

**Southwest Regional Orthopedics & Sports Medicine**

**J. Scott Ellis, D.O.  
ORTHOPEDICS SURGEON**

Welcome to our practice! We hope the following will be helpful to you. We respect you and your time and we would like to make your visit to our office as pleasant and as efficient as possible.

**LOCATION:**

We are located in the Professional Building at 2909 S. Hampton Rd., Suite B-110 Dallas, TX 75224.

**CANCELLATIONS:**

Please give us 24 hour prior notice if you are unable to make your appointment. After two failed appointments, the doctor may release you from his care. If you are over 15 minutes late we will reschedule your appointment.

**PRESCRIPTIONS:**

If you need a refill on a prescription, YOU need to call your pharmacy and request a refill. Refills are to be called in during office hours within 24 hrs from the request from the pharmacy! **PLEASE TRY TO CALL IN FOR A REFILL A FEW DAYS PRIOR TO RUNNING OUT OF THE MEDICATION.**

**FINANCIAL POLICY:**

We collect patient co-pays and/or deductible at the time of service.

**MEDICAL INSURANCE:**

Your insurance may not cover the full cost of your charges, regardless of insurance payment, remains are your personal responsibility.

**DISABILITY FORMS:**

If you are taken off work you may have disability forms for us to complete. All disability forms will be filled out on Tuesdays & Thursdays only, and we ask for 5-7 days for completion. Each form has a \$25 charge, which is required prior to the completion of the form.

**MEDICAL RECORDS:**

We charge \$25 for the first 20 pages and .15 per page there-after. The fee is collected prior to receipt of records and they are done on Tuesdays & Thursdays only. When requesting medical records, please contact our office at least 5 days prior to needing them.

We look forward to serving your medical needs. If you have any questions or comments, please feel free to call us at any time.

I acknowledge that I have been presented with a copy of Southwest Regional Orthopedics and Sports Medicine's notice of Privacy Practices and understand Dr. Ellis' office policies.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**PLEASE COMPLETE ALL ATTACHED INFORMATION**

OFFICE: 214-333-9175

FAX: 214-330-4609

2909 S. Hampton Rd., Suite B-110 // Dallas, TX 75224



**Southwest Regional Orthopedics & Sports Medicine**

**PLEASE READ AND SIGN:**

**CONSENT FOR TREATMENT**

By signing this consent, I am authorizing my physician to perform and/or order another person to perform all exams, test, procedures, and other care deemed necessary or advisable for the diagnosis and treatment of my/m child's medical condition. This consent is valid for each visit I make to Southwest Regional Orthopedics & Sports Medicine unless revoked by me in writing.

\_\_\_\_\_  
Signature of Responsible Party/ Patient/ Parent/ Legal Guardian

\_\_\_\_\_  
Date

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Southwest Regional Orthopedics & Sports Medicine to furnish medical information pertinent to my medical condition including, but not limited to, the diagnosis, treatment, and care offered or rendered to me/my child. I understand this information includes my/my child's insurer. If necessary, this may include all medical records, laboratory test, radio graphic examinations, reports and/or other materials in the possession of Southwest Regional Orthopedics & Sports Medicine relating to my medical/my child's medical condition and proposed or actual treatment.

\_\_\_\_\_  
Signature of Responsible Party/ Patient/ Parent/ Legal Guardian

\_\_\_\_\_  
Date

**PLEASE READ**

**Please give the office 24 hours notice for cancellation of an appointment if not given a \$25 charge will be billed to you.** If you have any questions you may speak with the office manager. Please sign upon receiving this notice. Thank you!

