DATE:_____

Paris Orthopedic Clinic, P.A.

Patient Information

PLEASE FILL OUT COMPLETELY!

PERSONAL INFORMATION

Patient Name: _____ (Last / First / Middle) Gender: ____ Doctor: _____

Address: _____ (Street and/or P.O. Box / City / State / ZIP)

Patient D.O.B: _____ SS#: _____ CIRCLE ONE **CELL HOME** Phone: _____

Marital Status: M S W D DL#: _____ (State) **CELL HOME** Phone: _____

This information is a requirement of the Affordable Care Act

Language Spoken: _____

Race? ☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ Native American ☐ Other_____

Ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Email Address (PLEASE PRINT CLEARLY): _____

Employer: _____ Phone: _____

Employer's Address: _____ (Street and/or P.O. Box / City / State / ZIP)

Spouse's Name: _____ Phone: _____

Contact Not Living with You: _____ Phone: _____

IF PATIENT IS A MINOR:

Father: _____ Phone: _____

Father's DOB: _____ SS #: _____ Phone: _____

Mother: _____ Phone: _____

Mother's DOB: _____ SS #: _____ Phone: _____

HEALTH INFORMATION

Which E.R. did you go to? _____ **Is This a Worker's Comp Injury?** ____ YES ____ NO

Referring Physician (First & Last Name): _____ **Date of Accident:** _____

Primary Care Physician (First & Last Name): _____

Problem Being Seen For: _____ **RIGHT or LEFT**

Pharmacy Preferred (Street Name and City) : _____

PRIMARY INSURANCE

Insurance Company: _____ Phone: _____

Policy / ID # : _____ **Group # :** _____

Employer: _____ Phone: _____

Policy Holder's Name: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's DOB: _____ SS #: _____ Phone: _____

Policy Holder's Address: _____ (Street and/or P.O. Box / City / State / ZIP)

SECONDARY INSURANCE

Insurance Company: _____ Phone: _____

Employer: _____ **Policy / ID # :** _____ **Group # :** _____

Policy Holder's Name: _____ Patient's Relationship to Policy Holder: _____

Policy Holder's DOB: _____ SS #: _____ Phone: _____

FINANCIALLY RESPONSIBLE PARTY

Responsible Party's Name: _____ Patient's Relationship to Guarantor: _____

Resp Party's DOB: _____ SS #: _____ Phone: _____

Address: _____ (Street and/or P.O. Box / City / State / ZIP)

SIGNATURE

I affirm the information stated above is true and correct to the best of my knowledge. I hereby authorize Paris Orthopedics & Sports Medicine to release information acquired in the course of my treatment for the purpose of obtaining insurance benefits. I understand that in the event the liable party does not pay my medical expenses I will be responsible for all charges. I also hereby authorize payment to be made directly to Paris Orthopedics & Sports Medicine for services that would otherwise be payable to me. I also authorize Paris Orthopedics & Sports Medicine to acquire any and all of medical records including my prescription medication history from other healthcare providers or third party pharmacy database for medical treatment purposes. Paris Orthopedics & Sports Medicine complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature of Patient or Legally Authorized Representative: X_____

Patient Osteoporosis History

Paris Orthopedics and Sports Medicine

Office Use ONLY
Blood Pressure: _____
Temperature: _____
Heart Rate: _____

Date: _____

Patient Name: _____

DOB: **Age:** **Sex:** **Current Height:** **Maximum Height:** **Weight:**

Have you been diagnosed with osteoporosis or osteopenia? Yes or No **Who is your PCP?** _____

Have you had a fracture after the age of 50? _____ **How did it occur?** _____

When was your last DEXA? _____

Where was it performed? _____

Has a grandparent, parent, or sibling had osteoporosis or a fall that resulted in a fracture? Yes or No

Do you have a history of any of the following?
IF NONE CHECK HERE: ☐

Diabetes	Y N	*COPD/Asthma*	Y N
Seizures	Y N	*GERD/Reflux*	Y N
Kidney disease	Y N	*Thyroid Issue*……	Y N
Cancer	Y N	*Radiation treatments*	Y N
Rheumatoid Arthritis	Y N	*Lupus*	Y N
Blood clots	Y N	*Difficulty swallowing*	Y N

Have you ever taken any of the following medications?

