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):

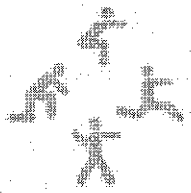
- o Spouse: (List full name of spouse) _____
- o Children (List full names & phone numbers) _____

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

  _____
- o 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

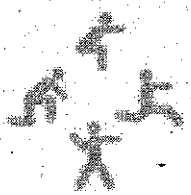
☐ My periods are normal for me ☐ I have been pregnant____times ____Still born
☐ I am Menopausal Post-menopausal ☐ I have had____vaginal deliveries ____c-sections
☐ Problems with deliveries & pregnancies List: _____

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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Knee-Patient Evaluation Form

Name:_____ Chart #:_____

Age:_____ Sex:_____ Which Knee:_____

How long have you had these symptoms:_____ Date:_____

Date this problem began:_____

1) My primary complaint is (Check all that apply):
   ___ pain ___ dull ache ___ loss of motion
   ___ swelling ___ grinding
   ___ giving out ___ locking
   ___ other (Please explain)_____
2) Did this problem start (Check all that apply):
   ___ gradually ___vehicle accident
   ___ suddenly ___ don't know
   ___ while playing sports-which sport_____
   ___while at work

IF YOU HAVE BEEN EXPERIENCING PAIN, PLEASE ANSWER THIS SECTION. If not, please go on to question 8.

3) The primary location of pain is (Check all that apply):
   ___ knee cap ___throughout the knee ___outer side
   ___ back ___ inner side ___deep inside
4) When does the affected knee hurt? (Please check one.)
   ___infrequently
   ___constantly
   ___when active
   4a) Does the affected knee hurt when you are resting? ___ yes ___ no
5) Does the pain in the affected knee occur at night? ___ yes ___ no
   5a) When pain occurs at night, does it awaken you? ___ yes ___ no
6) When is the pain made worse? (Check those that apply.)
   ___ sitting ___ standing ___ walking ___climbing stairs
   ___ getting up ___running ___ during physical exercise
7) The pain is relieved by: (Check all that apply.)
   ___ nothing ___ rest ___moving the knee
   ___ heat therapy ___ activity
   ___ cold therapy
   ___ medicine-if so, what kind?_____

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8) Is the affected knee ever swollen? (Check all that apply.)
___ Never ___Only after exercise or use
___ Infrequently ___At the time of the original injury, but not since then
___ Constantly

9) Are there any grating or grinding noises or sensations in the joint? (Check all that apply.)
___ None ___When climbing stairs
___ When getting up from a chair ___When descending stairs
___ When walking ___When I do deep knee bends

10) When does your knee lock (get stuck)?
___ Never ___At first, not now
___ Frequently or occasionally ___Continually

11) When knee gives out or buckles, it feels like: (Check all that apply.)
___ This does not apply ___ Knee cap shifts
___ Entire knee shifts ___ Something inside the knee shifts

12) What is the range of motion in your affected knee?
___ Same as ever
___ Unable to fully straighten the joint
___ Unable to fully bend or flex the joint

13) Mobility of the joint: ___ Able to walk normally ___ Walk with a limp

14) What activities are you unable to do? (Check all that apply.)
___ walk-how far? ___ ½ block ___less than ½ mile
___1 block ___greater than ½ mile
___ Climb ___ Jump ___ Squat ___ Run ___ Not affected

15) Are you using walking aids?
___ None ___ Cane ___ Crutches
___ Wheel chair ___ Brace ___ Walker

16) Were you treated by a physician for this problem? ___yes ___no
Doctor: _____
Address: _____
Diagnosis: _____
Treatment: _____
Type of Doctor: _____

17) Were you treated at an emergency room for this problem? ___yes ___no
Hospital: _____
Address: _____

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18) Did you have X-rays taken for this problem? ___yes ___no

Date	Location	Results

19) Did you have an arthrogram (dye test)? ___yes ___no

If yes, please list below:

Date	Location	Results

20) Did you have an arthroscopy or arthroscopic surgery performed on the affected knee (looking into the joint)?

___yes ___no **If yes, please list below:**

Date	Location	Results

21) Did you have an open surgery on the knee joint? ___yes ___no **If yes, please list below:**

Date	Doctor	Type	Results	Complications

22) Do you have any of the following medical problems

___ Heart disease
___ Lung disease
___ Rheumatoid arthritis
___ Inherited disease
___ Stomach ulcer
___ Circulatory problems
___ High blood pressure
___ Diabetes
___ Other arthritis
___ Gout
___ Bleeding tendency
___ Cancer
___ Other (Please describe): _____

23) Have you been under a doctor's care in the last two years? ___yes ___no

If yes, please list below:

Doctor:_____ Address:_____

Reason:_____

24) What medications are you currently taking?

Medication	Dosage

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25) Have you taken any of the following medications within the past six months?

Cortisone pills or shots	___yes	___no
High blood pressure pills	___yes	___no
Water pills	___yes	___no
Heart medicine	___yes	___no
Insulin	___yes	___no

26) Please list all known allergies and your reaction:

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

27) Please list any major surgeries you have had along with any complications that may have occurred:

Surgery	Complications
_____	_____
_____	_____
_____	_____
_____	_____

28) Please rate the overall level of physical health:

___ Excellent
___ Very good
___ Good
___ Fair
___ Poor

Height: _____ Weight:_____

Right handed _____ Left handed_____ Both _____

Do you smoke? ___yes ___no

29) Who referred you to us for this evaluation and care?

___ Physician
___ Former patient
___ Coach
___ Trainer
___ Found the office in the yellow pages
___ Word of mouth (includes other patients)