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
J. Scott Ellis, D.O. (office staff)

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**Southwest Regional Orthopedics & Sports Medicine**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Has there been any change in your general health within the past year: ..... YES NO
2. My last physical exam was on \_\_\_\_\_
3. Are you now under the care of a physician other than Dr. Ellis? ..... YES NO
4. The name of my Physician is \_\_\_\_\_
5. Have you had any serious illness or operations? ..... YES NO
  - a. What was the name of the illness or operation? \_\_\_\_\_
6. Do you have or have you had any of the following diseases or problems?
  - a. Rheumatic fever or rheumatic heart disease? ..... YES NO
  - b. Congenital heart lesions, mitral valve prolapsed hear murmur ..... YES NO
  - c. Coronary bypass surgery ..... YES NO
  - d. Heart Valve surgery or valve replacement ..... YES NO
  - e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis) ..... YES NO
  - f. allergy or hay fever ..... YES NO
  - g. sinus trouble ..... YES NO
  - h. Hives or Skin Rash ..... YES NO
  - I. Fainting spells, Seizures, Convulsions, or Epilepsy ..... YES NO
  - j. Stroke ..... YES NO
  - k. Diabetes ..... YES NO
    1. Do you have to urinate more than 6 times daily ..... YES NO
    2. Are you thirsty much of the time ..... YES NO
    3. Does your mouth frequently become dry ..... YES NO
  - l. Liver Disease (Hepatitis, Jaundice, Cirrhosis) ..... YES NO
  - m. Arthritis ..... YES NO
  - n. Inflammatory rheumatism (painful swollen joints) ..... YES NO
  - o. Stomach ulcers ..... YES NO
  - p. Kidney trouble ..... YES NO
  - q. Lung disease (tuberculosis, asthma, emphysema, or other) ..... YES NO
  - r. Venereal disease, AIDS, Herpes ..... YES NO
  - s. Nervous breakdown or emotional problems ..... YES NO
  - t. Cancer..... YES NO
  - u. headaches, backaches, neck aches ..... YES NO
  - v. Other: \_\_\_\_\_
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma
  - a. Do you bruise easily ..... YES NO
  - b. Have you ever required a blood transfusion ..... YES NOIf so, explain the circumstances: \_\_\_\_\_
8. Do you have any blood disorders such as anemia ..... YES NO
9. Have you had any surgery or x-ray treatment for a tumor, growth, or other condition of your head, neck, face, mouth, throat, or lips ..... YES NO
10. Are you taking any of the following:
  - a. DIET PILLS OF ANY KIND ..... YES NO
  - b. Antibiotics of sulfa drugs ..... YES NO
  - c. Anticoagulants (blood thinners) ..... YES NO
  - d. Medicine for high blood pressure ..... YES NO
  - e. cortisone (steroids) ..... YES NO

- f. Tranquilizers ..... YES NO
- g. Antihistamines ..... YES NO
- h. Aspirins ..... YES NO
- i. insulin, tobutamide(Orinase), or similar drugs ..... YES NO
- j. Nitroglycerin ..... YES NO
- k. birth control pills ..... YES NO
- l. Supplements ..... YES NO
- m. over the counter medicines ..... YES NO

Please list current medications (Including over the counter medications, vitamins, herbal supplements) You are currently taking


11. Are you allergic or have you reacted adversely to:
- a. Latex ..... YES NO
  - b. Tape (surgical, cloth) ..... YES NO
  - c. Local anesthetics ..... YES NO
  - d. Penicillin or other antibiotic ..... YES NO
  - e. Sulfa drugs ..... YES NO
  - f. Barbiturates, sedatives, or sleeping pills ..... YES NO
  - g. Aspirin ..... YES NO
  - h. Iodine ..... YES NO
  - i. codeine or other narcotics ..... YES NO
  - j. Demerol ..... YES NO
  - k. Valium ..... YES NO
  - l. Other (Please List) \_\_\_\_\_
12. Do you drink alcohol.....Yes No (If yes, how much/how often) \_\_\_\_\_
13. Have you or are you being treated for alcoholism ..... YES NO
14. Do you smoke or use other forms of tobacco products ..... YES NO  
 If so, what \_\_\_\_\_ How much \_\_\_\_\_
15. Do you have any disease, condition or problems not listed above that you think we should be aware of? If so, Please explain \_\_\_\_\_
16. Do you wear glasses or contacts ..... YES NO

**WOMEN**

- 17. Are you pregnant ..... YES NO
- 18. Do you have any problems associated with your menstrual period ..... YES NO
- 19. Date of your last menstrual period \_\_\_\_\_

\_\_\_\_\_  
 Signature of Responsible Party/ Patient/ Parent/ Legal Guardian

\_\_\_\_\_  
 Date