NORTH TEXAS
HAND CENTER, P.A.

Patient Name: ____ **Today's Date**: _________________
First Middle Last

Home Address: ____
City: __________________________________ State: ________________ Zip: ______________
Primary Phone: ( ) _________________________ Birth Date: _______________ Age: ______
Secondary Phone: ( ) ______________________ SSN: ______________________________
Email Address: ____
Employer: _______________________________________ Work Phone: ( ) ______________________

Marital Status: M S D W **Hand Dominance**: R or L

Responsible Party if patient is a minor

Name: ____
First Middle Last
Home Address: ____
City: ____ State: ____________ Zip: ____________
Primary Phone: ( ) _________________________ Birth Date: ______________ Age: ______
Secondary Phone: ( ) ___________________________

[Primary Insurance]
Name of Insurance Carrier: ____________________
Insured's Name: ____________________________
Insured's Date of Birth: _______________________
Member ID: _______________________________
Group #: _________________________________

[Secondary Insurance]
Name of Insurance Carrier: __________________________
Insured's Name: _________________________________
Insured's Date of Birth: ____________________________
Member ID: ____________________________________
Group #: ______________________________________

[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: _____________________

Adjusters Name: _____________________Telephone:_____________________ Claim #: ______________________

Referring Dr.____
Primary Dr. ____

Emergency Contact Name: __________________________ **Phone**: _______________ **Date of Birth**: ___________
Relationship to Patient: ______________________________

General Consent

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, and it assignees 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

Secondary Phone # _________________________
☐ Leave message with contact number only
☐ Leave message with detailed information

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

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**: ______________________________________

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

REASON FOR VISIT TODAY: ____

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

Condition	Date Diagnosed
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.		

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

Name of Medication	Dose (mg)	How often taken
1.		
2.		
3.		
4.		
5.		

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

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

PHARMACY NAME: ____________________________________ **LOCATION**: _______________________________

CARDIOLOGIST NAME: _________________________________ **PHONE:** _____________________________

DO YOU HAVE A HISTORY OR FAMILY HISTORY OF MALIGNANT HYPOTHERMIA? ☐ YES ☐ NO
(Adverse reaction while under general anesthesia)

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

General			**Musculoskelatal**	
Fatigue/Tired	☐Yes ☐No		Back Pain	☐L ☐R ☐Yes ☐No
Fever/Chills	☐Yes ☐No		Elbow Pain	☐L ☐R ☐Yes ☐No
Weight Loss	☐Yes ☐No		Finger Pain	☐L ☐R ☐Yes ☐No
Weight Gain	☐Yes ☐No		Hand Pain	☐L ☐R ☐Yes ☐No
Other: ______________________________			Joint Pain	☐L ☐R ☐Yes ☐No
			Joint Swelling	☐L ☐R ☐Yes ☐No
Skin, Hair, Nails			Muscle Pain	☐L ☐R ☐Yes ☐No
Bruising	☐Yes ☐No		Wrist Pain	☐L ☐R ☐Yes ☐No
Nail Problems	☐Yes ☐No		Other: ____________________________	
Rash	☐Yes ☐No			
Skin Changes	☐Yes ☐No		**Neuro**	
Hair Loss	☐Yes ☐No		Memory Loss	☐Yes ☐No
Other: ______________________________			Weakness	☐Yes ☐No
			Dizziness	☐Yes ☐No
Respiratory			Numbness	☐Yes ☐No
Cough	☐Yes ☐No		Fainting	☐Yes ☐No
Wheezing	☐Yes ☐No		Headache	☐Yes ☐No
Shortness of Breath	☐Yes ☐No		Other: ______________________________	
Other: ______________________________				
Cardiac			Any other concerns:	
Chest Pain	☐Yes ☐No			
Irregular Heart Beat	☐Yes ☐No			
Swelling Feet/Ankles	☐Yes ☐No			
Shortness of Breath	☐Yes ☐No			
Other: ____________________________				

Most Recent Influenza Vaccine: ___________________ **Most Recent Pneumococcal Vaccine:** ____________

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

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

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
MORE CHOICE: Gives patients a new way to communicate with their doctor
SET & TRACK GOALS: Use the portal to track your health conditions/wellness goals and chart progress
PATIENT CONTROLLED: You own your portal and all of the data within it and control who sees what

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!