Greater Dallas
Orthopaedics

Al Mollabashy, MD
Donald W. Hohman, Jr. MD
Cyrus Abbaschian, MD
Nathan F. Gilbert, MD

Jeffery Neumann, PA-C
Brittany Kovalic, PA-C

12230 Coit Road, Suite 100 • Dallas, Texas 75251
P: 214-252-7020 • F: 214-252-7025 • www.gdortho.com

Patient Name: _____ Social Sec Number: _____-_____-_____

Date of Birth: _____/_____/_____ Age: _____ Sex: M / F (circle one) Married Single Divorced Widow

Mailing Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email Address: _____

Employer Name: _____ Employer Phone #: (_____) _____-_____

Employer Address: _____ City: _____ State: ____ Zip: _____

Referring Physician: _____ Phone #: (_____) _____-_____

Primary Care Physician: _____ Phone #: (_____) _____-_____

Pharmacy: _____ Phone #: (_____) _____-_____

Person responsible for bill or parent (Complete only if different from patient)

THE ADULT ACCOMPANYING A MINOR TO HIS/HER APPOINTMENT IS RESPONSIBLE FOR PAYMENT

Guarantor Name: _____ Social Sec Number: _____-_____-_____

Relationship to Patient: _____ Date of Birth: _____/_____/_____

Address: _____ Phone #: (_____) _____-_____

Employer Name: _____ Employer Phone #: (_____) _____-_____

Employer Address: _____ City: _____ State: ____ Zip: _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Employer: _____ Employer Address: _____

Policy Holder's Social Sec Number: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ ID #: _____ Group #: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder Employer: _____ Employer Address: _____

Policy Holder's Social Sec Number: _____-_____-_____ Policy Holder's Date of Birth: _____/_____/_____

Greater Dallas
Orthopaedics

Al Mollabashy, MD
Cyrus Abbaschian, MD
Nathan F. Gilbert, MD

Jeffery Neumann, PA-C
Brittany Kovalic, PA-C

PATIENT HISTORY SURVEY

Patient Name: _____ ❑ M ❑ F Date of Birth: _____/_____/_____

Did you bring X-rays? ❑ Y ❑ N Labs? ❑ Y ❑ N Height: _____ Weight: _____

WHY ARE YOU HERE? **(CHIEF COMPLAINT)**: _____

_____

HISTORY OF PRESENT ILLNESS

WHAT BODY PART IS INVOLVED: ❑ R ❑ L ❑ Shoulder ❑ Arm ❑ Elbow ❑ Forearm ❑ Wrist/Hand ❑ Hip ❑ Thigh ❑ Knee ❑ Leg ❑ Ankle ❑ Foot ❑ Neck ❑ Back

How long have you had this problem: _____ ❑ Days ❑ Weeks ❑ Months ❑ Years

Did you have an injury? When? How? _____

_____

_____

ONSET: ❑ Gradual ❑ Sudden PAIN: ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe

PAIN QUALITY: ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning

ASSOCIATED SYMPTOMS: ❑ Swelling ❑ Numbness ❑ Weakness ❑ Other _____

SINCE PROBLEM STARTED: ❑ Getting Better ❑ Getting Worse ❑ Unchanged

DOES PAIN WAKE YOU FROM SLEEP: ❑ Yes ❑ No

WHAT MAKES YOUR SYMPTOMS WORSE: ❑ Activity ❑ Exercise ❑ Work

WHAT MAKES YOU FEEL BETTER: ❑ Rest ❑ Heat ❑ Ice ❑ Elevation ❑ Other _____

DO YOU HAVE THE FOLLOWING: ❑ Fever ❑ Chills ❑ Sweats ❑ Weightloss

DO YOU HAVE DIFFICULTY WITH CONTROL: ❑ Bowel ❑ Bladder

TREATMENTS TRIED: ❑ Injection ❑ Brace ❑ Therapy ❑ Cane/Walker ❑ Chiropractor ❑ Other _____

PREVIOUS ORTHOPAEDIC HISTORY

PREVIOUS INJURIES: _____

_____

❑ Previous Joint Replacement ❑ Previous Fracture Surgery ❑ Previous Bone/Joint Infection

