Account #_______________

COASTAL

ORTHOPEDICS, P.A.

SSN:_________________________________ **Patient Name:** ____

Date of Birth: ____ **Gender:** Male Female

Address:____ **City:** ____________________ **State:** ________ **Zip:** _________

Is the patient currently a resident of a Skilled Nursing Facility? Yes No

E-Mail Address: ____

Home Phone: ________________________________ **Work Phone:** ____________________________ **Cell Phone:** _____________________

Driver's License #:______________________ **State:** _______

Marital Status: Married Single Divorced Widowed

Employment Status: ____ Full-Time ____ Part-Time ____ Not Employed

Preferred Language: English Spanish **Patient Race:** White American Indian Unreported Black/African Am Asian Multi-racial

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unreported

Emergency Contact: __________________________ **Phone:** _____________________ **Relationship to patient:** _____________________

Responsible Party Information (Guarantor)

Patients Relationship to Guarantor: ____

Name: ____ **Date of Birth:** _____________________ **Gender:** Male Female

Address: ____ **City, State Zip** __________________________________

Phone: ____ **SSN:** ____

Authorization to Disclose Health Information

□ I give my authorization for Coastal Orthopedics to disclose and discuss my protected health information to the following family member or friend(s):

Name: ____ **Relationship:** ____

Name: ____ **Relationship:** ____

Appointment Reminder Authorization

We now offer Text Appointment Reminders for our patients. This convenient method is the most direct way for us to communicate to you the time and date of your next appointment. Please provide us the information necessary to receive your text appointment reminders in the future. We are committed to improving communication and service to our patients!

□ I grant permission for Coastal Orthopedics to utilize texting or email in order to inform me of my appointments.

Cell phone carrier: □ AT&T □ Verizon □ Sprint □ T-Mobile Other: ________________________

Patient/Guarantor Signature: ____ **Date:** ________________
(Parent /guardian if patient is a minor)

COASTAL

ORTHOPEDICS, PA

Policies and Notices

Patient Name: ____

The Patient and/or Guarantor for the account listed above acknowledge and agree to the following:
(Please initial Sections I-VI to confirm that you have read each section).

______ **I. CONSENT FOR TREATMENT:** I hereby consent to the evaluation and management services provided by Robert Williams, MD. Services may include diagnostic procedures such as x-rays and ultrasound. I understand that my consent may be revoked, in writing, at any time. However, such revocation does not release any financial obligation for services already rendered.

______ **II. RELEASE/OBTAIN INFORMATION:** By signing below I authorize (CO) to release to any insurance carrier represented as contractually responsible for payment in whole or in part of the my, or my dependent's, health care bill, such information as is deemed minimally necessary for the proper and accurate processing of such healthcare claims. Further, I understand that CO may provide to outside healthcare providers/services such information as is deemed minimally necessary to facilitate proper healthcare.

______ **III. STATEMENT OF FINANCIAL RESPONSIBILITY:** In consideration of medical treatment and service provided to the above-named patient, the patient or the undersigned Guarantor, unconditionally guarantees payment in full to Rob Williams, MD and CO. CO agrees to abide by the terms and conditions set forth in individual managed care contracts with which the patient and physician both participate. Claims on Patients covered by insurance that do not have a managed care contract with CO will submit for processing. However, the patient/guarantor is ultimately responsible for payment of the entire account balance regardless of insurance coverage or insurance benefit determination. Should an insurance carrier not pay on a claim within the mandatory 45-day State limit, the balance due will be the responsibility of the patient/guarantor. All co-pays are due at the time of service. The patient/guarantor understands he/she is responsible for providing accurate and complete information.

______ **IV. ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned hereby authorizes any insurance carrier represented as contractually responsible for payment in whole or in part of the patient's healthcare bill, including Personal Injury Protection or Medical Payment coverage, to pay directly to Rob Williams, MD and Coastal Orthopedics, PA proceeds and benefits payable to me. Additionally, I agree that any payments shall be applied toward any settlement or judgment I receive under any auto liability or uninsured/underinsured motorists coverage provided by Medical Payments coverage.

______ **V. PHYSICIAN OWNERSHIP DISCLOSURE:** During the course of your physician/patient relationship with Dr. Robert Williams, he may refer you to Coastal Imaging & Diagnostics or South Texas Surgical Hospital (the "Facility"). The address of the Coastal Imaging is 5945 McArdle Road, Corpus Christi, TX 78412. The address of South Texas Surgical Hospital is 6130 Parkway, Corpus Christi, TX 78414. Dr. Williams has an investment interest in the facility and therefore will receive, directly or indirectly, remuneration as a result of such referral. You have the option to choose to receive your care at a different facility and you will not be treated differently as a result of your decision.

