Bone & Joint Clinic
TEXAS HEALTH CARE FORT WORTH

Name: _____ Age: _____ Date: _____

Chief Complaint: _____

When did problem begin: _____ Which side: ❑ Right ❑ Left

How did the pain begin: _____ Does it wak you up at night? Yes No

What makes the pain worse: _____

What makes the pain better: _____

Have you had any (circle): X-rays MRI CT scan BoneScan EMG Other: _____

When _____ Where _____ Ordered by: _____

Have you had any Physical Therapy: ❑ Yes ❑ No Are you still working? Yes No Light duty

Have you been hospitalized for this problem: ❑ Yes ❑ No By whom: _____

Medical History: (continue on back if needed)

Medical Problems: _____

_____

IMPORTANT: Please list all medication, vitamins, OTC pain relievers, or any other substance taken orally on a regular basis.

_____

_____

_____

Drug, Tape or Dye Allergies: _____

Previous surgeries: _____

_____

_____

Have you ever had a blood transfusion: Yes No

Family/Social History

Does anyone in your family have a history of: (circle)

Heart Disease	Diabetes	Arthritis	Stroke
Kidney trouble	Muscular disease	Mental Illness	Other: _____
Substance Abuse	Cancer (please specify): _____		

Parent's age and health (if deceased: age at death and cause):

Do you smoke? ❑ Yes ❑ No How much? _____ Have you ever smoked? ❑ Current ❑ Former ❑ Never

Do you drink? ❑ Yes ❑ No How much? _____

Females: Is there any possibility you are pregnant? ❑ Yes ❑ No

Are you experiencing any of the following? (circle)

Fever	Hearing Loss	Depression	Skin infections	Weight Loss	Vision Loss
Insomnia	Painful Urination	Neight Sweats	Heartburn	Adnormal bleeding	
Blood in Urine	Chest Pain	Loss of Appetite	Cough	Irrigular Heart Beat	
Dizziness	Shortness of Breath	Rashes	Seizures	Wheezing	

Reviewed: _____

SHOULDER ASSESSMENT FORM
AMERICAN SHOULDER AND ELBOW SURGEONS

Subject ID: _____	Subject Initials: _____	Date: _____
Side: R L	Device: RSP TSA Hemi	DOS:
Side: R L	Device: RSP TSA Hemi	DOS:

Circle the number in the box that indicates your ability to do the following activities:
0 = Unable to do 1 = Very Difficult 2 = Somewhat Difficult 3 = Normal

ACTIVITY	LEFT ARM	RIGHT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back/do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb/Wash Hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lbs. above shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhand	0 1 2 3	0 1 2 3
9. Do usual work- List:	0 1 2 3	0 1 2 3
10. Do usual sport- List:	0 1 2 3	0 1 2 3

Pain

On the following scale of 0 – 10, please **circle** your answer.
How bad is your pain today?

0 = No pain at all 10 = Pain as bad as it can be

0 1 2 3 4 5 6 7 8 9 10

Function

On the following scale of 0 - 10, please **circle** what you consider to be the current overall function of your shoulder.

0 = My shoulder is Useless 10 = My shoulder is Normal

0 1 2 3 4 5 6 7 8 9 10

SIMPLE SHOULDER TEST

Subject ID: _____	Subject Initials: _____	Date: _____

Answer each question below by checking "Yes" or "No":	YES	NO
1. Is your shoulder comfortable with your arm at rest by your side?	☐	☐
2. Does your shoulder allow you to sleep comfortably?	☐	☐
3. Can you reach the small of your back to tuck in your shirt?	☐	☐
4. Can you place your hand behind your head with your elbow straight out to the side?	☐	☐
5. Can you place a coin on the shelf at the level of your shoulder without bending your elbow?	☐	☐
6. Can you lift one pound (a full pint container) to the level of your shoulder without bending your elbow?	☐	☐
7. Can you lift eight pounds (a full gallon container) to the level of your shoulder without bending your elbow?	☐	☐
8. Can you carry twenty pounds at your side with the affected extremity?	☐	☐
9. Do you think you can toss a softball under-hand twenty yards with the affected extremity?	☐	☐
10. Do you think you can toss a softball over-hand twenty yards with the affected extremity?	☐	☐
11. Can you wash the back of your opposite shoulder with the affected extremity?	☐	☐
12. Would your shoulder allow you to work full-time at your regular job?	☐	☐

PRIVIA MEDICAL GROUP NORTH TEXAS

PHYSICIAN: _____ (BEING SEEN TODAY)

LOCATION: _____ DATE: _____

PATIENT REGISTRATION INFORMATION

If Patient cannot be billed for these services (for example, minor children), please complete RESPONSIBLE PARTY SECTION below as well as this patient registration information section.

