# Northwest Orthopedic Associates, P.A.
# Rick Nixon, M.D.

Patient Name: _____

Your appointment with Dr. Nixon is scheduled for:

Mon Tues Wed Thurs Fri Date: ____/____/____

Appointment Time: ____:____ am pm

Our office is located at 1919 North Loop West, Suite 115, on the 610 feeder road between East T.C. Jester and Ella. Please call if you need directions.

The following information will be needed at the time of your visit:

- Insurance card(s) and photo id or driver's license
- Your medical history **must include** all medications and previous surgeries
- Any X-Rays or MRI taken in the past 6 months for the condition you are being seen for.

**All co-payments, deductibles, and co-insurance amounts will be collected at the time of service**. We accept cash, check, American Express, Visa and MasterCard.

Please visit our website at http://www.northwestkneecenter.com for more information about our clinic. We look forward to your visit and please call with any questions.

Phone: 713-864-2663
Fax: 713-802-0684

# PATIENT INFORMATION

Name_____ Birth date _____

Age _____ Sex □ M □ F □ Single □ Married □ Widowed □ Divorced

Address_____ Social Sec. #_____-____-_____

City _____ State _____ Zip _____

Home Phone _____-_____-_____ Work _____-_____-_____

Cell _____-_____-_____ Email: _____

Employer Name _____ Occupation _____

Employer Address _____ City_____ Zip_____

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## If Patient Is A Minor, This Section Must Be Completed

Parent/Guardian_____ Birth date_____ relationship_____

Physical address_____ City_____ Zip_____

Home#_____ Work#_____ Cell#_____

Employer Name_____ Occupation_____

Employer Address _____ City_____ Zip_____

**********

Emergency Contact_____ Phone _____-_____-_____

Pharmacy Name _____ Pharmacy Phone #_____

Referred by _____

## PRIMARY INSURANCE

Insurance Co. _____ Phone _____

Subscriber ID #_____ Group # _____

Insured's Name _____ Birth Date_____

Relation to patient (circle one) Self Spouse Parent Other

SSN # _____Employer Name _____

Employer Address_____ City_____ Zip_____

Employer Phone #_____

## SECONDARY INSURANCE

Insurance Co._____ Phone #_____

Subscriber ID #_____ Group #_____

Insured's Name _____ Birth Date _____

Employer _____ Relation to patient _____

## CONFIDENTIAL

### Patient Release of Information

Please list family members or other persons, if any, and their contact information with whom we may inform about your general medical condition and diagnosis (including treatment, payment and health care operations) **(***Information will only be released to the individuals named below***)**

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

-Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than your home.**

Address_____ City_____ Zip_____

-May confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail?

YES _____ NO _____

_____

Print Patient Name

_____ _____

Patient Signature / **Guardian or Parent Signature Date

**If patient under the age of 18

**Northwest Knee & Shoulder Center** **Rick Nixon, M.D.**

## ASSIGNMENT & RELEASE

I, the undersigned, certify that I , or my dependent(s) have current insurance coverage and assign directly to **Rick G. Nixon, M.D. , Northwest Orthopedic Associates, P.A.**, all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize Northwest Orthopedic Associates, P.A. to release all information necessary to secure payment of claim(s). I authorize the use of this signature on all insurance submissions.

Benefits quoted by my insurance carrier are not a guarantee of payment. Any payments made at the time of service or prior to any surgical procedure are only an estimate based on benefits received.

**I understand that I am financially responsible for all charges whether or not they covered by any insurance.**

_____ _____ _____

Patient/Insured Signature Relationship Date

****In order for your Insurance Carrier to process our claims in a timely manner, please complete the injury detail information IF applicable.****

## Injury Detail Information

Date of the Accident/Incident: _____

Where did the Accident/Incident occur? _____

How did the Accident/Incident occur? _____

## Request for Release of Medical Records

I hereby request that my medical records be released to:

**Rick Nixon, M.D.**
**Northwest Orthopedic Associates, P.A.**
**1919 North Loop West, Ste 115**
**Houston, Texas 77008**
**Please FAX medical records to: (713) 802-0684**

