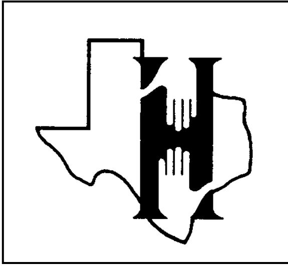

The Hand Center of San Antonio

Dr. David Green
Dr. David Person
Dr. Ramesh Srinivasan

Dr. Kunj Desai
Dr. James Saucedo
Dr. Mark Bagg

Whom may we thank for your referral?
DR. ______________________________
Phone ______________________________
Other______________________________
PCP________________________________

Patient Information

Patient Name_______________________________ DOB____/____/_____ Age__________ Sex: ___F ___M

Phone___________________Cell____________________ SSN_____-_____-_____ Marital Status_____________

Address_______________________________________City_____________________State_______Zip__________

Employer Name____Phone_____________________________

Emergency Contact____Phone____________________________

EMAIL: ____ Preferred Language: _________________________

Ethnicity: Hispanic or Latino Other Student Status: Full Time Part Time

Race: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander White Other

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

Secondary Insurance Name____

Name of insured_____________________________ Phone____________________ DOB____/_____/_____

SSN_____-______-______ Insurance ID Number _____________________Group Number_______________

Address_____________________________City______________________State__________Zip___________

Relationship to patient______________________

Work Related Information (for Worker's Compensation Injuries Only)

Employer___________________________Phone________________________Date of injury___________

Address____________________________City___________________State_________Zip_______________

________________________ Reviewed by

________________________ Date

________________________ Patient #/ Doctor #

The Hand Center of San Antonio

Green | Bagg | Person | Srinivasan | Saucedo | Desai

21 Spurs Ln., Ste. 310 San Antonio, TX 78240

NEW PATIENT INTAKE

Name: ___________________________________ Age: ____ ____Male ____Female Date:________

For Minor Children: Mother's Name __________________________ Father's Name ____________________

Are you: ____RIGHT-handed / ____LEFT-handed/ ____use BOTH equally? (What hand do you use more?)

What is your job or profession? ____

Chief Complaint - Please briefly describe in your own words the problem that brings you into the office today:

____

HISTORY OF PRESENT ILLNESS

1. **When did this problem begin**: (date of injury or onset) _____________________________________
2. **If you had an injury, how & where did it happen? What were you doing?**

____

3. **Problem is the result of** ____ Car Accident ____ Work Accident ____ Sport ____ Other ________
4. **Side of problem or injury** (please check one): ___Right / ___Left/ ___Both sides
5. **Location of problem or injury** (please check all that apply or use the "other" space to explain):

___Shoulder ___Elbow ___Forearm ___Wrist ___Hand ___Thumb ___ ___ Finger

Other: ____

6. **How would you describe your symptoms**: (please check all that apply)

___Pain ___Numbness ___Tingling ___Clicking ___Popping ___Locking ___Stiffness

7. **Quality of pain**: ___Sharp ___Shooting ___Stabbing ___Electric ___Dull ___Throbbing ___"Achy"

Other:____

8. **Severity of pain** (0 = no pain, 10 = most intense pain you have ever experienced); please check one:

____0 ____1 ____2 ____3 ____4 ____5 ____6 ____ 7 ____8 ____9 ____10

9. **Duration** (how long have you had symptoms?)____
10. **Frequency** (how often do you experience your symptoms?)

Please answer both questions by checking what best describes you:

a. "I experience these symptoms :___Rarely/___Sometimes /___Off & On /___Often /___Constantly"
b. "My symptoms occur mostly: ___In the morning / ___During the Day / ___At Night."

11. **Aggravating factors** (what makes it worse?)____
12. **What have you tried for it so far?** (please check all that apply)

___Nothing / ___Rest / ___Stretching / ___Medication / ___Cream / ___Splint or Brace /___ Heat /
___Ice / ___Steroid Injections / ___Surgery

Other: ____

13. **Alleviating factor** (what has made it better?)____
14. **Have you seen another physician or provider for this problem?** ___Yes / ___No

Where? ____ **When?** _______________

What did they do for you?____

15. **Do you have Legal Representation of related to your problem?** _____ Yes _____ No

Allergies

Do you have any allergies? ___ Yes ___ No If so, please list:

To **Medications**?

