

TEXAS KNEE AND SPORTS MEDICINE CENTER-PATIENT REGISTRATION

Please Print Clearly

*Form must be completed and signed by a parent or guardian 18 years of age or older

INFORMATION ABOUT THE PATIENT

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail: _____ Phone Number: _____

Sex: Male Female Status: Married Single Divorced Widow/Widower

Employer: _____ Job Description: _____

Emergency Contact: _____ Phone Number: _____

Referral Source: _____

MEDICAL INFORMATION

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

PHARMACY INFORMATION: I understand that the State of Texas now requires certain prescriptions to be sent to the pharmacy electronically. Please provide your preferred pharmacy below and your personal e-mail address for ePrescribe.

Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Allergies to Medications: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

ID Number: _____ Group Number: _____

Insurance Company Address: _____

(Located on the back of your insurance card)

Insurance Company Phone Number: _____

Patients Relationship to the Insured: Self Spouse Child Other

Secondary Insurance Carrier Name: _____ ID Number: _____

I authorize Texas Knee and Sports Medicine Center to release medical information that may be necessary to request reimbursement from insurance companies to show I have submitted a claim. I assign all medical and surgical benefits to include Major Medical and Surgical Benefit to which I am entitled to the Texas Knee and Sports Medicine Center. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges. Consent to Treatment: I hereby consent to evaluation, testing, and treatment as directed by Texas Knee and Sports Medicine Center or those under the supervision of Texas Knee and Sports Medicine Center.

Patient Printed Name: _____ Date: _____

Patient Signature: _____

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Texas Knee and Sports Medicine Center

L. D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine
4323 N. Josey Lane, Plaza I, Suite 307
Carrollton, TX 75010
Phone: 972-394-0118 Fax: 972-394-1058

FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last Name First Name

Email address: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, x-ray, DME, physical therapy, injections, casting and any other medical procedures ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, x-ray, DME, physical therapy, injections, casting or any other screening service or diagnostic testing ordered by the physician or physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment at the time of service.

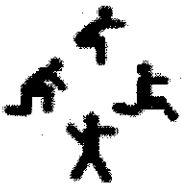
I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I understand that the physician and physical therapy may charge a \$30.00 fee if I do not show up for my appointment(s), or if I cancel without a 24-hour notice. I understand that if I cancel or reschedule my surgery after it has been scheduled I may be charged a cancellation/reschedule fee of \$100.00.

Signature: _____ Date: _____
(Please sign here – Patient or Responsible Party)

Responsible Party Name: _____ Relationship: _____
(Please print name of Responsible Party if different from Patient)



Texas Knee and Sports Medicine Center

L. D. Jennings, M.D.

PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Texas Knee and Sports Medicine Center, or the physician individually for services rendered to my dependents, or me, by the physician or those under his supervision. I understand that it is my responsibility to know my insurance benefits whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Texas Knee and Sports Medicine Center, is unable to collect from my insurance carrier for whatever reasons.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify and I have read and been offered a copy of Texas Knee and Sports Medicine Center "HIPAA Notice of Privacy Practices". I hereby authorize Texas Knee and Sports Medicine Center or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL, OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Texas Knee and Sports Medicine Center representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointments, referral arrangements, and diagnostic test results. I understand that I have the right to resigns this authorization at any time by notifying Texas Knee and Sports Medicine Center to that effect in writing.

DME/X-RAY/MEDICAL PROCEDURES/PHYSICAL THERAPY:

I understand that I may receive a separate bill if my medical bill includes DME, x-ray, medical procedures, or physical therapy. I further understand that I am financially responsible for any co-pay/deductibles/co-insurance, or balances due for these services if they are not reimbursed by my insurance or whatever reason.

SURGERY DEPOSIT:

I understand that I am responsible for 100% of the surgery deposit at the pre-operative appointment. If I am unable to provide full payment, a deposit can be discussed and agreed upon based on individual situations. In those cases, credit/debit card for automatic payments will be required along with a signed payment agreement.

PATIENT BALANCES:

I understand that I am 100% responsible for any co-pays, deductibles and/or coinsurance at the time of my appointment(s). If a balance is owed after my visit has been processed by my insurance company, I will be asked to pay that balance at my next appointment. Or a statement will be mailed to me for the outstanding balance, with a payment expected within 30 days. If a credit is due to the patient for overpayment, a refund will be processed back to the method of payment no earlier than six months from the last date of service or after all claims, redeterminations and/or appeals have been successfully processed by the insurance company.

