**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 Baylor Waxahachie, 1505 W. Jefferson, Suite 102, Waxahachie, Texas 75165.

**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 a 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: 972-923-3800 FAX: 927-351-9360
Baylor Waxahachie // 1505 W. Jefferson, Suite 102 // Waxahachie, Texas 75165
**Southwest Regional Orthopedics & Sports Medicine**

PATIENT'S NAME:______________________________________________________ DATE OF BIRTH: _________________________
SEX: M F SOCIAL SECURITY NUMBER: __________________________________________________________
HOME ADDRESS: ________________________________________________________ APT #: ________________________________
CITY: __________________________________________________________ ST: _________ ZIP CODE: _________________________
HOME PHONE#: _____________________________________________ WORK#: ___________________________________________
MOBILE#: ___________________________________________ PAGER#/OTHER: ___________________________________________

If you have an answering machine may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Southwest Regional Orthopedics & Sports Medicine?

______YES ______NO OTHER(EXPLAIN): ______________________________________________________________________

EMPLOYER: ___________________________________________________ OCCUPATION: ___________________________________
EMPLOYER ADDRESS: __________________________________________________________________________________________
CITY: __________________________________________________________ ST: _________ ZIP CODE: _________________________
MARITAL STATUS: _________ SPOUSE'S NAME: __________________________________ WORK#: _____________________
INCASE OF EMERGENCY WHO MAY WE CONTACT?: _____________________________________________________________
EMERGENCY CONTACT #: _______________________________________ RELATIONSHIP: ______________________________

WHICH BEST DESCRIBES YOUR WORK STATUS?

_________WORKING WITHOUT RESTRICTIONS
_________WORKING WITH RESTRICTIONS (MODIFIED DUTY)
_________UNABLE TO WORK DUE TO INJURY DATE LAST WORKED: _________________________
____HOMEMAKER ____STUDENT ____RETIRED ____OTHER: __________________________________________

IS THE REASON FOR YOUR VISIT TODAY A RESULT FROM <u>ANY</u> TYPE OF INJURY? YES / NO
IS YOUR VISIT TODAY RELATED TO AN AUTO ACCIDENT? YES / NO
IF AN INJURY, WHERE DID INJURY OCCUR?(CIRCLE ONE) HOME WORK SCHOOL OTHER
IF OTHER, PLEASE EXPLAIN: ______________________________________________________________________________________

WERE S-XRAYS TAKEN OF THIS INJURY/PROBLEM: NO/YES-WHERE? _______________________________________
HAVE YOU HAD AN MRI OR ANY OTHER TEST? NO/YES-WHERE? __________________________________________
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**INSURED INFORMATION**

PRIMARY INSURANCE: _________________________________ SECONDARY INSURANCE __________________________
IS YOUR INSURANCE THROUGH YOUR EMPLOYER OR YOUR SPOUSE'S? ___________________________________
IF INSURANCE IS THROUGH YOUR SPOUSE'S EMPLOYER, PLEASE COMPLETED THE FOLLOWING: SPOUSE'S EMPLOYER: ___________________________________________________________________
SOCIAL SECURITY#: ________________________________________
SPOUSE'S DATE OF BIRTH: _______________________________________________
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I IRREVOCABLY CERITY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE.

SIGNATURE: _________________________________________________________________ DATE: ________________________

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)

OFFICE: 972-923-3800 FAX: 927-351-9360

Baylor Waxahachie // 1505 W. Jefferson, Suite 102 // Waxahachie, Texas 75165

**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 NO
   If 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

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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