PREVIOUS TEST: ❑ X-Ray ❑ Bone Scan ❑ CT Scan ❑ MRI ❑ EMG/Nerve ❑ Other _____

Physician's Notes

PAST MEDICAL HISTORY

❑ Bleeding Problems ❑ HIV ❑ Emphysema ❑ Stroke ❑ Migraines ❑ Asthma ❑ Hepatitis ❑ Polio
❑ Anemia ❑ Fibromyalgia ❑ Osteoporosis ❑ Stomach Problems (Reflux, Ulcers) ❑ Arthritis ❑ Heart Problems
❑ Neuropathy ❑ Thyroid Problems ❑ Diabetes ❑ Kidney Problems ❑ Pneumonia ❑ Blood Clots
❑ Pulmonary Embolism ❑ Epilepsy ❑ High Blood Pressure ❑ Psychiatric ❑ Depression/Anxiety
❑ Rheumatoid Arthritis ❑ Gout ❑ Lupus ❑ Myopathy ❑ Lupus ❑ Gout ❑ Lupus

CANCER HISTORY

❑ Breast ❑ Prostate ❑ Lung ❑ Thyroid ❑ Colon ❑ Kidney ❑ Myeloma ❑ Lymphoma
❑ Skin Cancer ❑ Other _____

PAST SURGICAL HISTORY

Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____
Date: _____ Surgery: _____

SOCIAL HISTORY

Do you use tobacco? ❑ Y ❑ N Packs per day: _____ Years of Use: _____
Do you use alcohol? ❑ Y ❑ N ❑ Daily ❑ Weekly
Marital History: ❑ Single ❑ Married ❑ Divorced ❑ Widow
Employment: ❑ Student ❑ Disabled, how long: _____ ❑ Occupation: _____ Duration: _____

FAMILY HISTORY

❑ Diabetes ❑ Heart Disease ❑ High Blood Pressure ❑ Blood Clotting Problems ❑ Arthritis ❑ Cancer: _____

REVIEW OF SYSTEMS

❑ Chest Pain ❑ Constipation ❑ Abnormal Bleeding ❑ Abnormal Menstrual Cycle ❑ Cough ❑ Depression
❑ Cold Hands/Feet ❑ Growth Disturbance ❑ Incontinence Bowel ❑ Incontinence Urine ❑ Loss of Appetite
❑ Ear Pain ❑ Muscle Weakness ❑ Numbness Feet ❑ Numbness Hands ❑ Sleep Disturbance ❑ Fainting
❑ Impotence ❑ Sputum Production ❑ Fever ❑ Balance Problems ❑ Shortness of Breath ❑ Visual Disturbance
❑ Mania ❑ Seizures ❑ Sore Throat ❑ Swelling in the Legs ❑ Skin Rash ❑ Skin Ulcers ❑ Wheezing
❑ Unexplained Weight Loss ❑ Vomiting ❑ Stomach Pain ❑ Weight Gain

CURRENT MEDICATIONS: _____

_____

MEDICATION ALLERGY: ❑ Y ❑ N List: _____

_____
Patient Signature

_____
Date

_____
Physician Signature

_____
Date

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

In order to protect your privacy, Greater Dallas Orthopaedics, PLLC, asks you to list the family members, friends or any person(s) who can request or inquire regarding your Protected Health Information which includes medical condition and/or billing and financial information.

Name of Family Member/Friend/Other Person(s)	*Relationship to Patient*

HIPAA & RELEASE OF INFORMATION POLICY — *Please Read & Initial* _____

I hereby authorize Greater Dallas Orthopaedics, PLLC, to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Greater Dallas Orthopaedics, PLLC can refuse to see me. I have been provided the "Notice of Privacy Policies" for Greater Dallas Orthopaedics, PLLC which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other healthcare operations. I understand that I have the right to review such "notice" prior to signing this consent. I understand that I may revoke this consent at any time by notifying Greater Dallas Orthopaedics, PLLC in writing, but if I revoke my consent, such revocation will not affect any actions that Greater Dallas Orthopaedics, PLLC took before receiving my revocation. I understand Greater Dallas Orthopaedics, PLLC has reserved the right to change its privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that Greater Dallas Orthopaedics, PLLC restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other healthcare operations. I understand that Greater Dallas Orthopaedics, PLLC does not have to agree to such restrictions, but that once such restrictions are agreed to, Greater Dallas Orthopaedics, PLLC must adhere to such restrictions.