DISCLOSURE OF FINANCIAL INTEREST:

This disclosure covers entities that L. D. Jennings, M.D. has a(n) ownership/interest in: Texas Health Center for Diagnostics & Surgery of Plano, Texas, and Texas Health Presbyterian Hospital of Flower Mound, Texas. In addition, he has ownership/interest in MJ Surgical, PLLC. Services for the latter may be out of network and, as a result, you may receive an out of network bill. You have the option, at your discretion, to use an alternate health care facility or imaging center. You will not be treated differently by Dr. Jennings or Texas Knee and Sports Medicine Center.

PATIENT SIGNATURE: _____ DATE: _____

GUARANTOR SIGNATURE: _____ DATE: _____

(If different from patient)

GUARANTOR NAME (Please print): _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however, you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event that your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physician. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physician to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, medical assistant, and physical therapist and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

Signature Date

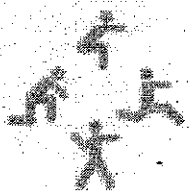
I authorize this facility to release information to (Please check all that apply):

- Spouse: (List full name of spouse) _____
- Children (List full names & phone numbers) _____

- Others: (List complete name & phone number) _____

- No one

Signature Date



L.D. Jennings, M.D.
Board Certified Orthopaedic Surgery
Board Certified Sports Medicine

General Medical History

Name: _____

Year	Illnesses
_____	<input type="checkbox"/> Heart trouble <input type="checkbox"/> Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Failure <input type="checkbox"/> Heart Murmur
_____	<input type="checkbox"/> Valve Disease Other _____
_____	<input type="checkbox"/> High Blood Pressure
_____	<input type="checkbox"/> Stroke
_____	<input type="checkbox"/> Ulcers: <input type="checkbox"/> Stomach <input type="checkbox"/> Duodenal <input type="checkbox"/> Colon
_____	<input type="checkbox"/> Diabetes (high blood sugar)
_____	<input type="checkbox"/> Liver Disease <input type="checkbox"/> Hepatitis Type A <input type="checkbox"/> Hepatitis Type B <input type="checkbox"/> Hepatitis Type C <input type="checkbox"/> Cirrhosis
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Stones <input type="checkbox"/> Infections
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Lung Disease <input type="checkbox"/> Emphysema <input type="checkbox"/> TB <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Cancer
_____	<input type="checkbox"/> Frequent Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Blood Disorders <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Bleeding Tendency
_____	<input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Eye Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Arthritis <input type="checkbox"/> Degenerative <input type="checkbox"/> Rheumatoid <input type="checkbox"/> Gout <input type="checkbox"/> Other _____
_____	<input type="checkbox"/> Cancer <input type="checkbox"/> Type _____
_____	<input type="checkbox"/> Psychological <input type="checkbox"/> Depression <input type="checkbox"/> Psychosis <input type="checkbox"/> Other _____
_____	<input type="checkbox"/> NO MAJOR ILLNESSES

Surgeries (Other than back or neck)

Year	Year
_____	<input type="checkbox"/> Tonsillectomy
_____	<input type="checkbox"/> Appendectomy
_____	<input type="checkbox"/> Gall Bladder
_____	<input type="checkbox"/> Hernia Repair
_____	<input type="checkbox"/> Vasectomy (males)
_____	<input type="checkbox"/> Hysterectomy
_____	<input type="checkbox"/> Prostate Operation
_____	<input type="checkbox"/> Biopsy
_____	<input type="checkbox"/> Fractures
_____	<input type="checkbox"/> Other _____

Major Injuries

Auto or cycle accidents, etc. please describe _____

NO MAJOR INJURIES

Hospitalizations

Explain: _____

Ladies-menstrual history

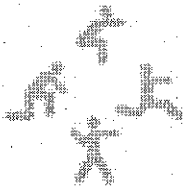
<input type="checkbox"/> My periods are normal for me	<input type="checkbox"/> I have been pregnant _____ times _____ Still born
<input type="checkbox"/> I am Menopausal Post-menopausal	<input type="checkbox"/> I have had _____ vaginal deliveries _____ c-sections
<input type="checkbox"/> Problems with deliveries & pregnancies	List: _____

Childhood diseases

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other (major only) _____
<input type="checkbox"/> Nothing Unusual	_____

Medications (give names and doses)

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Tylenol	<input type="checkbox"/> For other medical problems: _____
<input type="checkbox"/> Sleep meds: _____		
<input type="checkbox"/> Anti-inflammatories _____		<input type="checkbox"/> Pain meds: _____
<input type="checkbox"/> Muscle relaxants: _____		



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Name: _____

Allergies (please circle reaction)

