Orthopedic Institute At Renaissance
Orange Medical Plaza 1421-A N 2nd St. McAllen, TX 78501
Phone: (956)618-4414 Fax: (956) 618-4424
Haissam Elzaim, M.S., M.D., Ph.D.

New Patient information/Patient update

Last Name _____ First Name _____Middle/Initial____

Date of Birth _____ Sex: Male Female SS# _____

Please Circle: Single Married Widowed Divorce Legally Separated

Address_____City_____State_____Zip_____

Home Phone# _____Cell#_____ Email _____

Employer Name & Address _____

If Patient is a minor, Name of Parent or Legal Guardian_____ Relationship_____

DOB of Parent or Legal Guardian_____ SS# of Parent_____

Race: (Please Circle)

American-Indian Asian African-American Caucasian Other Pacific Islander Declined

Ethnicity: (Please Circle) Hispanic Non-Hispanic Declined

Language: (Please Circle) English Spanish Bilingual Other

DO WE HAVE PERMISSION TO DISCUSS YOUR MEDICAL CONDITION WITH ANY MEMBER OF YOUR HOUSEHOLD? NO / YES- IF YES

NAME_____ PHONE #_____RELATIONSHIP_____

Emergency Contact: _____Phone:_____

Referred By: _____

Primary Insurance_____ Secondary Insurance_____

Policy # _____ Policy #_____

Policy Holder/DOB _____ Policy Holder/DOB_____

By Signing Below I agree to the following:

I authorize the release of any medical information Necessary to process any claims and request payment of medical benefits to be assigned to this medical group. I understand that I am responsible for payment of all Medical services rendered to me. Any checks sent to me by my Insurance company will be forwarded to this Medical group to apply to my account should balance exist.

_____

Patient /Legal Guardian Signature Date

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Medicare Authorization

I request that payment of authorized Medicare benefits be made wither to me on my behalf to Dr. _____ for any services furnished me by that physician. I authorize ay holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes, release of medical information necessary to pay the claim. If "other health insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determine of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charges determination of the Medicare carrier.

_____

Beneficiary Signature Date

PLEASE TELL US WHY YOU ARE HERE....

_____

HAVE YOU HAD SURGERY ON THIS PART OF THE BODY? YES / NO
HAVE YOU SEEN ANOTHER ORTHOPEDIC? YES / NO
DID YOU HAVE AN ACCIDENT? YES / NO IF YES, PLEASE EXPLAIN BELOW:

WHEN DID THE ACCIDENT HAPPEN? Month _____Date _____ Year _____

WHERE DID THE ACCIDENT HAPPEN? SCHOOL _____ WORK _____HOME _____
CAR_____ OTHER _____ (park, retail store, etc.)

HOW DID THE ACCIDENT HAPPEN? Please describe in detail how the accident occurred.

_____

_____

_____

_____ _____

Patient's Signature or Parent if Patient is a Minor Date

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Questionnarie For New Patients

*Full Name:*_____ *DOB:*_____

*Chief complaint: Reason for your visit today?*_____
*Have you seen another specialist for this condition:*_____*name of the doctor:*_____
List of all pain medications that you have been taking for this condition:

_____

*Have you been doing physical therapy?*_____ *when was the last session?:*_____
*Any injection to the affected area?*_____ *when was the last time?*_____
*Any other treatment?*_____ *please explain:*_____
*For how long have you had the pain?*_____
*If work related,please explain what happen:*_____

_____
*If sports related, please explain what happen:*_____

_____
*Current pain level 0-10:*_____ *pain level in a bad day 0-10:*_____
Have you had any of the following studies:

Study name:	*Date of the study:*	*Where at:*
X Rays		
MRI		
CT Scan		
Ultrasound		
Labs		

Past medical history

Please mark with ***V*** *what applies*

Anemia		Deep venous thrombosis		Myeloma	
Anxiety/depression		Diabetes		Primary bone sarcoma	
Asthma		End renal stage disease		Pulmonary embolism	
Atrial fibrillation		Epilepsy		Osteopenia	
Alzheimer		Fibromyalgia		Rheumatoid arthritis	
Bipolas disorder		GERD		Sciatica	
Blood transfusion		Gout		Scoliosis	
Bursitis		Hepatitis		Seizure	
Cancer		Herniated disc		Sleep apnea	
Carpal tunnel syndrome		Hypertension		Stomach ulcer	
Cholesterol		Lymphoma		Thyroid problems	
COPD		Leukemia		Vitamin D deficiency	
Coronary artery disease		Obesity			

Please list any/all surgeries/injuries done in the past: _____

_____

_____

_____

_____

Please list current medications:_____

_____

_____

_____

_____

Are you allergic to any food/medication?:_____

Please list them:_____

What reaction would you have:_____

Family past medical history:

Please list all medical history :

Father:_____

Mother:_____

Grandparents:_____

Siblings:_____

Children:_____

Social history:

Do you smoke?:_____ how often?:_____

Do you drink caffeine?:_____ how many cups a weeks?:_____

Do you drink alcohol?_____ how many drinks per week?_____

Drugs?_____ what kind?_____ frequency:_____

What pharmacy will you use:_____

Address:_____

Phone #:_____

This above information is true and correct to the best of my belief

_____ _____

Patient signature Date