____

To **Foods**?

____

Are you allergic to latex? ___ Yes ___ No

Are you allergic to iodine? ___ Yes ___ No

Social History

Tobacco Use? (Required for all patients 13 years and older)

Types: ___Cigarettes ___Pipe ___Cigars ___Snuff ___Chew (Please check)

__ Yes, I currently smoke. I smoke ____ packs per day and have smoked for ____ years.

__ No, but I used to smoke. I smoked ____ packs per day for ____ years and quit ____________.

__ No, I have never smoked

Alcohol Use

What kind? ___Wine ___Beer ___Liquor (Please check)

Yes, ___ Rarely (1/month) ___ Occasionally (1-4/month) ___ Socially (1-2/week)

___ Frequently (3-5/week) ___ Daily

No, ___ Used to but stopped (date) _____________ ___ Never used alcohol

Do you use controlled or illegal substances?

Yes, ___ Rarely (<1/month) ___ Occasionally (1-4/month) ___ Socially (1-2/week)

___ Frequently (3-5/week) ___ Daily

No, ___ Used to but stopped (date) _____________ ___ Never used drugs

Which drugs do/did you use? (Please check)

___Amphetamines/Meth ___Anabolic Steriods ___Benzodiazepines ___Cocaine

___Hallucinogens ___Marijuana ___Opioids ___IV ___Inhaled ___Intranasal ___Oral

How often do you exercise?

___ Never ___ Rarely(<1/month) ___ Occasionally (1-4/month)

___ Frequently (3-5/week) ___ Daily

Do you have a Special Diet? ___ No Yes (describe) ___________________________________

Medications

1. Are you taking any pain medications? ___ YES ___ NO If so, please list all OR attach a separate list:

Pain Medications	Dose	Times per day	Reason for taking
______________________	__________	_____________	_________________________
______________________	__________	_____________	_________________________
______________________	__________	_____________	_________________________

2. **All other Medications** (Please include vitamins and supplements)

All other Medications	Dose	Times per day	Reason for taking
________________________	___________	_______________	____________________________
________________________	___________	_______________	____________________________
________________________	___________	_______________	____________________________
________________________	___________	_______________	____________________________
________________________	___________	_______________	____________________________

3. **Pharmacy**. Please list your preferred pharmacy.
Name:_______________________________________ Location: ___________________________________
Telephone # __________________________________

Past Medical History

1. **Have you or anyone in your immediate family ever had any of the following? (Check all that apply)**

Medical History	Patient	Father	Mother	Brother	Sister
No Medical Problems	______	______	______	______	______
Allergies	______	______	______	______	______
Anemia	______	______	______	______	______
Anxiety	______	______	______	______	______
Arthritis	______	______	______	______	______
Asthma	______	______	______	______	______
Back Pain	______	______	______	______	______
Bleeding/Clotting Disorder	______	______	______	______	______
Blood Transfusion	______	______	______	______	______
Cancer	______	______	______	______	______
Cardiovascular Disease	______	______	______	______	______
Congestive Heart Failure	______	______	______	______	______
COPD	______	______	______	______	______
Depression	______	______	______	______	______
Diabetes Type 1	______	______	______	______	______
Diabetes Type 2	______	______	______	______	______
GERD	______	______	______	______	______
Gastrointestinal Disorder	______	______	______	______	______
Glaucoma	______	______	______	______	______
GYN Problems	______	______	______	______	______
Headaches	______	______	______	______	______
Heart Attack	______	______	______	______	______
Heart Murmur	______	______	______	______	______
Hepatitis	______	______	______	______	______

Medical History	Patient	Father	Mother	Brother	Sister
HIV	______	______	______	______	______
Hypertension	______	______	______	______	______
Insomnia	______	______	______	______	______
Kidney Disease	______	______	______	______	______
Lipid Disorder	______	______	______	______	______
Musculoskeletal	______	______	______	______	______
Osteoporosis	______	______	______	______	______
Positive PPD	______	______	______	______	______
Rheumatoid Arthritis	______	______	______	______	______
Seizures	______	______	______	______	______
Stroke	______	______	______	______	______
Substance Abuse	______	______	______	______	______
Thyroid Disorder	______	______	______	______	______
Tuberculosis	______	______	______	______	______
Other (please list below)	______	______	______	______	______