- | | | | | |
|--------------------------------------|------|--------------------|--------------------------|-----------------|
| <input type="checkbox"/> Penicillin | rash | breathing problems | required hospitalization | nausea/vomiting |
| <input type="checkbox"/> Sulfa | rash | breathing problems | required hospitalization | nausea/vomiting |
| <input type="checkbox"/> Keflex | rash | breathing problems | required hospitalization | nausea/vomiting |
| <input type="checkbox"/> Codeine | rash | breathing problems | required hospitalization | nausea/vomiting |
| <input type="checkbox"/> Other _____ | rash | breathing problems | required hospitalization | nausea/vomiting |
| <input type="checkbox"/> None | | | | |

Family Medical History

- Mother: Alive and well-age _____ Alive but suffers with _____ Age _____
 Deceased: cause _____ Age at death _____
- Father: Alive and well-age _____ Alive but suffers with _____ Age _____
 Deceased: cause _____ Age at death _____
- I have _____ living brothers/sisters; _____ deceased brothers/sisters: cause _____

Members of my family (brothers, sisters, grandparents, aunts, uncles) suffer with the following:

- | | | |
|------------------------------------|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer: type _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Back problems |
| | | <input type="checkbox"/> Don't know |

Social History

- Married Separated Divorced Widow/widower Single: No. of children: at home _____ away _____
- I work as a _____
- I am retired from _____
- I live with my children or other relatives. Explain _____
- I drink beer wine "hard" drinks none
 Daily socially I consider myself to drink too much
 Others think I drink too much
- I smoke cigarettes pipe cigars _____ packs/day for _____ years
- My recreational activities include jogging bicycling sports (list _____)

Review of Systems

Do you have problems other than neck or back?

- Eyes Ears Nose Throat

Explain _____

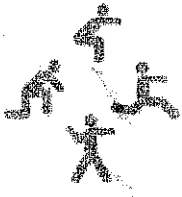
- Skin, moles, spots or sores that is unusual. Explain _____
- Unusual lumps or bumps under skin like large lymph nodes. Explain _____
- Trouble breathing: Short of breath Cough Pain with breathing Other _____
- Chest pain/discomfort Sharp Aching Arm discomfort along with chest discomfort
 When under stress with activity after meals Other _____
- Trouble with stomach or bowels Nausea/vomiting Stomach pain Diarrhea Constipation
- Bleeding in bowel movements Black/tarry stools Other _____
- Trouble with legs Fatigue with walking/relieved by rest Other _____
- Trouble with nerves Anxious/fearful I feel down/depressed

Ladies

- Problems with menstrual periods vaginal bleeding after menopause vaginal discharge
 Other problems you need to discuss with a doctor

Men

- Problems with sexual function Discharge other problem you need to discuss with a doctor



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Back Evaluation Sheet

The problem which brought me to the doctor today is:

- 1) Low back pain or discomfort Middle back pain or discomfort Abnormal curvature of back (i.e. scoliosis)
 2) Buttock and/or leg pain or discomfort on the right side or left side
 3) Leg more painful Back more painful

For:

- 1) Neck pain or discomfort Shoulder pain or discomfort
 2) Upper back pain or discomfort Arm/hand pain or discomfort on the right side or left side
 3) Neck more painful Shoulder more painful Arm more painful

Please draw the discomfort pattern below:

Mark areas of your body where you feel the described sensations. Use the appropriate symbol.

Mark the areas of radiation. Include all affected areas.

Ache ^^^^^^ Numbness oooooo Pins & Needles ===== Burning xxxxxxx Stabbing //////////////

