

**Patient Information** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Male/Female \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone/Carrier \_\_\_\_\_

Mailing/Physical Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email Address \_\_\_\_\_

Social Security# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_ Primary Language \_\_\_\_\_

Employer / School \_\_\_\_\_ Employer/ School City \_\_\_\_\_ Employer/School phone # \_\_\_\_\_

IF MARRIED: Name of Spouse \_\_\_\_\_ Cell / Alternate Phone# \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION NOTE: The Responsible Party is the person who obtains insurance coverage for themselves and/ or their dependents.**

Full Name \_\_\_\_\_ Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone# \_\_\_\_\_

DOB \_\_\_/\_\_\_/\_\_\_ SSN \_\_\_\_\_ -- \_\_\_\_\_ -- \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone # \_\_\_\_\_

Parent/s or Guardian (if minor) \_\_\_\_\_

**EMERGENCY CONTACT NAME ( NOT IN SAME HOUSEHOLD)** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Insurance Information (Complete All Insurance Information Thoroughly)**

**Primary Insurance:** \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Employer \_\_\_\_\_ Subscribers DOB \_\_\_/\_\_\_/\_\_\_ Relationship \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Employer \_\_\_\_\_ Subscribers DOB \_\_\_/\_\_\_/\_\_\_ Relationship \_\_\_\_\_

- I certify that the information provided is correct. I understand that the information provided will be used to manage my account and process insurance claims.
- I understand that the insurance is filed as a courtesy to me and there may be a difference between my benefits and fees.
- I assign payment of medical benefits to: James R. Parker, M.D. – Parker Sports Medicine and Orthopedics.

Signature **X** \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

What problem/s are you being seen for today? (Please indicate right, left, or both):

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Finger (R, L, B) | <input type="checkbox"/> Elbow (R,L, B)      | <input type="checkbox"/> Toe (R, L, B)       | <input type="checkbox"/> Knee (R, L, B)  |
| <input type="checkbox"/> Hand (R, L, B)   | <input type="checkbox"/> Upper Arm (R, L, B) | <input type="checkbox"/> Ankle (R, L, B)     | <input type="checkbox"/> Thigh (R, L, B) |
| <input type="checkbox"/> Wrist (R, L, B)  | <input type="checkbox"/> Shoulder (R, L, B)  | <input type="checkbox"/> Foot (R, L, B)      | <input type="checkbox"/> Hip (R, L, B)   |
| <input type="checkbox"/> Forearm (R, L,B) | <input type="checkbox"/> Neck                | <input type="checkbox"/> Lower Leg (R, L, B) | <input type="checkbox"/> Back            |

Date of Injury: \_\_\_\_\_ Place of Injury (ex. Home/Work/School) and how it occurred: \_\_\_\_\_

\_\_\_\_\_ Diagnostic Studies (Circle One): X-rays, MRI, CT, Other: \_\_\_\_\_

Location & Date: \_\_\_\_\_ Who referred you to us? \_\_\_\_\_ Is this a second opinion? Y or N

Hand Dominance: Right or Left Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

### MEDICAL HISTORY QUESTIONNAIRE

Pharmacy: Name- \_\_\_\_\_ Location- \_\_\_\_\_

Medications: Please list all current (prescribed and over-the-counter) medications you are taking: If you have list, turn in when returning form. \_\_\_\_\_ (med)- \_\_\_\_\_ (doctor)

\_\_\_\_\_ (med)- \_\_\_\_\_ (doctor) \_\_\_\_\_ (med)- \_\_\_\_\_ (doctor)

\_\_\_\_\_ (med)- \_\_\_\_\_ (doctor) \_\_\_\_\_ (med)- \_\_\_\_\_ (doctor)

\_\_\_\_\_ (med)- \_\_\_\_\_ (doctor) \_\_\_\_\_ (med)- \_\_\_\_\_ (doctor)

Allergies: Are you allergic to any medication?  No  Yes

If yes, please list medication (type, date, and provider): \_\_\_\_\_  
\_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_

Operations: Have you ever had surgery?  No  Yes

If yes, please list operation (type, date, and provider): \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_

### Lifestyle:

Do you smoke?  No  Yes  Former  Smokeless

Cigarettes/cans per day? \_\_\_\_\_ How many years? \_\_\_\_\_ How long quit? \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes, how much daily? \_\_\_\_\_

History of drug abuse?  No  Yes

(Check all that apply and list physician treating you for each problem)