FINANCIAL POLICY — *Please Read & Initial* _____

You acknowledge full financial responsibility for services rendered by Greater Dallas Orthopaedics, PLLC and authorize your insurance plan to be billed and benefits to be paid directly to Greater Dallas Orthopaedics, PLLC for services you received. You assign to Greater Dallas Orthopaedics, PLLC, as your designated authorized representative, all medical benefits or insurance reimbursement, if any, otherwise payable to you for services provided from any insurance policy, self-insured health plan, Medicare or Medicaid in your name or on your behalf, which includes, but is not limited to, **CO-PAYS, DEDUCTIBLES, CO-INSURANCE, PRE-EXISTING CLAUSES, EXCLUDED CONDITIONS,** and/or **TERMINATION OF COVERAGE**. Furthermore, you assign to Greater Dallas Orthopaedics, PLLC the right to appeal or dispute the decision of the insurance company in order to pursue payment. You understand acceptance of insurance does not relieve you from any responsibility concerning payment for services and that you are financially responsible for all charges whether or not they are covered by you insurance including any deductibles or co-insurance charges. You agree to pay all legal fees as well as collection costs in the event of default of payment of charges that are your financial responsibility.

You acknowledge that Greater Dallas Orthopaedics, PLLC providers may be an out-of-network provider with your insurer. Greater Dallas Orthopaedics providers are contracted with many, but not all insurance plans. Please confirm that your physician/provider and physician assistant-certified (Jeffrey Neumann PA-C, Brittany Kovalic, PA-C) are contracted through Greater Dallas Orthopaedics, PLLC with your specific insurance plan/product. In some circumstances your insurer will send the payment directly to you. Therefore, you agree to endorse insurance checks and forward it to Greater Dallas Orthopaedics, PLLC within 30 days of receipt.

You acknowledge that North Star Diagnostic Imaging leases and provides radiology services at Greater Dallas Orthopaedics. Radiology services rendered are through North Star Diagnostic Imaging, and billed separately. Physicians at Greater Dallas Orthopaedics have no ownership nor partnership interest at North Star Diagnostic Imaging.

PHYSICIAN FINANCIAL DISCLOSURE — *Please Read & Initial* _____

Pursuant to Federal and Texas Law please note that physicians at Greater Dallas Orthopaedics have financial agreements with the following entities: (a) Texas Health Surgery Center Addison; (b) Baylor Surgicare/Baylor Medical Center Uptown; (c) Baylor Scott & White Health System and (d) Texas Health Resources - Presbyterian Hospital Dallas. If you are referred to any of these entities in the course of your care, your physician will receive direct or indirect remuneration. If you have any questions regarding this paragraph, please discuss with them with your physician directly.

TEXAS DEPARTMENT OF INSURANCE MEDIATION DISCLOSURE — *Please Read & Initial* _____

If they have a dispute about an outstanding bill received from an out-of-network hospital-based health care provider, you are eligible to have the dispute resolved through mandatory mediation if the out-of-network bill is more than $500. Your participation is voluntary. If you elect mediation, the out-of-network hospital-based physician/care provider and your health care plan must meet to discuss the outstanding bill. If the mediation is unsuccessful, the dispute may also be able to be resolved in court. More information can be found at: http://tdi.texas.gov/consumer/cpmediation.html

ACKNOWLEDGEMENT — *Signature Required*

- I acknowledge that I received the "Notice of Privacy Policies" for Greater Dallas Orthopaedics, PLLC.
- I hereby authorize Greater Dallas Orthopaedics, PLLC to release any information requested by the above named Insurance Company or Companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents. I have read and understand the "HIPAA & Release of Information Policy" and the "Financial Policy" established by Greater Dallas Orthopaedics, PLLC. I further acknowledge that I accept the terms outlined in each of the policies.

_____ _____

Signature of Patient or Patient's Representative | Date

_____ _____

Printed Name of Patient or Patient's Representative | Representative's Relationship to Patient