______ **VI. NOTICE OF PRIVACY PRACTICES** I understand that as part of performing healthcare services, Coastal Orthopedics, PA (CO) creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I have been provided with a Notice of Privacy Practices (NPP) that provides a more complete description of the uses and disclosures of certain health information. I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures may have already been made based on my prior consent. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health care operations, be restricted. I also understand that CO and I must: agree to any restriction in writing on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

I acknowledge and accept the terms and conditions set forth in Sections I, II, III, IV and V of this policy statement:

Signed: ____ Date: ______________________

Relationship to Patient: ____________________________

COASTAL

ORTHOPEDICS, PA

Medical Records Release Authorization

Patient Name: _________________________________ DOB:_________________

Please release my medical records, including all reports, images, and related materials to:

Coastal Orthopedics, PA
5920 Saratoga Blvd. Suite 600-A
Corpus Christi, TX 78414
Fax: 361-994-7046

____ __________

Patient's Signature (or Parent if patient a minor) Date

COASTAL ORTHOPEDICS

New Patient Health History

Office use only: #

Please fill out this form to the best of your ability and feel free to ask us for help if you need it. Filling this form out completely will help us minimize any inconvenience to you.

Last Name: | First Name: | Date of Birth: | Gender: (M) (F)

Referral Source: | Primary Care Physician: | Pharmacy: | Pharmacy Location:

What problem may we help you with? | When did this problem start?

YOUR HEIGHT ft in

YOUR WEIGHT lbs

How did this problem occur?

I was injured as a result of:
- ☐ employment accident ☐ auto accident ☐ home accident ☐ other

Which other doctors have treated you for this?

What other treatments have you had for this problem?

Have any of these been helpful?

Has your problem been studied using any of the following tests within the last year?

- ☐ MRI scan ☐ CT scan / myelogram ☐ Nerve conduction study / EMG
- ☐ Bone scan ☐ Other tests: ______________________________

Which facility performed these studies?

Pain

1. Please rate your ***average*** level of pain over the last week: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
2. My pain is: (select one) ☐ constant ☐ intermittent
3. My pain is: (select one) ☐ sharp ☐ dull ☐ aching ☐ burning ☐ stabbing

YOUR GENERAL HEALTH: ☐ current flu vaccine ☐ current pneumonia vaccine ☐ current tetanus vaccine

- ☐ blood clots/DVT/PE
- ☐ coagulation defects
- ☐ congestive heart failure
- ☐ coronary artery disease
- ☐ heart attack
- ☐ heart disease
- ☐ MRSA (staph infection)
- ☐ religious affiliation - Jehovah's Witness
- ☐ sleep apnea
- ☐ GI bleeding

- ☐ alcohol abuse
- ☐ Alzheimer's disease
- ☐ anemia
- ☐ anxiety disorder
- ☐ arthritis (osteoarthritis)
- ☐ asthma
- ☐ atrial fibrillation
- ☐ bipolar disorder
- ☐ cancer
- ☐ COPD/emphysema
- ☐ dementia
- ☐ depression

- ☐ diabetes
- ☐ drug abuse
- ☐ fibromyalgia
- ☐ GERD (reflux)
- ☐ glaucoma
- ☐ gout
- ☐ hepatis
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ HIV/AIDS
- ☐ kidney disease
- ☐ liver/stomach/bowel disease

- ☐ migraine
- ☐ neurological disorders
- ☐ osteoporosis
- ☐ Parkinson's disease
- ☐ peripheral neuropathy
- ☐ prostate problems
- ☐ rheumatoid arthritis
- ☐ scoliosis
- ☐ seizures
- ☐ stroke
- ☐ thyroid disease
- ☐ tuberculosis

Please list any other medical conditions in these spaces. If you need additional room, attach additional pages.

Office Use

Vital Signs SYS DIA HR

YOUR ORTHOPEDIC HISTORY:

Which hand is your dominant hand? ☐ RIGHT ☐ LEFT

In this section, please provide as much detailed information as you can about any orthopedic surgeries you have undergone. Indicate which side the surgery occurred on (if appropriate), the specific name of the procedure you underwent, the surgeon who performed the procedure, and the year it was performed.

Side:	Procedure/surgery:	Surgeon:	Year:
R L			
R L			
R L			
R L			
R L			

Attach additional pages as required.

