WELCOME TO DR WARNOCK'S OFFICE

Please Help Us By Filling Out The Questionnaire Completely

Name____ Date__________________

Age____ Sex_____ Date of Birth__________ Height_____ __ Weight_______

Have you or a family member been seen by Dr Warnock? ___Yes ___No

Who referred you to Dr Warnock? Circle below

Emergency Room Physician Insurance

Internet Friend Other

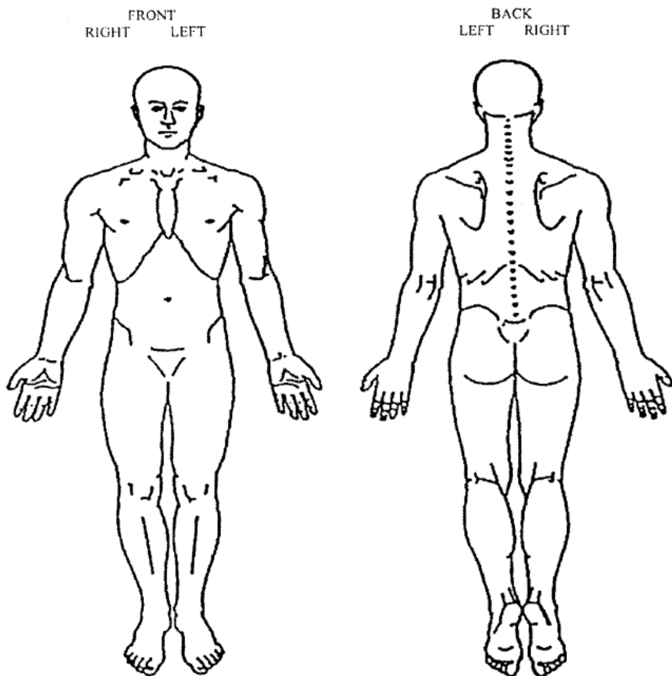
If other please list: ____________________

My Primary Care Physician/Pediatrician is:
____

The main reason for my visit today is:
____
____

Please circle the area where the pain/injury is located:

_____Right _____Left _____Both



Pain Level on a Scale of 1-10 ______

The date my injury/symptoms started was:
____
____

I have had this pain for how long:

______Days
______Months
______Years

Is this a work related injury?
____Yes ____No

Describe how your injury occurred: Fall, etc
____
____

The pain is worse when I:
____
____

The pain is better when I:
____
____

I have had the following for this condition:
_____ Medication
_____ Injections
_____ Physical Therapy
_____ Xrays
_____ MRI
_____ Surgery

Please list all doctors you have seen for this problem:
_____Primary Care Physician
_____ER doctor
_____Chiropractor
_____Trainer
_____Work Doctor
_____Other_______________________

My goal for this visit is:
____

Medications

_____I am taking no medications

I take the following Medications:
(include Herbal medications)

____
____
____

Blood thinners:
_____Coumadin
_____Aspirin
_____Plavix

Medical History

_____I have No Medical conditions or Illnesses

List your Current medical conditions

____
____
____

Allergies

_____I have no known Allergies

I am allergic to the following:
_____X-ray dye
_____Iodine
_____Shell Fish
_____Medications (Please List)

____
____

Orthopedic Surgery History

____
____

Surgical History

Please list all other prior surgeries

____
____
____

Family History

List of diseases that may be hereditary
_____Hypertension _____ Diabetes
_____Heart Problems _____ Epilepsy
_____Osteoporosis _____ Stroke

Review of major medical events among your immediate family members.
(Father, Mother, Brothers, Sisters)

____
____
____

Social History

Occupation ___________________________

Marital status:
_____Single _____ Divorced
_____Married _____Widowed _____ Other

Tobacco:
_____Yes
_____No

Alcohol:
_____never
_____social
List type and amount per week__________.