Social Security #: _____ Driver's License # _____ State: _____

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Alt/Cell Phone: (___)_____ Day Phone: (___)_____ Email: _____

Race_____ Language_____ Ethnicity ☐ Hispanic/Latin ☐ Non Hispanic/Latin

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____

Emergency Contact: *(Please indicate a friend or relative not living at the same address.)*

_____ _____ (___) _____
NAME RELATIONSHIP EMERGENCY CONTACT #

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient is responsible unless a minor child or guardian. RESPONSIBLE PARTY SECTION must be completed.

Patient Relationship to Responsible Party: Child ____ Other _____ Resp. Party SS #: _____
SPECIFY

Name: _____ ___ ___ ___/___/___ ___ S M D W O
LAST FIRST MI SEX DATE OF BIRTH (MM DD YY) AGE MARITAL STATUS

Address: _____ _____ ___ _____ (___) _____
MAILING ADDRESS APARTMENT CITY ST ZIP HOME PHONE

Full-Time Part-Time Retired Unemployed Student Employer's Name: _____
EMPLOYMENT STATUS (PLEASE CIRCLE ONE) or School

Employer's Address: _____ _____ ___ _____
MAILING ADDRESS CITY ST ZIP

Occupation: _____ (___) _____ (___)
WORK PHONE EXT

OTHER PATIENT INFORMATION

Spouse's Name: _____ Employer: _____

___/___/___ Spouse's Work Phone: (___) _____(_____) Occupation: _____
DATE OF BIRTH EXT

PRIMARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (___) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ___/___/___ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other_____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Address: _____ _____ _____ _____
STREET CITY ST ZIP

SECONDARY INSURANCE

Please complete the information below and provide a copy of the insurance card.

Insurance Company: _____ Address: _____ (____) _____
STREET or P.O. BOX PHONE

Co-Pay Amount: (if applicable) _____ _____ _____ _____
CITY ST ZIP

Primary Care Physician: _____

Policy Holder: _____ ___ ___ ____/____/____ _____
LAST FIRST MI SEX DATE OF BIRTH SS #

Patient Relationship to Insured Party: Self___ Spouse___ Child___ Other _____
(SPECIFY)

Employer's Name: _____ _____ _____
INSUREDS ID GROUP NAME AND/OR NUMBER

Employer's Address: _____ _____ _____ _____
STREET CITY ST ZIP

WORKER'S COMPENSATION

Worker's Compensation Insurance Name: _____

Address: _____ City: _____ State _____ Zip _____ Adj. _____

Claim #: _____ DOI _____ Phone _____

What Employer: _____

ACCIDENT INFORMATION

Was this the result of an accident? ___Yes ___No Where did it occur? ___At Work ___Auto Accident ___Other

Date of Accident_____Have you reported this injury to your employer? ___Yes ___No When _____

Describe accident briefly: _____

Do you have an attorney representing you? ___Yes ___No Who is the attorney? _____

REFERRAL INFORMATION

Who referred you? _____ Address: _____ Phone: _____

Family Physician _____ Address: _____ Phone: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/NOTICE OF PRIVACY PRACTICES/APPOINTMENT OF AUTHORIZED REPRESENTATIVE

PLEASE READ

Privia Medical Group North Texas (PMG), and its physicians are committed to securing the privacy of your health information. Accord-ingly, we have posted our "Notice of Privacy Practices" in the reception area. You are not required to read this notice. However, we would like your acknowledgement that you have been advised that PMG has such a Notice of Privacy Practices.

I hereby assign, transfer and set over to PMG, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint PMG to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If surgery is indicated, I am responsible for furnishing insurance claim forms to the office prior to surgery.

_____ _____ _____ _____
PATIENT SIGNATURE DATE WITNESS SIGNATURE