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: _____

NORTH TEXAS HAND CENTER, P.A.

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.

NORTH TEXAS HAND CENTER, P.A.

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			

NORTH TEXAS HAND CENTER, P.A.

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:** _____

COVID Vaccine: ☐ YES ☐ NO Date of COVID Vaccine: _____

Date of COVID Vaccine: _____

NORTH TEXAS
HAND CENTER, P.A.

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

This is portal is only for sending and receiving secure emails.

It is not for medical or prescription information.

What Can I NOT Do?

Medication List and Health History – THIS INFORMATION IS NOT TRANSMITTED

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.

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

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!