ORTHOPAEDIC KNEE SHOULDER & SPORTS SURGERY
REGISTRATION FORM

(Please Print)

Today's date: | PCP:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here: | Preferred Language: (circle) English / Spanish / Other_____

Email address: | Ethnicity[ ]Not Hispanic or Latino [ ] Hispanic or Latino (optional)

Preferred method of contact | Race: _____(optional)

Home Phone: | Cell Phone: | Email:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance ☐ BCBS ☐ HUMANA ☐ UNITED HEALTHCARE ☐ CIGNA ☐ AETNA ☐ BCBS HMO ☐ HUMANA HMO ☐ MEDICARE ☐ MEDICAID ☐ Other

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: Date of Birth / / | Group no.: | Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other | Subscriber S.S No.:_____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Orthopaedic Knee Shoulder & Sports Surgery or insurance company to release any information required to process my claims. I designate Orthopaedic Knee Shoulder & Sports Surgery to act as the authorized representative for any subsequent appeals related to benefit denials. If patient is under 18 years of age, Parent or Guardian please sign below.

Patient/Guardian signature | *Date*

PHARMACY NAME: | LOCATION: | PHONE:

ORTHOPEADIC KNEE, SHOULDER AND SPORTS SURGERY
MICHAEL HECKMAN, M.D.,P.A.

Welcome to our Clinic! We appreciated the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read and sign at the bottom. A copy will be given for your records.

1. PAYMENTS. All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.

2. CANCELLATIONS/NO SHOW. If you need to cancel your appointment please call us 24 hours prior to your appointment time. We reserve the right to bill you a $25.00fee to cover our administrative costs. An appointment will not be made until the NO SHOW fee is paid.

3. APPOINTMENT TIME. We ask that our patient arrive on time for their appointments. This will facilitate our ability to see you as scheduled. In an effort to serve all of our patients well, patients arriving pas their appointment time may be rescheduled.

4. HMO & PPO REFERRALS. If your policy required written authorization from your Primary Care Physician, we will request authorization, in advance, for the established patients. This is done as a courtesy for our patients; however, we cannot guarantee authorization will be granted. Please keep in touch with your physician to ensure your visit is pre-authorized, to avoid having the financial responsibility for medical services provided to you.

5. CHANGE OF INFORMATION. Please provide us with any change regarding your address, phone number or insurance information as soon as possible. Change of insurance will require the completion of a new patient demographic form and many not be changed over the phone.

6. MEDICATION REFILL REQUESTS. Please contact your pharmacy first. They will contact our office for authorization of the refill.

7. AFTER HOURS CARE. In an emergency, please dial our main number at 9210)558-4600 and leave a message with the answering service. In a life threatening emergency, call 911.

8. MEDICAL RECORDS REQUSET. Request for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 days to properly completed written requests. FEES: As per the rules adopted by Texas State Board of medical Examiners, our office will charge $25.00 for the first 20 pages and $.50 for each page thereafter and the actual cost of mailing, shipping or deliver where applicable.

9. COMPLETION OF FORMS. As per the rules adopted by the Texas State Board of medical Examiners, our office will respond to the requests for the completion of medical forms following the receipt of the appropriate fees. Forms will be completed within five business days.

10. COLLECTIONS AGENCY FEES. In the event that your account is turned for collection to a collection agency, you will be responsible for the collections agency fees.

11. OWNERSHIP DISCLOSURE. Michael Heckman, M.D. has ownership in Foundation Surgical Hospital, RXpress Pharmacies and Alamo Imaging. You may be referred to one or more of these in the course of your treatment.

12. The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize [Name of Practice] or insurance company to release any information required to process my claims. I designate Orthopaedic Knee Shoulder & Sports Surgery to act as the authorized representative for any subsequent appeals related to benefit denials. If patient is under 18 years of age, Parent or Guardian please sign below.

Signature _____ Patient Name _____ Date _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

ORTHOPAEDIC KNEE, SHOULDER, AND SPORTS SURGERY
MICHAEL HECKMAN, M.D., P.A.

ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to Michael Heckman, M.D., P.A. for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize Michael Heckman, M.D., P.A. to release to my insurance company, referring physician and other consultants on my case information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date: _____ Patient Name: _____ Signed: _____

CERTIFICATION

Michael Heckman, M.D., P.A. is pleased to offer you treatment. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation.

I _____ hereby certify that I am/am not seeking treatment for an illness or injury that resulted from an incident/accident at my place of work or from a motor vehicle accident.

MVA / Date of Incident _____

Print Patient Name _____ Date _____

Patient Signature _____

Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of Michael Heckman, M.D., P.A.. I authorize release of my medical records to:

- ☐ Primary Care Physician: _____
- ☐ Spouse: _____
- ☐ Family Member: _____
- ☐ Coach/Trainer: _____
- ☐ Adjuster (WC Only: _____
- ☐ Nurse Case Manager (WC Only): _____
- ☐ Other: _____ Relationship: _____

Print Patient Name _____ Date _____

Patient Signature _____

PRESCRIPTION HISTORY AUTHORIZATION

I authorize Michael Heckman, M.D. and his staff to download my prescription history for recordkeeping and treatment history.

Print Patient Name _____ Date _____

Patient Signature _____

Orthopedic Knee, Shoulder and Sports Surgery

Michael M. Heckman, M.D., P.A.

Records Release Form

Name: _____ **Date:** _____

DOB: _____ **S.S.#:** _____

I _____, **authorize the Orthopaedic Knee, Shoulder & Sports Surgery / Michael M. Heckman, M.D.,P.A. to:**

_____ **request and receive records from** _____

_____ **release my records to** _____

Which includes, but not limited to:

Office Reports **Therapy Reports** **Lab Results**

Operative Reports **Routine X-ray Films & Report (s)** **MRI Films & Report (s)**

CT Scan Films & Report (s) **Arthrogram Films & Report (s)** **NC/EMG Report**

This authorization covers the patients care from _____ **to** _____

Purpose of disclosure: _____ **Medical Care** _____ **Attorney** _____ **Ins. Co.**
_____ **Other:** _____

This authorization shall be valid for 180 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

_____ _____
Patient, Signature or Guardian Date

9150 Huebner Rd., Suite #: 330 San Antonio, Texas 78240 * 210-558-4600 Fax #: 558-4605

MICHAEL M. HECKMAN M.D., P.A.

Arthroscopic Surgery & Sports Medicine
Board Certified/Fellowship Trained

☐ **Yes, I would like an invitation to join the Orthopaedic Knee, Shoulder & Sports Surgery Patient Portal!**

☐ **No, I decline reason:**_____

Please ask the receptionist or call
210-558-4600 for your invitation to join.

Please specify the type of account you want
In advance (*for example, check one of three*):

☐ View chart
☐ Make a payment
☐ Both

*Yes, I'd like to opt for paperless billing.
Please send my billing statement via email.

Account Holder: _____

Patient name: _____

Email: _____

Please print clearly

Is the patient under 18?

☐ Yes
☐ No

If patient is over 18, please ask for form to grant permission for account holder to view records and make payments.

(for example, this may apply to a patient who is over 18, but registered under a different account holder, such as a parent or guardian who has permission to make payment on behalf of the patient.)

Signature of responsible party or account holder

_____

9502 Huebner Road, Ste 301 | San Antonio, TX 78240 | P: 210-558-4600 | F: 210-558-4605 | www.sanantoniosportsmedicine.com

Orthopaedic Knee Shoulder & Sports Surgery

Michael M. Heckman MD

Patient Name_____ Date_____

Date of Birth_____ Age_____ Chart No._____

Primary/ Family Physician_____ Referred by_____

Reason for your visit_____

Hand Dominance is: Right / Left / Ambidextrous

How did it happen?_____

When did it happen? _____ Is this an ongoing problem? Yes / No If yes, How long?_____

Have you received any treatment for this problem? If yes, describe_____

Have you had any studies performed? Yes / No. If yes, which Studies? _____

Describe the pain: _____ (sharp, dull, aching, burning, constant, intermittent)

