

**WHITE ROCK ORTHOPEDIC ASSOCIATION  
PATIENT REGISTRATION**

TODAYS DATE: \_\_\_/\_\_\_/\_\_\_

<b>PATIENT INFORMATION</b>	LAST NAME	FIRST NAME	MIDDLE	DATE OF BIRTH	AGE	SEX	
	NUMBER, STREET, APT.NO.			CITY	STATE	ZIP	HOME PHONE
	EMPLOYER			WORK ADDRESS		WORK PHONE	
	OCCUPATION	SOC. SEC. #	DL # & STATE			CELL PHONE	
	<b>REFERRED BY:</b> PHYSICIAN NAME:					OTHER:	
<b>PARTY RESPONSIBLE FOR PAYMENT AND/OR SPOUSE INFORMATION</b>	NAME		DATE OF BIRTH	AGE	SEX		
	ADDRESS		HOME PHONE	CELL PHONE			
	EMPLOYER		OCCUPATION	WORK PHONE			
	ADDRESS		SOC. SEC. NO.				
<b>EMERGENCY CONTACT</b>	NAME	ADDRESS	PHONE NO.	RELATION TO PT.			
<b>INSURANCE INFORMATION</b>	NAME OF INSURANCE CO. (PRIMARY)			NAME & DOB OF POLICY HOLDER (PRIMARY)			
	I.D./MEMBER #	GROUP #	MEDICARE #	MEDICAID #			
	NAME OF INSURANCE CO. (SECONDARY)		NAME & DOB OF POLICY HOLDER (SEC. INS.)				
	I.D./MEMBER # (SEC. INS.)		GROUP # (SEC. INS.)				
<b>PREFERRED PHARMACY</b>	Pharmacy Name		Pharmacy Address		Pharmacy Number		

**WHITE ROCK ORTHOPEDIC ASSOCIATION  
MEDICAL HISTORY**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Reason for today's visit:     Illness         Accident        Date of injury: \_\_\_\_\_

IS THIS A WORK RELATED ACCIDENT?     YES     NO    (OUR OFFICE DOES NOT ACCEPT WORKERS COMP)

IS THIS INJURY DUE TO AN AUTO ACCIDENT?     YES     NO

The date you first started having symptoms for THIS injury/accident/pain: \_\_\_\_\_

The date you were first seen by Dr. Goldman or Dr. Goldberg for THIS injury/accident/pain: \_\_\_\_\_

Have you had recent x-rays for THIS injury/accident/pain?     YES     NO    If yes, when and where were they done? \_\_\_\_\_

**GENERAL MEDICAL HISTORY:**

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- |  |  |   |                                       |                                      |
|--|--|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Ulcer           | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gout        |
| <input type="checkbox"/> Kidney disease  | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Rheumatoid Arthritis |                                       | <input type="checkbox"/> Stroke      |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hepatitis            |                                       | <input type="checkbox"/> HIV         |
- Other medical problems: \_\_\_\_\_

**SURGERY:**

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- Previous joint replacement? Which & when? \_\_\_\_\_
- Back Surgery
- |  |                                       |  |   |  |
|--|---------------------------------------|--|---|--|
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall bladder  | <input type="checkbox"/> Thyroid        | <input type="checkbox"/> Hernia repair |
| <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Cancer surgery |  |
- Other surgeries: \_\_\_\_\_

**MEDICATIONS:**

Please list **ALL** medications you are currently taking: \_\_\_\_\_

Coumadin     Aspirin     Prednisone     Anti-inflammatory: \_\_\_\_\_

**ALLERGIES TO MEDICATIONS:**

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE ALLERGIC TO:

- |                                     |                                |                                  |                                 |                                  |
|-------------------------------------|--------------------------------|----------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Aspirin |
|-------------------------------------|--------------------------------|----------------------------------|---------------------------------|----------------------------------|
- Anti-inflammatories
- Other: \_\_\_\_\_