Fosamax/Alendronate	Reclast	Tymlos	*Seizure meds*
Boniva/Ibandronate	Prolia	Evista	Chemotherapy
Actonel/Risedronate	Forteo	*Topamax*	*Prednisone/steroids*

Men: Have you had testosterone levels check? Yes or No

Women: When did you go through menopause? _____

Were you ever placed on hormones? Yes or No

Have you ever had any of the following surgeries?

Hysterectomy complete or partial	Year: _____	Joint replacement	Year: _____
Oopherectomy (ovaries)	Year: _____	Spinal surgery	Year: _____
Lap band, gastric sleeve, gastric bypass	Year: _____		

Do you take calcium, vitamin D or K, or multivitamins?

1. _____	**Dosage:** _____	**1** _____	**5** _____
2. _____	**Dosage:** _____	**2** _____	**6** _____
3. _____	**Dosage:** _____	**3** _____	**7** _____
4. _____	**Dosage:** _____	**4** _____	**8** _____

What are your current medications?

Medication allergies? _____

Do you exercise regularly? _____

Have you had more than 2 falls in the last year? _____

Do you use an assistive device for mobility? cane walker wheelchair scooter

Do you Smoke? *Currently Never Former* **Packs per day?** _____ **Year Started?** _____ **Year Stopped?** _____

Do you use Smokeless Tobacco? *Currently Never Former* **Year Started?** _____ **Year Stopped?** _____

Do you drink Alcohol? *YES or NO* **How Frequently?** _____

What is your current living situation? Living at home Living with family Assisted living facility Nursing Home

STEVEN D. ROWLAN, M.D.
S. DREW TEMPLE, M.D.
DAVID J. DE LA GARZA, M.D.
GREGORY V. GREEN, M.D.

MARK B. GIBBS, M.D.
MICHAEL P. ELLIOTT, D.O.
CARMEN L. HOLMES, P.A.

PRIVACY PRACTICE ACKNOWLEDGEMENT

I acknowledge I have been given the opportunity to receive a copy of Paris Orthopedic Clinic's Notice of Privacy Practices.

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement.
- ☐ An emergency situation prevented us from obtaining acknowledgment.
- ☐ Other (please specify)

****

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

☐ I _____ hereby **authorize** the release of medical information (by telephone, mail or otherwise) by physicians and staff of Paris Orthopedics and Sports Medicine to (please list name and relationship)

Name/Relationship	**Address/Phone Number**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

☐ I **DO NOT** authorize the release of medical information to my family members.

_____

Patient Signature Date

Paris Orthopedics and Sports Medicine

Policy: Opioid Prescriptions	
Approved by: Board of Directors	**Date Approved**: 08/30/2019 **Date Revised:** 09/06/2019

Policy:

Effective September 1, 2019, Texas House Bill 2174 states that for the treatment of acute pain, a provider may not issue a prescription for an opioid in an amount that exceeds a 10-day supply and may not provide for a refill of an opioid.

As a result of Texas House Bill 2174 and in the effort to help curb opioid abuse in the United States, Paris Orthopedics and Sports Medicine (POSM) will follow the procedure outlined below when prescribing opioids.

Procedure:

1. Patients referred by a medical provider to POSM: The referring provider is responsible for managing all pain medications until a final treatment plan has been recommended by a provider at POSM. The final treatment plan is dependent upon the POSM provider having all of the diagnostic tests available for his/her review in order to make a diagnosis and recommend a treatment plan.

2. Patients who are self-referred to POSM and are non-operative: In the event a non-operative treatment strategy is implemented, and opioid pain management is required, it will be limited to 10 days.

3. Post-operative patients: In the event surgery has been performed by a surgeon at POSM, postoperative opioid pain management by POSM will be limited to 10 days. Careful reassessment will take place for further prescription needs. Much of what we treat is painful, and we want to be sure that your pain and recovery is well managed.

4. If the patient has a pain management doctor, the patient is responsible for notifying their pain management doctor of any procedures that may require alterations in their pain management regimen.

5. Patients who have a current pain management contract with an outside provider: POSM will not assume refilling baseline prescriptions for those patients who are on opiates for chronic pain or under the care of a pain management physician.

I have read and agree to the Paris Orthopedics and Sports Medicine Opioid Policy

_____ _____ _____

Patient Name (Please Print) Signature of Patient or Guardian Date