2. If you have or have had any other medical conditions not listed here, please specify.

____
____
____
____

Past Surgical History

1. Have you had any of the following (please check all that apply):

No Surgeries _____
Appendectomy _____
CABG _____
Elbow Surgery _____
Foot Surgery _____
Gall Bladder _____
Hand Surgery _____
Hernia Repair _____
Hip Surgery _____
Hysterectomy _____
Knee Surgery _____
Mastectomy _____
Neck Surgery _____
Shoulder Surgery _____
Spine Surgery _____
Tonsillectomy _____
Wrist Surgery _____
Other____________________________

2. Have you had any other surgeries for the current problem? ___ **YES** ___ **NO**
Surgeries for This Problem and if they helped?____
Surgeon ____ **Year** ___________

Review of Systems

Have you had or are you currently having problems with any of the following?

Please check all that apply and describe all CHECKED responses.

Systems	Comments
General	
Weight gain	___
Weight loss	___
Fatigue	___
Insomnia	___
Fever	___
Night-sweats/chills	___
Eye	
Glasses/contacts	___
Cataracts	___
Glaucoma	___
Ear/Nose/Throat	
Sinus trouble	___
Hearing loss	___
Ringing in ears	___
Heart	
Irregular heartbeat	___
High blood pressure	___
Chest pain	___
Fluttering in chest	___
Coronary disease	___
Lung	
Shortness of breath	___
Difficulty breathing	___
Lung disease	___
Persistent cough	___
Stomach	
Decreased appetite	___
Constipation	___
Heartburn	___
Nausea	___
Diarrhea	___
Hepatitis __A__B__C	___
Muscles	
Arthritis	___
Fractures	___
Sprains	___

Systems	Comments
Urinary Tract	
Kidney stone	___
Bladder/kidney infections	___
Prostate problems	___
Painful urinating	___
Skin	
Masses	___
Blisters	___
Non-healing wounds	___
Dermatitis	___
Neurology	
Seizures	___
Tingling	___
Numbness	___
Severe headaches	___
Mental Health	
Anxiety	___
Depression	___
Other (please describe)	___
Endocrine	
Increased thirst	___
Diabetes	___
Thyroid	___
Blood/Lymph	
Bleeding or clotting problems	___
Anemia	___
Swollen or enlarged lymph nodes	___
Immunological	
Hay fever	___
Lupus	___
HIV/AIDS	___

BP: _____/_____
HT: __________
WT: __________

I understand that any person who knowingly and with intent to defraud any insurance company or other persons, files a statement or 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, parent or guardian (if minor) Date

The Hand Center of San Antonio
Terms of Agreement

Please INITIAL after each term of agreement.

_____ The Hand Center of San Antonio has the right to release confidential medical information to other parties involved
in my care including my insurance carrier, my referring physician and/or my primary physician.
_____ If my insurance requires a referral and I do not obtain one in advance of my appointment, I will be required to
make payment in full or reschedule my appointment.
_____ I understand an agree that I am financially responsible for all in-network and/or out of network balances owed to
The Hand Center of San Antonio as assigned by my insurance carrier.
_____ I understand and agree that a deposit may be required 3 days prior to scheduled surgery.
_____ I understand copay, coinsurance, and deductibles are due at the time of service.
_____ I understand the charges incurred are not final until the chart has been reviewed and the billing process is completed.

Acknowledge of Receipt of Notice of Privacy Practices

I acknowledge that I have been given an opportunity to review the Notice of Privacy Practices from The Hand Center of San Antonio and that I may request a copy for my records if I so choose.

_______________________________________ ________________________
Signature of Patient or Legal Representative Date

_______________________________________ ________________________
Print Name of Patient or Legal Representative Date

Acknowledgement and Authorization to Treat

I,___________________________Legal Guardian/Parent/Self, authorize medical treatment by a staff physician associated with, The Hand Center of San Antonio.

