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: ____________________

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

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/PHYSCIAL 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):

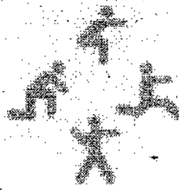
- Spouse: (List full name of spouse) ______________________________
- Children (List full names & phone numbers) ______________________________

  ____
- 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

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

Surgeries (Other than back or neck)

Year		Year	
____	☐ Tonsillectomy	____	☐ Hysterectomy
____	☐ Appendectomy	____	☐ Prostate Operation
____	☐ Gall Bladder	____	☐ Biopsy
____	☐ Hernia Repair	____	☐ Fractures
____	☐ Vasectomy (males)	____	☐ Other ____________

Major Injuries

Auto or cycle accidents, etc. please describe ____________________

☐ NO MAJOR INJURIES

Hospitalizations

Explain: ____________________

Ladies-menstrual history

☐ My periods are normal for me ☐ I have been pregnant ____ times ____ Still born
☐ I am Menopausal Post-menopausal ☐ I have had ____ vaginal deliveries ____ c-sections
☐ Problems with deliveries & pregnancies List: ____________________

Childhood diseases

☐ Rheumatic Fever ☐ Other (major only) ____________________
☐ Nothing Unusual

Medications (give names and doses)

☐ Aspirin ☐ Tylenol ☐ For other medical problems: ____________
☐ Sleep meds: ____________
☐ Anti-inflammatories ____________ ☐ Pain meds: ____________
☐ Muscle relaxants: ____________

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Name: ______________________________

Allergies (please circle reaction)

- ☐ Penicillin rash breathing problems required hospitalization nausea/vomiting
- ☐ Sulfa rash breathing problems required hospitalization nausea/vomiting
- ☐ Keflex rash breathing problems required hospitalization nausea/vomiting
- ☐ Codeine rash breathing problems required hospitalization nausea/vomiting
- ☐ Other_______ rash breathing problems required hospitalization nausea/vomiting
- ☐ 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:

☐ Stroke ☐ High blood pressure ☐ Cancer: type__________________________
☐ Diabetes ☐ Heart Trouble ☐ Lung disease ☐ Back problems
☐ Arthritis ☐ Other_____________________________ ☐ 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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_____ ☐ Stroke

_____ ☐ Ulcers: ☐ Stomach ☐ Duodenal ☐ Colon

_____ ☐ Diabetes (high blood sugar)

_____ ☐ Liver Disease ☐ Hepatitis Type A ☐ Hepatitis Type B ☐ Hepatitis Type C ☐ Cirrhosis
☐ Other ________________________

_____ ☐ Kidney Disease ☐ Stones ☐ Infections
☐ Other ________________________

_____ ☐ Lung Disease ☐ Emphysema ☐ TB ☐ Chronic Bronchitis ☐ Cancer
☐ Frequent Pneumonia ☐ Asthma ☐ Other ________________________

_____ ☐ Blood Disorders ☐ Anemia ☐ Leukemia ☐ Bleeding Tendency
☐ Other ________________________

_____ ☐ Eye Disease ☐ Glaucoma ☐ Other ________________________

_____ ☐ Arthritis ☐ Degenerative ☐ Rheumatoid ☐ Gout ☐ Other ________

_____ ☐ Cancer ☐ Type ________________________

_____ ☐ Psychological ☐ Depression ☐ Psychosis ☐ Other ________________________

☐ NO MAJOR ILLNESSES

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Year		Year	
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_____	☐ Appendectomy	_____	☐ Prostate Operation
_____	☐ Gall Bladder	_____	☐ Biopsy
_____	☐ Hernia Repair	_____	☐ Fractures
_____	☐ Vasectomy (males)	_____	☐ Other ________________________

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