Does the pain radiate or move to another area, if yes where? _____

What makes the pain better? _____Worse? _____

Has the pain changed since the onset? (Better, worse, different)_____

Are there prior injuries to this area? Yes/ No. If yes how and when?_____

Did you receive any treatment for prior injury? Yes / No. If yes, prior treatment?_____

On a scale of 0 for No Pain to 10 for Unbearable Pain, what is your pain level NOW? _____

With this current injury, what is the Worst pain level you have had _____ Least pain level _____

Do you have any associated symptoms? (Swelling, numbness, tingling, bruising) _____

Is this a Work related Injury? Yes/ No. If yes Date of Injury entered by Employer_____

Is this a Sports injury? Yes/ No If yes, what School: _____

Is an Attorney involved? Yes / No If yes, Name_____

Vital Signs: Ht._____ Wt._____ BP._____ Pulse_____

Physician Initials_____

ORTHOPAEDIC KNEE SHOULDER AND SPORTS SURGERY

ADDITIONAL INFORMATION: Circle Correct Answer

1. Have you ever had a Pneumonia Vaccination? Yes No

   If yes, When?_____

2. Have you ever had an Influenza Vaccination? Yes No

   If yes, when was the last vaccine?_____

3. Have been told you have Osteoporosis (thinning of the bones)? Yes No
4. Have you had a bone density study? Yes No

   If so when was your last study?_____

5. In the even that you are unable to make a decision concerning your medical care, who would you want to make decisions for you?_____
6. Was the injury we are seeing you for today due to a fall? Yes No

   If yes, when did it occur?_____

7. Have you fallen in the past 12 months? Yes No

   If yes, How many times in the past 12 months? _____

8. If you have arthritis, have you tried over the counter Medications? Yes No Which ones? Tylenol Ibprophen Asprin Other_____

Patient Signature_____Date_____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobic
- ☐ Diabetes – Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia or Reflux Disease
- ☐ HIV or AIDS
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Polio
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other:_____	Y/N	_____	☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

SOCIAL HISTORY

Occupation _____

Education ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Exercise Level ☐ None (No exercise) ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

Caffeine ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
# of cups/cans per day? _____

Alcohol
Do you drink alcohol? ☐ Yes ☐ No
If so, how often?
☐ Occasionally ☐ < 3 times a week ☐ > 3 times a week
How many drinks per week? __

Tobacco
Do you use tobacco? ☐ Yes ☐ No

If not currently, did you ever use tobacco? ☐ Yes ☐ No
☐ Cigarettes - _____pks./day
☐ Chew - _____/day
☐ Cigars - _____/day
☐ # of years_____
Or year quit _____

Drugs
Do you currently use recreational or street drugs? ☐ Yes ☐ No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular
- ☐ Arm Pain on Exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure on Exertion
- ☐ Irregular Heart Beats (Palpitations)
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of Breath When Lying Down
- ☐ Shortness of Breath When Walking
- ☐ Swelling (edema)

Constitutional
- ☐ Exercise Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (____lbs)
- ☐ Weight Loss (____lbs)

Eyes
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Date of Last Exam:_____

Ears/Nose/Mouth/Throat
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Infections
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in Stool
- ☐ Change in Appetite
- ☐ Frequent Indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Difficulty Urinating
- ☐ Incomplete Emptying
- ☐ Increased Urinary Frequency
- ☐ Urinary Loss of Control

Hematologic/Lymphatic
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin)
- ☐ Changes in Moles
- ☐ Dry Skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow Skin/Eyes)
- ☐ Rash

Musculoskeletal
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness

Neurological
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless Legs
- ☐ Seizures
- ☐ Weakness

Psychiatric
- ☐ Alcohol Overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do Not Feel Safe in Relationship
- ☐ Mania
- ☐ Sleep Problems

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

	ALLERGY	REACTION
1.		
2.		
3.		

FAVORITE PHARMACY

☐ Walgreens

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			

Parent, Guardian, or Caregiver Signature

Date