GENERAL INFORMATION

Referring Doctor & Phone No: ________________________________ Preferred Pharmacy: ____________________
Primary Care Doctor & Phone No: ______________________________ Pharmacy Phone #: ____________________

PATIENT INFORMATION (Please Print)

O Mr. O Mrs. O Ms. Date of Birth: ____________________
Patient Last Name:____________________________ First Name: _______________________ (MI): _____
Address: __________________________________ City/State/Zip: ____________________________________
Home Phone: ______________________ Cell: ________________________ Work: _______________________
Marital Status: Single — Married — Widowed – Divorced MALE / FEMALE
Employer: _________________________ Occupation: __________________
Email Address: ________________________________

RESPONSIBLE PARTY INFORMATION (If different than above)

Last Name: ___________________________ First Name: ___________________________ MI: _________________
Address: ____
City/Sate/Zip: ____
Home Phone: _________________________ Cell #: ________________________ Work #: ________________________
SSN: ______________________ Date of Birth: __________________________ MALE / FEMALE
Employer: ____ Occupation: ____________________________________
Relationship to Patient: ____

INSURANCE INFORMATION (Please be sure to give your Insurance card and Driver's license to the receptionist)

EMERGENCY CONTACT INFORMATION

Please list 2 contacts that you consent to have your medical information released to in the event of an emergency.

Name	Phone number	Relationship

1545 E Southlake Blvd, Suite 280
Southlake, Tx 76092 817-332-7867 (Office) 817-332-7861 (Fax)

PAST MEDICAL, SURGICAL AND SOCIAL HISTORY

SURGICAL HISTORY:

TYPE OF SURGERY	YEAR	TYPE OF SURGERY	YEAR

FAMILY HISTORY OF SIMILAR CONDITION:

FAMILY MEMBER	TYPE OF CONDITION	DATE DIAGNOSED	LIVING OR DECEASED

MEDICAL CONDITIONS (please circle only those that apply to you):

Diabetes Type I	Blood clots in legs	Hepatitis B or C	H.I.V./AIDS
Diabetes Type II	Blood clots in lungs	Liver Disease	Leukemia
High Blood Pressure	Thyroid Disorder	Bleeding disorder	Asthma
High Cholesterol	Kidney Problems	Hemophilia	C.O.P. D
Heart Disease	Epilepsy or Seizures	Sickle Cell Anemia	Other:
Heart Attack	Stroke	Cancer	
Heart Valve Problem	Ulcers or Open wounds	Anesthetic Problems	

CURRENT MEDICATIONS: (Leave blank if you brought a list):

ALLERGIES TO MEDICATIONS: ____

SOCIAL HISTORY:

TOBACCO	PREVIOUS SMOKER	ALCOHOL
Do you smoke tobacco?	If you have smoked in the past…	Do you drink alcohol?
How many packs/day?	How many years did you smoke for?	Number of drinks/day?
How many years?	When did you quit?	

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CONSENT TO TREATMENT

I hereby consent to routine diagnostic examination, procedures, and/or medical treatment as recommended to me by medical providers of Dr. Ben Deheshi Orthopedics. I understand that these are recommendations and I may revoke my consent at any time without any prior notification. I further understand that recommended tests, procedures, and/or surgeries do not carry guarantees and have inherent risks. I am entitled to an explanation of these risks and may request further discussion with my Provider.

HIPAA

HIPAA is the Health Insurance Portability and Accountability Act. It establishes policies and procedures for maintaining the privacy and the security of individually identifiable health information. Dr. Ben Deheshi Orthopedics fully complies with the national regulations for the use and disclosure of Protected Health Information (PHI) in healthcare treatment, payment and operations. All patient information is kept fully confidential in a secure electronic medical record software only accessible by our Physicians and medical office staff.

ASSIGNMENT OF BENEFITS

I understand that services rendered to me by Dr. Ben Deheshi Orthopedics are my financial responsibility and that Dr. Ben Deheshi Orthopedics, as a courtesy, will bill my Insurance Company. I authorize my insurance company to pay my benefits directly to Dr. Ben Deheshi Orthopedics and I understand that I will be fully responsible for any outstanding balance on my account.

I authorize Dr. Ben Deheshi Orthopedics to release any information necessary to adjudicate the claim.

I understand that should my insurance company send payment to me; I will forward the payment to Dr. Ben Deheshi Orthopedics within 48 hours.

I authorize Dr. Ben Deheshi Orthopedics to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

I hereby authorize Dr. Benjamin Deheshi, Orthopedic Surgeon, to obtain or release my medical records and medication history to or from my pharmacy, my health plans, medical device companies, other medical facilities where I have had previous medical care and other healthcare providers as it pertains to my care.

By signing below, I affirm that I fully understand and accept the contents of this documentation.

___________________________________	___________________________________
Signature of Patient or Representative	***Date***

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