- |  |  |
|--|--|
| <input type="checkbox"/> Hypertension - _____          | <input type="checkbox"/> Cancer (list type)- _____               |
| <input type="checkbox"/> High cholesterol- _____       | <input type="checkbox"/> Stroke (ischemic/hemorrhagic)- _____    |
| <input type="checkbox"/> Kidney Disease- _____         | <input type="checkbox"/> CAD: Coronary Artery Disease- _____     |
| <input type="checkbox"/> Stomach Ulcers- _____         | <input type="checkbox"/> PVD: Peripheral Vascular Disease- _____ |
| <input type="checkbox"/> GI Disease- _____             | <input type="checkbox"/> Heart Failure- _____                    |
| <input type="checkbox"/> Diabetes- _____               | <input type="checkbox"/> History of blood Clots- _____           |
| <input type="checkbox"/> Asthma- _____                 | <input type="checkbox"/> HIV/AIDS- _____                         |
| <input type="checkbox"/> COPD- _____                   | <input type="checkbox"/> MRSA- _____                             |
| <input type="checkbox"/> Thyroid- _____                | <input type="checkbox"/> Gout- _____                             |
| <input type="checkbox"/> Neurologic Disease- _____     | <input type="checkbox"/> Seizures- _____                         |
| <input type="checkbox"/> Malignant Hyperthermia- _____ | <input type="checkbox"/> Other- _____                            |



**REVIEW OF SYSTEMS**

(Please check all that you are currently experiencing)

**EYES**

- Eye disease
- Wear Glasses
- Blurred or double vision

**EAR/NOSE/THROAT**

- Hearing loss or ringing
- Chronic sinus problems
- Nose bleeds
- Sore throat
- Swollen glands in neck

**CARDIOVASCULAR**

- Heart trouble
- Chest pain/angina
- Palpitation
- Heart Murmur
- Hypertension

**RESPIRATORY**

- Chronic cough
- Shortness of breath
- Asthma
- Emphysema/COPD

**GASTROINTESTINAL**

- Loss of appetite
- Nausea/vomiting
- Frequent diarrhea
- Constipation
- Abdominal pain

**MUSCULOSKELETAL**

- Joint pain
- Joint stiffness or swelling
- Weakness of muscles
- Muscle pain/cramps

**GENITOURINARY**

- Frequent urination
- Burning/painful urination
- Blood in urine
- Hernia

**INTEGUMENTARY**

- Rash or itching
- Change in skin color
- Change in hair or nails

**NEUROLOGICAL**

- Frequent headaches
- Light headed/dizzy
- Numbness/tingling
- Seizures/tremors
- Paralysis

**PSYCHIATRIC**

- Memory loss/confusion
- Nervousness
- Depression
- Insomnia

**FAMILY HISTORY:** Please indicate if any member of your family (mother, father, sister, brother, uncle, aunt, etc.) have ever been treated for any of the following. If yes, please list the relatives relationship to you.

<u>ILLNESS</u>	<u>RELATIONSHIP</u>	<u>ILLNESS</u>	<u>RELATIONSHIP</u>
Stroke: (maternal/paternal)	_____	Bleeding problems: (M/P)	_____
Hypertension: (maternal/paternal)	_____	Anemia/Sickle Cell: (M/P)	_____
Heart problems: (maternal/paternal)	_____	Diabetes: (M/P)	_____
High cholesterol: (maternal/paternal)	_____	Rheumatoid/Arthritis: (M/P)	_____
Lung problems: (maternal/paternal)	_____	Seizures: (M/P)	_____
Kidney disease: (maternal/paternal)	_____	Drug abuse: (M/P)	_____
Cancer: (maternal/paternal)	_____	HIV/AIDS: (M/P)	_____
Malignant hyperthermia: (maternal/paternal)	_____	Other: (M/P)	_____

Patient/Parent Signature X \_\_\_\_\_ Date \_\_\_\_\_

Patients Name: \_\_\_\_\_

## PARKER SPORTS MEDICINE OFFICE POLICIES

### Insurance

The patient is responsible for providing Parker Sports Medicine with the correct insurance information and obtaining any referrals required by the insurance company. Please bring photo identification and current insurance card to every visit.

The patient is responsible for responding to requests from the insurance company to provide any additional information they may require. If this information is not provided and they do not pay us because of the delay, the account will become due and payable in full at that time. Contrary to common understanding, all procedures (e.g., injections, aspirations, simple hardware removal) are considered surgical procedures by most insurance companies, so the fees for these services may apply to a separate surgical deductible, copayment, or coinsurance.

