



The Hand Center of San Antonio

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

Dr. Kunj Desai
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 Steroids 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** Dose Times per day Reason for taking
(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 and 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
#/Doctor#

Date

Patient

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.

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 #