Drugs:
_____never
_____prescription
_____illegal

When last used___________________________
Name of drug used________________________

Please circle the Following describing any symptoms you may have:

ROS:

Fever	Loose teeth
Chest Pain	Angina
Skin infections	Rashes
Cracked teeth	Weakness
Mouth/Tooth Infection	Gout
Head or eye problems	bleeding
Difficulty breathing	Depression
Difficulty urinating	Anxiety
Infections	Hot flashes
Irregular menstrual cycles	clotting disorder

No problems with general anesthesia

I have had the following problems with Anesthesia:

____
____

PATIENT INFORMATION SHEET

Date:____________________ Account#____________________

Patient's **LEGAL** name:____ Date of Birth:______________
(First) (Middle) (Last)

SS#____________________ Address: ____
(Street) (Apt#) (City, State, Zip Code)

Home# ______________________ Work#______________________ Cell#__________________________

Marital Status: M S D W (Circle One) Sex: Male / Female (Circle One) Ethnicity: __________________________

Employer/School Name: ____

Address: ____ Occupation: ____________________
(Street) (City, State, Zip Code)

If patient is a Minor – Name of person responsible: ______________________________ Relationship: __________________

Address: ____ Home# ________________Cell#________________
(Street) (City, State, Zip Code)

PRIMARY INSURANCE: INS Holder's **LEGAL** name: ____

Relationship to Patient: ____________________________ Date of Birth: ______________ SS#_______________________

Insurance Co: ________________________ PH# ________________ Policy #_________________ Group#____________

Employer Name/ Address: ____PH#________________

SECONDARY INSURANCE: INS Holder's **LEGAL** name:____

Relationship to Patient: ____________________________ Date of Birth: ______________ SS#_______________________

Insurance Co: ________________________ PH# ________________ Policy #_________________ Group#____________

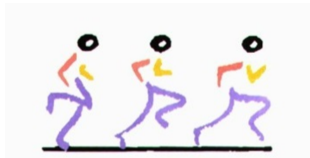
Employer Name/ Address: ____PH#________________

EMAIL ADDRESS: ____ Preferred Language:_________________

PHARMACY NAME: ________________________ PHARMACY PHONE # ____________________________________

I hereby authorize the Fondren Orthopedic Group L.L.P. to receive payment of the surgical/medical benefits for services and of the release of any information acquired for processing insurance claims and to other doctors or health care facilities and I hereby unconditionally guarantee full and prompt payment of all services and product charges rendered to me.

Signature:____ Date: _________________________



Fondren Orthopedic Group, L.L.P.

K. Mathew Warnock, M.D., P.A.
ORTHOPEDIC SURGERY
SPORTS MEDICINE
Board Certified

7401 S. Main St.
Houston, TX 77030
(713) 799-2300

18220 State Hwy 249, Suite 330
Houston, TX 77070
(281) 807-4380

Authorization for the Use and Disclosure of Information

This authorization must be dated and signed by the consumer or a person authorized by law to give this authorization. File copy and facsimile transmission are considered equivalent to the original (unless applicable state law provides otherwise).

The Employee Retirement Income Security Act (ERISA) mandates that carriers respond to appeals only from a member or a member's personal representative. I authorize Fondren Orthopedic Group, L.L.P. to be my personal representative, which allows their providers to, **(1)** submit any and all appeals when my insurance company denies my benefits to which I am entitled, **(2)** submit any and all aspects for benefit information from my insurance company, and **(3)** initiate formal complaints to any state of federal agency that has jurisdiction over my benefits. I also agree that any fines levied against my insurance company will be paid to the above physician group for acting as my personal representative.

I ____ authorize Fondren Orthopedic Group, L.L.P., and its subsidiaries/affiliates, to use or disclose my medical, claim, or benefit records, including identifiable health information contained in these records, as described below. I understand these records may contain information created by other persons or entities, including health care providers as well as information regarding mental health services [Note: psychotherapy notes may be used/disclosed only pursuant to a separate authorization pertaining only to psychotherapy notes].

