



The Hand Center of San Antonio

**Dr. David Green, Dr. William Pederson
Dr. Mark Katz, Dr. Stace Rust
Dr. David Person, Dr. Mark Bagg**

Whom may we thank for your referral?

DR _____
Phone _____
Other _____
PCP _____

Patient Information

Patient Name _____ DOB ____/____/____ SSN ____ - ____ - ____ Age ____
Sex ____ F ____ M Phone _____ Cell _____ Full/Part time student ____
Address _____ City _____ State _____ Zip _____
Employer Name _____ Phone _____
Emergency Contact _____ Phone _____

Primary Insurance Information

Primary Insurance Name _____
Name of insured _____ Phone _____ DOB ____/____/____
SSN ____ - ____ - ____ Insurance ID Number _____ Group Number _____
Address _____ City _____ State _____ Zip _____
Relationship to patient _____

Secondary Insurance Information

Primary Insurance Name _____
Name of insured _____ Phone _____ DOB ____/____/____
SSN ____ - ____ - ____ Insurance ID Number _____ Group Number _____
Address _____ City _____ State _____ Zip _____
Relationship to patient _____

Work Related Information

Employer _____ Phone _____ Date of injury _____
Address _____ City _____ State _____ Zip _____

Reviewed by _____

Date _____

Patient #/ Doctor # _____

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Patient Consent of Release of Confidential Medical Information

Please list below the names of the person/persons to which we may release your medical health information.

Name	Relationship
_____	_____
_____	_____
_____	_____

Terms of Agreement

Please initial after each term of agreement

- The Hand Center has the right to release confidential medical information o my referring physician and/or my primary physician _____.
- If your insurance requires a referral and we do not have one, a payment will be required in full. _____
- I understand and agree that I am financially responsible for all in-network and/or out of Network balance owed to the Hand Center of San Antonio. _____
- I understand and agree that a deposit maybe required prior to surgery. _____

Acknowledge Of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices from The Hand Center of San Antonio.

_____ Signature of Patient or Legal Representative	_____ Date
_____ Print Name of Patient or Legal Representative	_____ Date

Acknowledgement and Authorization to Treat

I hereby acknowledge the information given is true to the best of my knowledge and I understand the terms and agreements made with The Hand Center, Inc.

I, _____ Legal Guardian/Parent/Self, authorize medical treatment by a staff physician associated with, The Hand Center, Inc.

Signature Date ____/____/____

Responsible Party Name _____ DOB ____/____/____ SS# _____ - _____ - _____

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Mark A Katz, Stace S Rust

David W Person, Mark R Bagg

Initial Patient Visit Form

Date _____

Name: First _____ M.I. _____ Last _____

What are you seeing the doctor for? _____

Hand Dominance _____ Right _____ Left _____ Both/Ambidextrous

Result of Problem: _____ Car Accident _____ Work Accident _____ Sport _____ Other

Date of Injury and/or when you first noticed the problem _____

Do you have legal Representation related to your problem? _____ Yes _____ No

Medications:

Please list your Pharmacy information and all medications, including doses (if known) that you are currently taking. Include over the counter drugs, herbs, vitamins, etc.

Pharmacy	Address	Phone Number

Medication	Dose	Frequency

Please include any medications, latex, foods, shellfish, tape products, or other solutions

Allergy	Reaction

Past Medical History:

Please list all current and/or prior major illnesses and/or injuries. Include conditions controlled with medications.

_____	_____
_____	_____
_____	_____

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Past Surgeries and Hospitalization:

Please list any prior surgeries and/or hospitalization along with any complications:

SURGERY/HOSPITALIZATION	YEAR	COMPLICATIONS (IF ANY)

Family history:

Please list family history of disease and include any diseases related to you current problem:

MEMBER	ALIVE (YES/NO)	DISEASE HISTORY (CAUSE OF DEATH)
Grandmother (mother's side)		
Grandmother (father's side)		
Grandfather (mother's side)		
Grandfather (father's side)		
Mother		
Father		
Sister/Brother		
Sister/Brother		
Sister/Brother		
Other		

Social History:

Occupation (status): _____ Date last worked: _____

Exercise _____ >3 days/wk _____ <3 days/wk _____ occasionally _____ Never

Type of exercise: _____

Special Diet? _____ Yes _____ No Describe: _____ Smoke

currently? _____ Yes _____ No # _____ packs per day for _____ years: Quit smoking? _____ yrs Drink

Alcohol? _____ Yes _____ No If yes, how often and amount? _____

History of substance abuse? _____ Yes _____ No what? _____

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Review of Systems: Have you had or are you currently having problems with the following?
Please mark with an X yes or no and describe all YES responses.

PROBLEMS	YES	NO	DESCRIBE ALL YES REPSONSES
Arthritis/joints			
Blackouts/fainting			
Bleeding problems			
Blood Transfusions			
Bone/ Muscle			
Cancer			
Diabetes			
Digestion/GI problems: ulcers, diverticulitis, etc.			
Eyes			
Ears, nose, throat			
Epilepsy/Seizures			
High blood Pressure			
Heart: chest pain, irregular rhythms, palpitations, etc.			
Hepatitis A, B, C			
HIV			
Hay fever/Allergies			
Kidney/Bladder problems			
Lung, Breathing			
Loss of balance/dizziness			
Numbness/Tingling			
Polio			
Prostate enlargement			
Psychological problems			
Skin/Breast problems			
Thyroid (hyper/hypo)			
Other:			

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information or who conceals, for the purpose of misleading, information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Signature of patient, Representative, or Guardian (if minor)

Date

Below for Office use only:

Physician	Date	Physician	Date	Physician	Date