Front

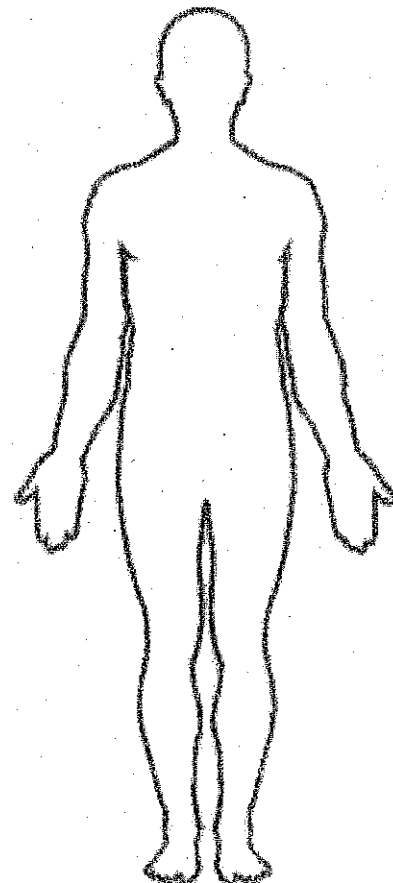
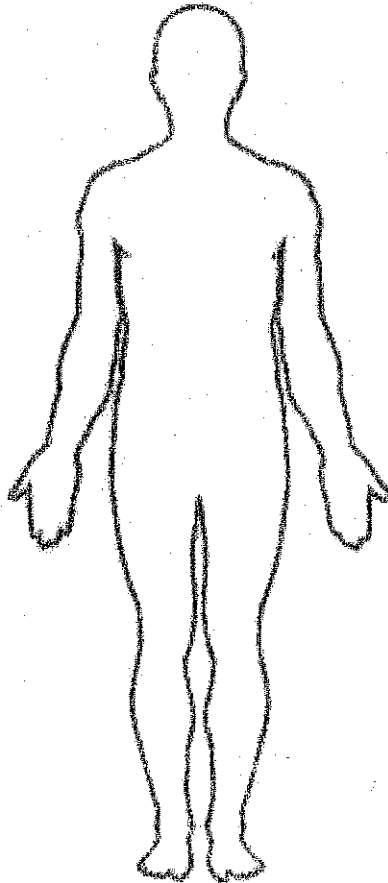
Back

Right

Left

Left

Right



Right

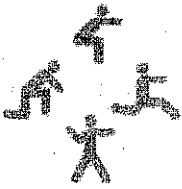
Left

Left

Right

Front

Back



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Mark "X" on the line:

1) How bad is your low back pain?

0 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
 No pain

Worst Possible

2) How bad is your leg pain now?

0 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
 No pain

Worst Possible

3) How bad is your neck or upper back pain now?

0 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
 No pain

Worst Possible

4) How bad is your arm pain right now?

0 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
 No pain

Worst Possible

Explain how your pain began:

- Injury On the job

Explain how it happened: _____

Date of Injury: _____

I don't know how it began

My problem is chronic Age it began _____

I remember an injury

Describe injury: _____

Previous Treatment (for neck or back):

None

Yes-physician's name: _____

He prescribed:

Medications (give names):

Anti-Inflammatories _____

no help

some relief

much relief

Muscle relaxers _____

no help

some relief

much relief

Pain meds _____

no help

some relief

much relief

Others _____

no help

some relief

much relief

Physical Therapy _____

no help

some relief

much relief

Traction _____

no help

some relief

much relief

Exercises _____

no help

some relief

much relief

Injections: Describe _____

no help

some relief

much relief

Manipulation (osteopath) _____

no help

some relief

much relief

Chiropractor's name: _____

Heat

Ice

no help

some relief

much relief

Surgery (Age _____) Describe: _____

no help

some relief

much relief

I have had the following tests:

Regular X-rays

CAT scan

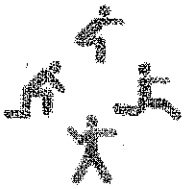
MRI

Myelogram

Discogram

EMG

I have seen other doctors for my condition. List types of doctors and who they were: _____



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The following make my discomfort better:

- Neck Bed rest Massage Stretching/"popping" neck Other _____
 Nothing helps Heat Ice
- Back Bed rest Decreased activities Bending forward Bending backward Bending neck to the left
 Bending neck to the right

The following make my discomfort worse:

- Neck Activity Bending neck forward Bending neck backward Bending neck to the left
 Bending neck to the right
- Back Activity Bending forward Bending backward Sitting Standing Walking
 Sneeze/cough/strain
 Other: _____

I also have the following problems:

- Specific weakness of muscles in arms or hands
- Generalized weakness of arms or hands due to pain or discomfort
- Numbness Tingling of: arms hands
 legs feet toes
- Specific weakness in legs
- Generalized weakness of legs due to pain and discomfort
- My legs fatigue or hurt when I walk too far
 - This is relieved by resting my legs
 - I can walk less than a block 1-2 blocks more than 3 blocks
- Trouble with my bladder (urine) control
 - Can't empty bladder
 - Loss of urine (accidents)
- Trouble with bowels
 - Constipation
 - Loss of control (accidents)
- My pain is worse at night
- My pain awakens me from sleep

Job History:

My job is: _____

My job requirements are:

- Heavy-Lifting over 60 lbs/frequent bending and stooping
- Medium-Lifting 30-50 lbs
- Light-Lifting 10-20 lbs
- Sedentary-Sit most of the time, very little lifting
- My job is highly stressful, it makes me tense