I understand that once health information about me has been disclosed by Fondren Orthopedic Group, L.L.P. to a third party, the health information may no longer be protected under federal privacy laws.

Fondren Orthopedic Group, L.L.P.
Printed Name of Consumer's Representative

PROVIDER
Relationship to consumer

____
Signature of Consumer

____
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 note specifically listed on this form.)

Please list those person's (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other Doctors/Specialist 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 another individual in your absence. **Is it OK for such messages 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? ____________________

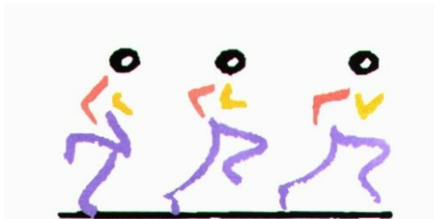
Other: ____

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

May we contact you by email to obtain feedback or suggestions to help improve our practice as well as any feedback or personal testimony regarding your care or your experience in our office? ___YES___NO

Email: ____

______________________________	______________________________
Signature of Patient or Legal Representative	**Date**



FONDREN ORTHOPEDIC GROUP, L.L.P.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I, [name of patient] ____, acknowledge and agree that I have reviewed a copy of **Fondren Orthopedic Group'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

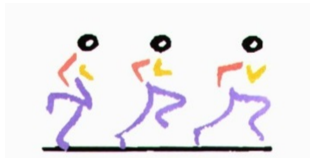
Clinic Use Only:

Fondren Orthopedic Group, L.L.P. made the following good faith efforts to obtain the above-referenced individual's written acknowledgment of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgment, including the reasons (if known) why the written acknowledgment was not obtained.]**:

____
____
____
____

____________________________________ ____________________________________
Signature of Employee Date

____________________________________ ____________________________________
Print Name of Employee Date



Fondren Orthopedic Group, L.L.P.

Patient Name: ________________________________ Clinic ID: Willowbrook-Dr. K Mathew Warnock

Insurance Company: ___________________________ S.S.# ________________________________

Provider Number: ______________________________ Statement Group: _______________________

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information accquired in the course of my examination and/or treatment.

I understand this may include the release of any medical and other information required in the process of claims for payment. I also authorize the release of information to another doctor or healthcare facility to which the patient may be transferred or referred.

MEDICARE/MEDICAID – PATIENT'S CERTIFICATION: I certify that the Medicare/Medicaid information given by me is correct. As this office does accept assignment with Medicare/Medicaid, this information will be used for the processing my Medicare/Medicaid claims for payment. I also understand, due to government regulations, that if Medicare coverage is available to me, I must inform my physician. I also understand, if in addition to Medicare/Medicaid, I am covered under an **EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKER'S COMPENSATION,** or any other insurance which may be responsible for payment, I must inform this office.

I have read and understand the above statement regarding MEDICARE/MEDICAID coverage.

- ☐ Medicare is my primary coverage.
- ☐ Medicaid is my primary coverage.
- ☐ Medicare is my secondary coverage.
- ☐ Medicaid is my secondary coverage.
- ☐ I am NOT covered by MEDICARE or Medicare HMO.
- ☐ I am NOT covered by Medicaid or a Medicaid HMO.
- ☐ This is a work-related condition, injury or symptom.
- ☐ This is NOT a work-related condition, injury, or symptom.
- ☐ Payment is required today for all copays, deductibles, Co-insurance amounts that may be due by the patients.

ASSIGNMENT OF BENEFITS: I hereby authorize payment to the Fondren Orthopedic Group, L.L.P. of the surgical and or medical benefits, if any, otherwise payable to me for the services I have received.

FINANICAL OBLIGATION: The undersigned hereby unconditionally guarantees full and prompt payment of all charges incurred as a result of services rendered to me during the course of my medical treatment.

______________________________________ ______________________________________

Signature of Insured/Guardian Date Witness Date