Do you smoke?     YES     NO    If yes, how much? \_\_\_\_\_

Do you drink alcohol?     YES     NO    If yes, how much? \_\_\_\_\_     Social Drinker

Illegal Narcotic Use?     YES     NO    Please explain: \_\_\_\_\_

Are you pregnant?     YES     NO    If yes, how far along? \_\_\_\_\_

**WHITE ROCK ORTHOPEDIC ASSOCIATION**

**ACKNOWLEDGEMENT OF REVIEW OF  
NOTICE OF PRIVACY PRACTICES**

**I have reviewed or have been given an opportunity to review, this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**PLEASE LIST BELOW ANY PERSON(S), DOCTORS OFFICE OR COMPANY WE MAY RELEASE YOUR MEDICAL INFORMATION TO.**

\_\_\_\_\_  
**Additional Authorized Patient Personal Representative**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Additional Authorized Patient Personal Representative**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Additional Authorized Patient Personal Representative**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Additional Authorized Patient Personal Representative**

\_\_\_\_\_  
**Relationship**

## WHITE ROCK ORTHOPEDIC ASSOCIATION FINANCIAL POLICY AND BILLING PROCEDURES

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION SHEET"
- FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE PREVIOUSLY BEEN MADE AND AGREED UPON
- REFERRALS, IF ANY ARE NECESSARY, MUST BE PRESENTED AT THE TIME OF YOUR VISIT

**The fees that we charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance companies can vary greatly on the types of coverage available. You will need to check with your insurance company regarding the specific coverage you may have.**

If you are an HMO or PPO patient, it is your responsibility to make sure all referral information from your primary care physician is in our office prior to your visit. We will require this referral authorization before we can render any services to you. If you do not provide the appropriate referral information at the time of your visit and services are rendered to you, you agree to pay our doctors their billed rate as a fee-for-service patient foregoing any health care insurance coverage you may otherwise have had.

If you have Medicare, we will file the claim forms representing services rendered to you as "assignment accepted".

If you have any secondary insurance, you agree to provide us with this information at the time of your visit so that we may file the appropriate claim forms for you.

All patients are responsible for paying their annual deductible balance, co-insurance payments, and any non-covered service charges at the time of your visit.

**We do not accept Medicaid or Worker Compensation patients other than for emergency room services.** If you are a Medicaid or Worker Compensation patient or anticipate applying for Medicaid or Workers Compensation for the payment of the services rendered to you, by signing this agreement you understand that our doctor is accepting you as a **private-pay patient** and not as a Medicaid or Workers Compensation patient for any non-emergent services rendered to you and that you will be responsible for paying for the non-emergent services you receive from any of our doctors. We will not file a claim to Medicaid or to any Worker Compensation insurance carrier for the non-emergent services provided to you. If your employer states that it is self-funded and agrees in writing to pay for the services rendered to you from its own funds, we will agree to bill your employer, however, you agree to be liable for the fee charged and agree to waive any rights you may have under the Texas Worker Compensation statutes should your employer fail to pay the claim(s) in full.

**Please remember that your insurance coverage is a contract between you and your insurance company. Coverage for services and levels of payment by your insurance company depend on the terms of the contract between you and your insurance carrier. You are responsible for any amounts not covered by your plan.**

I, \_\_\_\_\_, (Patient or legal guardian) HAVE READ THE ABOVE INFORMATION AND FULLY UNDERSTAND THAT I AM RESPONSIBLE FOR THE PAYMENT OF ALL APPLICABLE CHARGES AT THE TIME SERVICES ARE RENDERED. I AUTHORIZE THE RELEASE OF MY MEDICAL AND BILLING INFORMATION FOR THE PURPOSE OF PAYMENT OF INSURANCE BENEFITS TO MYSELF OR TO MY PHYSICIAN. I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MY INSURANCE POLICY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I WILL PAY TODAY'S CHARGES WITH:

- Personal Check       Cash       Visa       MasterCard       Discover