____   ________________________

Patient or Legal Representative Signature   Date

____   __________   __________________________

Responsible Party Name   DOB   SS#

OFFICE USE ONLY:

____

Reviewed by   Date   Patient
#/Doctor#

Applicable Non - Applicable

The Hand Center of San Antonio

Alternate Caregiver Consent Form

Except for life threatening emergencies, we are **not able to treat your minor child** unless he or she is accompanied to our office by a parent, legal guardian or designated adult. In order to designate an adult to bring your child into our office for medical care in your absence, you must have the following form completed, signed, and on file for each designated adult for each of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form or a signed note from a parent may need to be rescheduled.

I AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO BRING IN MY CHILDREN TO THEIR APPOINTMENTS:

Name: ________________________________ Relationship to my child: _________________________

Name: ________________________________ Relationship to my child: _________________________

Name: ________________________________ Relationship to my child: _________________________

I attest that the above named individual(s) are all 18 years of age or older as of this date. I authorize the above named individual(s) to consent to treatment for my children. This may include, but not limited to, consent for necessary medications, vaccinations, procedures and hospitalization. This practice may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in this child, and that under most circumstances, a follow up call to me personally should not be necessary.

I agree to hold _________________________________ and its staff harmless for any disagreement between the above named individual(s) and myself regarding medical treatment decisions.

I attest that I am the parent or legal guardian of the following children (see page 2) and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

____ ______________________________

Signature of Parent/Legal Guardian Date

____ ______________________________

Name of Parent/Legal Guardian - Print Phone Number

Child 1

Full Name: ____

Birth date and age: ____

Height and weight: ____

Allergies, symptoms and treatment: ____________________________________

Medications/Dosage:

1. ____

2. ____

3. ____

4. ____

Child 2

Full Name: ____

Birth date and age: ____

Height and weight: ____

Allergies, symptoms and treatment: _______________________________________

Medications/Dosage:

1. ____

2. ____

3. ____

4. ____

The Hand Center of San Antonio

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient name: ____

ID number: ____

Date of Birth: ____

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this is authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider - the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:

____

____

Persons/organizations receiving the information:

____

____

Specific description of information (dates included):

____

____

Purpose of requested use or disclosure:

____

____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____________. If I fail to specify an expiration date, this authorization will expire in six months.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.
4. I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.
5. If I have questions about disclosure of my health information, I can contact the office staff or the physician.

____ ________________

Signature of Patient/Legal Representative Date

____ ________________

If signed by Legal Representative, Relationship to Patient Date

THIS DOCUMENT WILL BE RETAINED BY THE PROVIDING ORGANIZATION FOR 6 YEARS.

Applicable Non - Applicable

The Hand Center of San Antonio

SELF PAY POLICY

Because Orthopedic and Plastic Surgery care can be extremely expensive, it is very important to ensure that our patients understand The Hand Center Self Pay Policy clearly prior to an appointment.

A deposit of $300.00 is required at the time of check in. This is not to say that this is going to be the entire cost of the visit or that this is all that you will be required to pay at the time of the visit. An initial office visit alone may cost $160.00 on average and this does not include x-rays, injections or fracture care. These additional services can range anywhere from $102.00 to $1,800.00 or more.

At the end of your appointment, we will obtain an estimate* of the total charges from the physician. If your estimate* exceeds your deposit, you will be expected to pay the difference at that time. New patient visits can range from $160.00 to $900.00. You will receive a discount of 30% off of your charges for paying your estimate* in full.

If the patient requires surgery, you will be provided with a surgery fee estimate*. You will be required to pre-pay this estimate* no less than 72 hours prior to the surgery appointment or your surgery could be postponed until payment is received. Charges for these services could escalate into the thousands of dollars depending upon the type of surgery required. We do our best to prepare an accurate estimate* prior to the surgery, however, it is only an estimate*. The actual charges cannot be known until after the procedure has been performed. In addition to the physician's fees, you will be required to make a deposit to the facility and anesthesiologist. These fees will be quoted to you by the provider of that service and it is your responsibility to make arrangements directly with that provider in advance.

Your signature below indicates that you have read this policy in its entirety and that you understand your financial obligations.

*Charges incurred are not final until the chart has been reviewed by the billing department for accurate billing.

__________________________________ ________________

Responsible Party Signature Date

__________________________________ ________________

Printed Name Chart #