YOUR OTHER SURGICAL HISTORY:

Do you have any of the following: cardiac pacemaker, implanted defibrillator, spinal cord stimulator, vagal nerve stimulator, or implanted pain or baclofen pump? ☐ YES ☐ NO

- ☐ angioplasty/heart stenting
- ☐ aortic aneurysm repair
- ☐ appendectomy
- ☐ bladder surgery
- ☐ cataract removal
- ☐ ear, nose, or throat surgery
- ☐ gallbladder removal
- ☐ gastric bypass/other weight surgery
- ☐ hemmorhoidectomy
- ☐ heart bypass surgery
- ☐ hernia repair surgery
- ☐ kidney stone surgery
- ☐ large bowel resection/colectomy
- ☐ other abdominal surgery
- ☐ other heart/blood vessel surgery
- ☐ other kidney surgery
- ☐ release of abdominal adhesions
- ☐ removal of spleen (splenectomy)
- ☐ small bowel resection
- ☐ thyroid surgery
- ☐ tonsillectomy

Women only:

- ☐ c-section
- ☐ hysterectomy
- ☐ lumpectomy/mastectomy
- ☐ oopherectomy (ovary removal)
- ☐ other gynecological surgery
- ☐ tubal ligation

Men only:

- ☐ prostate surgery

Other Surgeries: Please list any other surgeries/procedures you have undergone.

YOUR SOCIAL HISTORY:

What is your current work status?

- ☐ Work full-time
- ☐ Currently work part-time
- ☐ Currently unemployed
- ☐ Retired
- ☐ Homemaker
- ☐ Disabled since: MM/DD/YYYY

What is your current living situation?

- ☐ Live independently with spouse
- ☐ Live independently alone
- ☐ Live with my parents
- ☐ Live with other family
- ☐ Live in an assisted-living facility or nursing facility
- ☐ Different living situation

Do you currently have children or other dependents in your home?

☐ Yes ☐ No Number of dependents: #

Tobacco Usage:

- ☐ Never smoked or used other tobacco
- ☐ Past smoker / tobacco user
- ☐ Current smoker:

Number of packs: # Number of years: #

Alcohol Consumption

- ☐ Do not drink
- ☐ Drink moderately (2 or fewer drinks per day)
- ☐ Drink 3 or more drinks per day

Education Level:

☐ currently in school or college

What is the highest level of education you completed? ____________________

Recreational Drug Use: ☐ none

- ☐ marijuana
- ☐ cocaine
- ☐ intravenous drugs
- ☐ other: ____________________

YOUR FAMILY'S HISTORY:

Please check the appropriate box if these conditions occur in your family. ☐ none

☐ anesthesia problems	☐ coagulation defects	☐ GI bleeding	☐ kidney disease	☐ other (listed below):
☐ blood clots	☐ COPD	☐ heart disease	☐ mental illness	FAMILY HX
☐ cancer	☐ diabetes	☐ high blood pressure	☐ thyroid disease	

REVIEW OF SYSTEMS:

Check the appropriate box if you are currently having any of these symptoms. If you aren't having any of them, please check "none".

General:	Cardiovascular:	Gastrointestinal:	Skin:
☐ none	☐ none	☐ none	☐ none
☐ fever	☐ chest pain	☐ vomiting	☐ rash
☐ chills	☐ palpitations	☐ diarrhea	☐ bumps
☐ recent weight loss	☐ chest tightness/pressure	☐ dark, tarry stools	☐ itching

Eyes:	Throat/neck:	Genitourinary:	General:
☐ none	☐ none	☐ none	☐ none
☐ sensitivity to light	☐ swollen glands	☐ difficulty urinating	☐ depression
☐ blurry vision	☐ goiter	☐ painful urination	☐ suicidal thoughts
☐ double vision	☐ neck stiffness	☐ blood in urine	☐ homicidal thoughts

ENT:	Respiratory:	Neuro:
☐ none	☐ none	☐ none
☐ nosebleeds	☐ coughing up blood	☐ seizures
☐ sore throat	☐ coughing up phlegm	☐ numbness
☐ ear ache	☐ shortness of breath	☐ dizziness

MEDICATIONS

Please list the names of current prescription and over-the-counter medications. You do not need to include vitamins or herbal supplements. The strength and dose does not need to be included.

Medications (NAMES ONLY). Do not include vitamins/herbals	(continued)
1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

ALLERGIES

Please list allergies and adverse reactions that you have to medications. Also list any allergies you have to food, animals, chemicals, etc.

☐ **I have no allergies or adverse reactions to disclose.**

Drug/Substance:	Your Reaction:

Please indicate whether or not you have any of the following allergies:

Ⓨ Ⓝ betadine allergy Ⓨ Ⓝ latex allergy Ⓨ Ⓝ tape/adhesive allergy

Ⓨ Ⓝ contrast injection allergy Ⓨ Ⓝ metal allergy

PATIENT'S STATEMENT

To the best of my knowledge, the questions on this form have been answered accurately and completely. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the physician or physician assistant of any changes in my medical status.

Patient signature (or parent/guardian if minor)

MM/DD/YYYY