PATIENT INFORMATION

When registering, please present proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made.

Patient Information
Name_____
Address_____
City_____State____Zip_____
Phone_____Marital Status_____
Date of birth_____Age_____Sex___
Drivers license#_____State___
Soc.Sec.#_____
Employer_____Student: Y N

Patient's Employer
Employer_____
Occupation_____
Address_____
City_____State____Zip_____
Phone_____

Patient Information
Injury or complaint_____
How did injury occur?_____
_____
_____
Referred by:_____
Did you get hurt on the job_____
Auto Accident_____
Date injured_____
Do you have an attorney_____
Attorney name_____

Patient's Spouse/Parent/Guardian
Spouse/Guardian_____
Relationship_____Phone_____
Address_____
City_____State____Zip_____
Employer_____Phone_____
Address_____
City_____State____Zip_____
Soc.Sec.#_____

Emergency Contact/Nearest Relative
Name_____
Address_____
City_____State____Zip_____
Phone_____

Insurance Information
Ins. Co_____
Insured person_____
Insurance Company Address
_____
City_____State____Zip_____
Phone_____
Policy#_____Group#_____
Subscriber#_____
Employer_____

Secondary Ins._____
Insured person_____
Insurance Company Address
_____
City_____State____Zip_____
Phone_____
Policy#_____Group#_____
Subscriber#_____
Employer_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help you expedite insurance carrier reimbursements. However, the patient is responsible for all fees, regardless of insurance coverage. You are required to pay at the time of the service, unless other arrangements have been made in advance with our office manager. We will file your insurance when surgery is involved.

I hereby authorize Ian J. Reynolds, M.D., to furnish information to the insurance carrier/referring physician concerning my illness and treatment and I hereby assign to the physician all insurance payments for medical services rendered to myself or my dependents (when filed by the physician's office.) I also authorize medical information to be faxed upon request.

I understand that I am responsible for any and all amounts not covered by my insurance company.

Signature_____ Date_____

NAME: _____ DATE: _____

OCCUPATION: _____

CHIEF COMPLAINT: _____

PRESENT ILLNESS

_____

ALLERGIES

CURRENT MEDS

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

WOMEN ONLY: PREGNANT ? [ ]YES [ ]NO

MEDICAL HISTORY

[ ] SMOKE _____ [ ] ALCOHOL _____ [ ] DRUGS _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

❑ Headache _____
❑ Shortness of breath _____
❑ Heart palpitations _____
❑ Heart murmur _____
❑ Chest pain _____
❑ Dizziness/Fainting _____
❑ Peripheral vascular disease _____
❑ Allergies/Hay fever _____
❑ Asthma _____
❑ Bronchitis _____
❑ Pneumonia _____
❑ Ulcer _____
❑ GI disorder _____

❑ Lactose intolerance _____
❑ Gallbladder disease _____
❑ Prostate disease _____
❑ Bowel irregularity _____
❑ Incontinence _____
❑ Sexual/menstrual dysfunction _____
❑ Venereal disease _____
❑ Frequent infections _____
❑ Hepatitis _____
❑ Anemia _____
❑ Arthritis _____
❑ Osteoporosis _____
❑ Nervousness _____

❑ Depression _____
❑ Gout _____
❑ Scarlet fever _____
❑ Chronic rashes _____
❑ Rheumatic fever _____
❑ Mumps _____
❑ Measles _____
❑ Rubella _____
❑ Polio _____
❑ Diphtheria _____
❑ Tetanus _____
❑ Other _____
❑ Other _____

PATIENT SIGNATURE DATE

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

What is the best phone number for us to contact you?

Phone Number: _____

What is this number (Home, Work, Cell, Other)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis and medication information) at this number?** _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.

Home Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Work Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Cell Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Other: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____ _____

Print name of Patient or Legal Representative **Relationship to Patient**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

IAN J. REYNOLDS, M.D., P.A.

I, **[name of patient]** _____, acknowledge and agree that I have reviewed a copy of **Ian J. Reynolds, M.D., P.A.'s Notice of Privacy Practices.**

_____ _____

Patient Signature Date

_____ _____

Signature of Patient's Legal Representative (if applicable) Date

_____ _____

Print Name of Legal Representative Relationship to patient

Clinic Use Only

Ian J. Reynolds, M.D., P.A. made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

_____

_____

_____

_____

_____ _____

Signature of Employee Date

_____ _____

Print Name of Employee Title

MEDICARE SIGNED CONSENT STATEMENT FROM BENEFICIARY

TO: MEDICARE/ SSA OR HCFA

PATIENT NAME:_____

PATIENT ADDRESS:_____

CITY_____ST_____ZIP_____

PATIENT CLAIM NUMBER:_____

S P E C I F I C I N F O R M A T I O N REQUESTED:_____
_____
_____

I AM THE INDIVIDUAL TO WHOM THE INFORMATION PERTAINS, OR AM AUTHORIZED TO CONSENT, ON BEHALF OF THE INDIVIDUAL, TO THE RELEASE OF THE INFORMATION. I UNDERSTAND THAT ANY FALSE REPRESENTATION TO KNOWINGLY AND WILLFULLY OBTAIN INFORMATION FROM SOCIAL SECURITY RECORDS IS PUNISHABLE BY FINE OF NOT MORE THAT $5000.00 OR ONE YEAR IN PRISON OR BOTH.

BENEFICIARY'S SIGNATURE (OR REPRESENTATIVE'S SIGNATURE, IF APPLICABLE)

_____

PURPOSE TO DISCLOSE INFORMATION:_____
_____

TIME FRAME FOR DISCLOSING INFORMATION_____

DATE OF SIGNATURE_____

PARTY TO WHOM THE INFORMATION IS TO BE SENT:
IAN J. REYNOLDS, M.D.
450 MEDICAL CENTER BLVD. STE 206
WEBSTER, TEXAS 77598

THANK YOU

Ian J. Reynolds, M.D., P.A.

Orthopedic Surgery
450 Medical Center Blvd. Suite 206
Webster, Texas 77598

281-332-9676
409-948-4940
FAX-281-338-7723

Certified by American
Board of Orthopedic Surgery

To all our Medicare patients, we are required by law to inform you that _____

_____

prescribed by Dr. Reynolds may not be covered under your Medicare Insurance. This means that this expense will be your responsibility. Your signature below indicates you understand the above and accept responsibility for payment if Medicare does not cover it. However, you have the right to refuse this service.

I understand and agree that I will be responsible for payment of the service(s) listed above if Medicare does not cover them.

_____ _____
signature date

I refuse the service(s) listed above, even though I realize they are deemed to be medically necessary by Dr. Reynolds.

_____ _____
signature date