Print Patient Name: _____ birth date: _____

Signature: _____ Today's date:_____

# Medical History

Patient:_____ Date of birth:_____

Which body part is involved?_____ ☐ left ☐ right ☐ both

Check any symptoms that you are having ☐ pain ☐ swelling ☐ weakness ☐ instability ☐ numbness

Describe any other symptoms:_____

When did it begin?_____ Rate your pain on a scale of 1-10 (10 being worst):___

Was it caused by an injury? ☐ yes ☐ no Was it job related? ☐ yes ☐ no

Describe accident/injury (if applicable): _____

_____

How did it begin? ☐ gradually ☐ suddenly Is the condition ☐ intermittent or ☐ constant?

What makes the condition worse? _____

_____

What makes the condition better? _____

_____

Have you had a similar problem in the past? ☐ yes ☐ no. If yes, describe: _____

_____

Have you seen another health care provider for this problem? ☐ yes ☐ no. If yes, who? _____

_____

What specific treatment/testing have you had for this problem? ☐ none

| | | |
|---|---|---|
| ☐ MRI/xrays/CT | ☐ narcotic medication (Vicodin, Lortab) | ☐ Orthovisc/Synvisc |
| ☐ brace | ☐ NSAIDs (Advil, Aleve) | ☐ orthotics/insoles |
| ☐ cast | ☐ physical therapy | ☐ ice or heat therapy |
| ☐ cortisone injection | ☐ shoe modification | ☐ crutches/cane/walker |

☐ other – describe: _____

Patient: _____

What specific things does your condition prevent you from doing? _____

_____

How do you exercise? _____

How far can you walk without stopping? (if applicable) _____ blocks or _____ miles

**Primary Care Physician**: _____ **Cardiologist**: _____

**Past Medical History:** Check any illnesses you may have or have had in the past. ☐ none

☐ Gastric Ulcer ☐ HIV/AIDS ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Chest pain/Angina

☐ Diabetes ☐ Heart Disease ☐ Osteoarthritis ☐ Bleeding Disorder ☐ Hypercholesterolemia

☐ Stroke ☐ Asthma ☐ Gout ☐ Hypothyroidism ☐ Hyperthyroidism

☐ Mental Illness (include Alzheimer's, Dementia, Bipolar, ADD, ADHD, Depression, etc.): _____

_____

☐ Hepatitis: specify _____ ☐ High Blood Pressure: when was last EKG? _____

☐ Liver, Kidney, Bladder problems: specify _____

☐ Cancer: specify _____

☐ Other: _____

**Past Surgical History:** Check any surgeries that you have had. ☐ none

☐ Total joint replacement: specify (type & year) _____

☐ Fracture repair: specify (type & year) _____

☐ Heart Surgery ☐ Hysterectomy ☐ Back surgery: specify _____

☐ Other: _____

Patient: _____

**Height**: _____ **Weight**: _____

**Medications:** Include all prescriptions, over the counter, and dietary supplements. Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications. ☐ none

| Name | Strength | Frequency | Name | Strength | Frequency |
|---|---|---|---|---|---|
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**Allergies:** Check all that apply. ☐ no known drug allergies

☐ Demerol ☐ Anesthetic ☐ Penicillin ☐ Codeine ☐ Iodine ☐ Sulfa ☐ Aspirin

☐ Morphine ☐ Other: _____

**Social History:**

Do you smoke? ☐ yes ☐ no Packs/Day: _____ Number of years you have smoked: _____

Do you drink alcohol? ☐ yes ☐ no Drinks/Week: _____

Do you use recreational drugs (marijuana, cocaine, other)? ☐ No ☐ Yes; frequency _____

**Family History:** Check all that have significance in your family's history. ☐ none

Father has ☐ Arthritis ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer ☐ Other: _____

Mother has ☐ Arthritis ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer ☐ Other: _____

Siblings have ☐ Arthritis ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer ☐ Other: _____

List family history of orthopedic problems: _____

_____

**THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:**

Signature of person filling out form: _____ date: _____