

Release of Information

The purpose of this form is to alert our office as to those family members and/or friends who may be scheduling or canceling appointments on your behalf and/or will need to have access to your medical information.

Please note: Our office will automatically release information to your listed primary care physician upon request.

To Parents of Minor Children: Please fill out this form if there are stepparents, grandparents or friends who will take part in your child's care.

I, _____ (patient/guardian), give my permissions for the following people to have access to any and/or all of my personal medical information. I understand that I will not be notified if any of the following persons make an inquiry regarding my medical condition(s) or history.

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Name: _____ D.O.B. _____

Patient Signature

Date

If you do not wish for us to disclose your health information to anyone, please sign and date below.

Patient Signature

Date

Dr. David Y. Liao, D.O. Orthopedic Center, LLC

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provisions of healthcare services, Dr. David Y. Liao Orthopedic Center creates and maintains health records and other information describing among other things, my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have a right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices, and prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services and auditing functions, etc.) and that the organization is not required to agree to restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations, be restricted. I also understand that the Practice and I must: agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patients Name (Printed)

Date

Patients Signature (Guardian if Minor)

Social Security Number

Dr. David Y. Liao, D.O. Orthopedic Center, LLC

Patient Information

Name: _____ DOB: _____ Age: _____

SSN: _____ Male ___ Female _____ Marital Status: S M D W

Mailing Address: _____ Apt No: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Work Address: _____

Spouse Name: _____ DOB: _____ SSN: _____

Spouse Employer: _____ Phone: _____

If Patient is a Minor or Student

Mother's Name: _____ DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Father's Name: _____ DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Phone: _____

Emergency Contact (Not Living with you)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Who is your Primary Care Physician? _____ **Phone:** _____

Dr. David Y. Liao, D.O. Orthopedic Center, LLC

Assignment of Benefits

I hereby instruct and direct _____ Insurance Company to pay, by check, made out and mailed to:

Dr. David Y. Liao, D.O.
P.O. Box 835
Terrell, Texas 75160

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make the check out to me and mail to the above address.

I understand that I am responsible for any amounts not covered by my Insurance Company.

I understand that any unpaid amounts over 90 (ninety) days will be submitted for collections and an 18% interest fee will be applied. _____ (Please Initial)

I hereby authorize Dr. David Y. Liao, D.O. to furnish information to the Insurance Carriers on my behalf.

A copy of this authorization shall be as valid as the original.

Patient/Guardian Signature: _____ Date: _____

Attention All Medicare Patients

1. Are you currently residing in any type of Nursing Home, Skilled Nursing, or Assisted Living Facility? YES NO

2. Have you been a resident of any type of Nursing Home, Skilled Nursing, or Assisted Living Facility in the past two months? YES NO

3. If you answered Yes to either of the above questions, please provide the name and address of the Facility and the dates you resided there:

Patient/Guardian Signature: _____ Date: _____

(Please note: Our office may need to contact the Nursing Facility in which you reside or have resided, in order to properly care for your needs, due to Medicare's regulations with Consolidated Billing. Your appointment may have to be rescheduled until this information has been obtained.)

Symptoms

Patient Name: _____ Date: _____

If you were injured, was it:

- _____ At Home
- _____ At Work
- _____ Auto Accident

Did your pain come on:

- _____ Suddenly
- _____ Gradually

Is the Pain:

- _____ Constant
- _____ On and Off

Other: _____

Are you able to:

- | | | |
|---------------------|-----|----|
| Work | Yes | No |
| Sleep Normally | Yes | No |
| Do Daily Activities | Yes | No |
| Care for Yourself | Yes | No |
| Function Normally | Yes | No |

Approximate Height: _____

Approximate Weight: _____

Have you ever had this problem before _____ When _____
Who treated you: _____

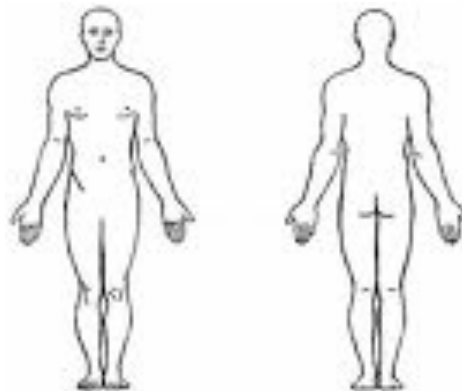
Women Only: Are you able to have children _____ If no, why _____
When was your last menstrual cycle _____ Was it normal _____

ARE YOU NOW OR COULD YOU BE PREGNANT **YES** **NO**

Using the diagram below: Circle the area(s) of pain and tell us on a scale of 1-10 (1 being the least amount of pain and 10 being the worst), how you rate your pain in each area.

Area 1- Pain is (1-10) _____ Area 2- Pain is (1-10) _____ Area 3- Pain is (1-10) _____

In the figures at the right, please mark your areas of pain or discomfort using these symbols:
+++ Burning /// Stabbing Pins & Needles xxx No Feeling



When or What Activities make the pain worse? _____
What makes the pain better? _____

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History

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO

IF YES, WHAT: _____

ARE YOU CURRENTLY TAKING ANY TYPE OF BLOOD THINNING MEDICATION, INCLUDING ASPIRIN? _____ IF YES, WHAT: _____

Current Medications

(Prescription and Over the Counter)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations and Surgeries

Please list all surgeries and periods of Hospitalization (Give Dates)

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please mark any conditions that you now have or have recovered from in the past:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Endocrine Disease | <input type="checkbox"/> Bone Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Congenital Heart | <input type="checkbox"/> Urinary/Genital Dys. | <input type="checkbox"/> Claudication |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anemia | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Menstrual Dys. | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Ovarian Cysts | <input type="checkbox"/> Alcohol/Drug Problem |

Family History: Has anyone in your immediate family (Mother, Father, Grandparents, Siblings, etc...) had:

<u>Condition</u>	<u>Who</u>	<u>Condition</u>	<u>Who</u>
Heart Disease	_____	Epilepsy	_____
Hypertension	_____	Glaucoma	_____
Stroke	_____	Bleeding Disorders	_____
Cancer	_____	Kidney Disease	_____
Diabetes	_____	Thyroid Disease	_____

Habits:

Do you now or have you ever smoked? _____ Packs/Day _____ Stopped _____
Do you use alcohol? _____ How Often _____ Amount _____
Coffee or Caffeine? _____ How Often _____ Amount _____
Recreational Drugs? _____ What _____ How Often _____