We accept most major insurance companies including, but not limited to, Medicare, BCBS, IMS, Aetna, United Health Care, Humana, City of Amarillo and Tricare. We accept most Medicare replacement plans. We do not accept Superior Chips/Medicaid and Amerigroup Medicaid. Please call the office or check your insurance website to see if we are in-network.

### Payment

All copayments and deductibles are due at the time of the office visit. Any remaining balance after the insurance has paid is the patient's responsibility and is due upon receipt of the bill. If your account has a balance due, please plan to pay that balance before or at the time of any upcoming appointment. Patients without insurance coverage should be prepared to pay the visit balance on the date of the visit. We accept cash, checks, Visa, MasterCard, Discover, American Express, and CareCredit. Past due accounts are turned over to a collection agency.

### Medical Records

Medical records can be obtained by the patient or sent to another office with completion of a written request. A fee may be charged for these records. Please allow 24 hours for all requests to be completed.

### HIPAA

All medical records are protected as required by law. Copies of our privacy policy are available at our office.

### Prescriptions

Please bring a list of all medications the patient is taking (including over-the-counter medicines) to each visit.

To request a prescription refill, please call our office with the patient's name, date of birth, preferred pharmacy, and name of the desired prescription. Some prescriptions may require an office visit to be refilled.

\_\_\_\_\_ X Patients/Guardians Initials



Parker Sports Medicine and Orthopedics

7000 W. 9th Avenue
Amarillo, TX 79106

Phone: 806-350-2663 Fax: 806-350-2664

Authorization for the Disclosure of Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_
Social Security Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_
Address: \_\_\_\_\_

I hereby authorize and request Parker Sports Medicine and Orthopedics to [ ] provide to or [ ] receive from:

Name/Facility: \_\_\_\_\_
Address: \_\_\_\_\_
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

This type and amount of information to be used or disclosed is as follows:

Specify date(s) of Encounter(s)/Hospitalization(s): \_\_\_\_\_
[ ] Complete Medical Record [ ] History & Physical [ ] Operative Report
[ ] Physician's Office Progress Notes [ ] Lab Reports [ ] Problem List
[ ] X-Ray Reports [ ] X-Ray Films [ ] Discharge Summary
[ ] Photographs, Videotapes, digital or other images [ ] Other \_\_\_\_\_

with regard to \_\_\_\_\_ medical/hospital records for the purpose of:

(Patient Name)
[ ] Continuity of Care [ ] Billing and Payment of Bill [ ] Other (explain) \_\_\_\_\_

I understand that this authorization can be revoked, in writing, at any time except to the extent that disclosure made in good faith has already occurred in reliance upon this authorization. This authorization applies to the following: hospitals, medical providers, school officials, athletic trainers, coaches, and family members.

This authorization is for full disclosure of all health data which may include any information related to care for my impairment(s), information about how my impairment(s) affects my ability to complete tasks and activities of daily living, information about how my impairment(s) affect my ability to work; and/or related to drug, alcohol, mental health, psychiatric conditions, and/or sexually transmitted disease, Sickle Cell Anemia, including AIDS/HIV information (42 CFR part 2). Such records will be disclosed unless you specify information that you wish to be excluded.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 16-524. If I have questions about disclosure of my health information, I can contact Parker Sports Medicine and Orthopedics.

Facsimile transmission of this form will be deemed as having the same force and effect as an original. The risks associated with the use of facsimile transmission are understood.

This form [ ] was read BY me [ ] was read TO me. I have been offered the opportunity to ask questions about this form, and I fully understand its contents and meaning. All blanks were filled in before the form was signed by me.

X \_\_\_\_\_ Date
Patient or Authorized Representative Signature
If signed by Legal Representative, Relationship to Patient: \_\_\_\_\_
\_\_\_\_\_ Date
Witness Signature





**Parker Sports Medicine and Orthopedics**  
**Acknowledgement of Receipt of Notice of Privacy Policy**

I, \_\_\_\_\_, acknowledge that I have received a copy of the Parker Sports Medicine and Orthopedics Notice of Privacy Policy.

X \_\_\_\_\_  
Patient Signature

X \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's legal representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient's legal representative (if applicable)

\_\_\_\_\_  
Relationship to patient

---

**FOR OFFICE USE ONLY:**

Parker Sports Medicine and Orthopedics has made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt 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.\****

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Office Representative: \_\_\_\_\_

Date placed in Patient's chart: \_\_\_\_\_