learn about all the tools your portal has to offer by watching the 3-minute video that appears when you first log in. If you wish to view this video later, you can always access it by clicking on the My Account dropdown in the right hand corner and selecting Preferences.

Congratulations! You can now access your health information and start managing your care online!