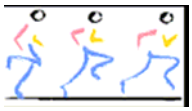


Fondren Orthopedic Group L.L.P.

Patient Information	**Provider #:**		**Account Number:**	
Patient's Name (First MI Last)	**Gender** M☐ F☐ **DOB** **Age**		**DL#**	**SSN**
Address	**City** **State**		**Zip Code**	**Home Ph:** **Cell Ph:**
Email Address	**Race**		**Ethnicity**	**Preferred Language**
Patient's Employer	**Business Phone**		**Marital Status** M☐S☐D☐W☐	**Referring / Primary MD**
Employer Address			**Employer #**	
Spouse's Name	**Spouse's Employer**		**DOB**	**SSN**

Guarantor Information (if patient is a minor)			
Guarantor's Name	**Relationship to Patient**	**DOB**	**SSN**
Billing Address	**City** **State**	**Zip Code**	**Emergency Phone**

Insurance Information			
Insurance Carrier Name-Primary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN** **DOB**	**Relationship**
Insurance Carrier Name - Secondary	**Identification Number**	**Group Number**	**Ins. Phone Number**
Name of Policy Holder	**Employer**	**SSN** **DOB**	**Relationship**

What other ways may we contact you? Please circle YES or NO if you would like us to leave a message at the numbers you provide:

Home #: YES or NO **Work #:** YES or NO **Cell:** _____ YES or NO **Other #:** _____ YES or NO

FAMILY AND FRIENDS: Please let us know what persons we may share info with (i.e. family, friends, other doctors etc.) and list them below:

NAME RELATIONSHIP TO YOU PHONE #

1. _____

2. _____

3. _____

Please check one of the following: ☐ This **IS** a work-related injury. ☐ This **IS NOT** a work-related injury

MEDICARE / MEDICAID - PATIENT'S ONLY

I certify that the MEDICARE information given by me is correct. As this office does accept assignment with Medicare, this information will be used for the purpose of processing my Medicare claims for payment. I 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, I am covered under an EMPLOYER GROUP HEALTH INSURANCE, LIABILITY, NO-FAULT, WORKERS' 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 coverage.

☐ Medicare is my **primary** coverage.
☐ Medicare is my **secondary** coverage.
☐ I **am not** covered by Medicare or a Medicare HMO

☐ Medicaid is my **primary** coverage.
☐ Medicaid is my **secondary** coverage.
☐ I **am not** covered by Medicaid or a Medicaid HMO

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

FINANCIALOBLIGATION: The undersigned Hereby unconditionally guarantees full and prompt payment of all personal balances incurred as a result of services rendered to me during the course of my medical treatment.

☐ Payment is required today for all co-pays, deductibles, or co-insurance amounts that maybe due by the patient.

X_____ _____
Signature of Patient/Parent/or Guardian Date

RELEASE OF INFORMATION: I hereby authorize Fondren Orthopedic Group, L.L.P. to release any or all information acquired in the course of my examination and / or treatment. I understand that this may include the release of any medical or other information required in the processing of claims for payment. I also authorize the release of information to another doctor or health care facility to which the patient may be transferred or referred.

X_____ _____
Signature of Patient/Parent/or Guardian Date

CONSENT TO CARE: I authorize and direct Fondren Orthopedic Group, L.L.P. to perform upon me injections, draw blood and / or any other procedure or treatments the doctor may in his best judgment determine advisable for my well being.

X_____ _____
Signature of Patient/Parent/or Guardian Date

WELCOME TO DR. WARNOCK'S OFFICE

Name_____ Date_____

Age_____ Sex_____ Date of Birth_____/_____/_____ Height_____ Weight_____

Pharmacy Name/ Location:_____ Pharmacy Phone #_____

Have you or a family member been seen by Dr. Warnock?
_____Yes _____No

Who referred you to Dr. Warnock? Circle Below

Emergency Room Physician Internet

Insurance Friend Other

If other please list:

_____

The main reason for my visit today is:

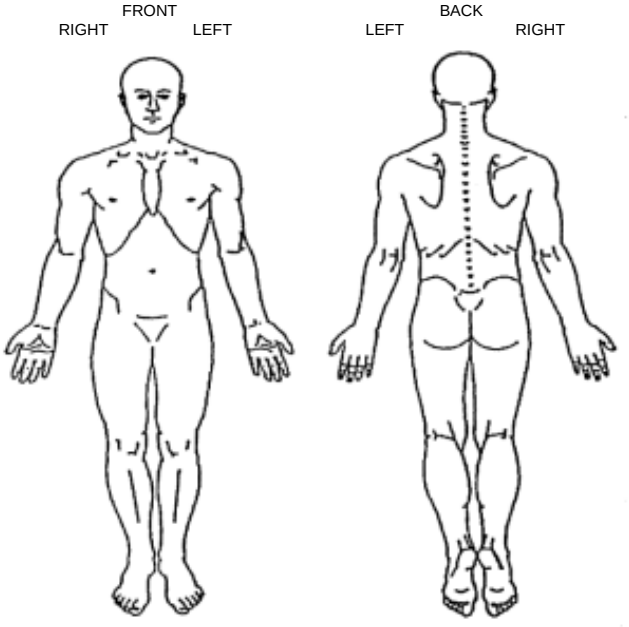
_____

_____

Pain Level on a Scale of 1-10 _____

My pain/injury is located: ____Right ____Left ____Both

Please circle the area where you hurt.



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 treatment(s) for this problem:

_____ Medication
_____ Injections
_____ Physical Therapy
_____ X-rays
_____ MRI
_____ Surgery

For this problem I have seen:

_____ Primary Care Physician
_____ ER Doctor
_____ Chiropractor
_____ Trainer
_____ Work Doctor
_____ Other _____

Medications

I take the following Medications:

_____

_____

_____

Do you take Blood Thinners? Yes / No

Allergies

I am allergic to the following:

_____ X-ray dye
_____ Iodine
_____ Shell Fish
_____ Penicillin
_____ Codeine
_____ Medications (Please List)

_____

Medical History

List your Current medical conditions:

_____

_____

_____

Are you a Diabetic? Yes / No

Do you take Insulin? Yes / No

Are Immunizations up to date? Yes / No

Is Flu Vaccination up to date? Yes / No

Surgical History

Please list all prior surgeries:

_____

_____

_____

Social History

Occupation _____

Marital status:
_____ Single _____ Divorced
_____ Married _____ Widowed

Tobacco: How Often:
_____ Yes _____ Per Day
_____ No _____ Other

Alcohol:
_____ Never
_____ Social
List type and amount per week _____

Family History

List of diseases that run in your family:

_____ High Blood Pressure
_____ Diabetes
_____ Heart Problems
_____ Arthritis
_____ Cancer
_____ Gout

Ethnicity _____

Please circle the following, describing any symptoms you may have:

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
Numbness/Tingling	

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

FONDREN ORTHOPEDIC GROUP L.L.P.

I, _____, 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, LLP made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]:**

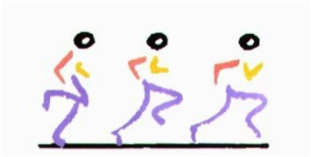
_____

_____

_____

_____ _____
Signature of Employee Date

_____ _____
Print Name of Employee Title



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