Texas Health Physicians Group℠

Welcome Back to Texas Health Physicians Group

As you may already know, our practice is one of the more than 250 Texas Health Physicians Group (THPG) practices located in 11 North Texas counties. THPG has more than 950 physicians, physician assistants, nurse practitioners and medical professionals dedicated to providing safe, quality care for all our patients. THPG's primary care and specialist network represents 59 medical specialties, in addition to offering sleep lab services, infusion services and diagnostic imaging.

When you continue your care with a THPG primary care or specialty care provider, the registration information that you completed previously is stored in the Electronic Health Record THPG maintains. If you have any questions about the registration information you previously provided please let us know.

Benefits of being a THPG patient

As we hope you have experienced, there are many benefits to being a THPG patient, here are just a few:

- An improved patient experience with one-time registration to most (soon to be all) THPG locations
- Improved transition of care between all Texas Health providers
- Improved safety, better outcomes and increased efficiencies that can happen when all parts of the health care system work in close collaboration.
- As part of Texas Health Resources, THPG patients have access to over 29 hospital locations and more than 100 outpatient facilities, satellite emergency rooms, surgery centers, behavioral health facilities, fitness centers and imaging centers.

Contact us

Visit THPG online at **www.THPG.org** to find a physician or practice.

Thank you for the privilege of allowing us to continue to care for your health care needs

If you have any questions or concerns, please ask one of our staff members.

FORT WORTH ORTHOPEDICS

Disclosure regarding ancillary services/research programs

Patient's Name: _____ DOB: _____

Ancillary Services

Your physician may refer you to one or more "Ancillary Services" in connection with your medical care. An "Ancillary Service" is a service relating to your medical care or treatment. The following types of services are Ancillary Services:

Magnetic Resonance Imaging (MRI)	Bone Density Imaging
Mammography	Nuclear Imaging
Ultrasound	Laboratory
Computer Tomography (CT)	Durable Medical Equipment (DME)
Positron Emission Tomography (PET)	Echo Cardiograph
X-Ray	Sleep Therapy
Infusion Therapy	Audiology

Your physician may have an economic interest in or a business relationship with the company or person who provides the Ancillary Services. You are not obligated to use the provider that your physician refers you to. You are free to use any provider you choose.

Research Programs

Your physician may ask if you would like to participate in a clinical trial or other research program. These programs may be sponsored by a drug company or may be part of a governmental research program. **Your physician may be compensated for services rendered in connection with these programs. You are not obligated to participate in any research program and your permission will be obtained prior to your participating in a program your physician believes may be appropriate for you.**

Please feel free to ask your physician if you have any questions about a particular Ancillary Service or Research Program.

Signature: _____ Date: _____

Patient/Guardian if Minor

X-Ray Consent Form

Date of Service: _____

Patient name: _____ DOB**: _____**

I authorize the performance of a diagnostic x-ray(s) examination of myself which my provider may consider necessary or advisable in the course of my examination and treatment.

_____ Date _____
(Signature of Patient or Legal Representative)

_____ Date_____
(Witness)

If Patient is a Minor

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray(s) of this minor which the provider may consider necessary or advisable.

_____ Date_____
(Signature of Guardian or Legal Representative)

Consentimiento Para Radiografia

Nombre Del Paciente: _____ Fec. Nac. _____

Autorizo la realizacion del examen diagnostic de rayos x de mi mismo, la cuál el medico considere necesaria o coveniente en el curso de mi examen y tratamiento.

_____ Fecha_____
(Firma Del Paciente o Del Representate Legal)

_____ Fecha_____
(Testigo)

Paciente Menor De Edad

Yo soy el padre/representante legal de _____ que tiene la edad de, _____ años. Autorizo la realizacion del examen diagnostic de rayos x del menor de edad, la cuál el medico considere necesaria o conveniente.

_____ Fecha_____
(Firma Del Paciente o Del Representate Legal)

Pregnancy Questionnaire

Your provider has ordered an X-Ray examination. To prevent radiation of an unborn child we request that you answer the following questions:

Any chance of Pregnancy? Yes ☐ No ☐

First day of last menstrual cycle_____

Please check any of the following that apply?

Birth Control/IUD	Yes ☐ No ☐	Tubal Ligation	Yes ☐ No ☐
Menopause	Yes ☐ No ☐	Hysterectomy	Yes ☐ No ☐
Vasectomy	Yes ☐ No ☐	Other _____	

_____ Date_____
(Signature of Patient or Legal Representative)

Cuestionario De Embarazo

El doctor a ordenado una examinacion de radiografias. Para evitar radiación en un bebe no nacido, se require que conteste estas preguntas:

Hay posibilidad de embarazo? Si ☐ No ☐

Cuál fue el primer dia de su ultimo periodo? _____

Por favor marque todos los que sean pertinentes?

Pastillas Anticonceptivas/IUD	Si ☐ No ☐	Ligadura de trompas	Si ☐ No ☐
Menopausia	Si ☐ No ☐	Histerectomia	Si ☐ No ☐
Vasectomia	Si ☐ No ☐	Otro _____	

_____ Fecha_____
(Firma Del Paciente o Del Representate Legal)

Fort Worth Orthopedics

Medical History Part 1

Name: _____Age: _____DOB:_____

Primary care doctor: _____Who referred you? _____

Chief Complaint: _____

When did the problem begin/surgery date: _____ Which side: Right / Left

How did the pain begin: _____ Does it wake you at night? Yes / No

What makes the pain worse: _____ What makes the pain better: _____

How would you rate your pain between 1 and 10, with 10 being the worse pain you have ever experienced: _____

Are you experiencing any of the following? (circle)
Fever Chills Weakness Leg swelling Tingling Sensory change Other:_____

Have you had any (circle): Xrays MRI CT scan BoneScan EMG Mylelogram Other: _____

Have you had Physical Therapy: Yes / No

Please list all medications, vitamins, OTC pain relievers, or <u>any other substance</u> taken orally on a regular basis.

_____

Drug, Tape or Dye Allergies: _____

Medical History: (continue on back if needed) _____

Surgical History: _____

Family History: Does anyone in your family have a history of:

	Heart disease	Diabetes	Arthritis	Stroke	Kidney trouble	Muscular disease	Mental illness	Substance abuse
Please list family member(s)								

Are you right or left handed? Left / Right **Females:** Is there any possibility you are pregnant? Yes / No

Social History: Do you smoke? (please circle) Yes / Former smoker / No, never smoked / If yes, how much? _____

Work related injury: Worker's Compensation? Yes / No **Is there an attorney involved?** Yes / No

Signature: _____ Date: _____
Patient/Guardian if Minor

STUDENT ATHLETES ONLY

Name of School you attend: _____

May we provide your athletic trainer and their associates with your health information? ❑ Yes ❑ No

If yes, Name of Trainer _____ Phone # _____

Fort Worth Orthopedics

Medical History Page 2

Name: _____Age: _____DOB:_____

(Please circle)

1. Do you have a medical history of blood clots? **Yes / No**
   If yes, please explain: _____
2. Family history of blood clots? **Yes / No**
   If yes, please explain: _____
3. Do you have a medical history of MRSA or antibiotic resistance infection? **Yes / No**
   If yes, please explain: _____

Females:

1. Birth control medication(s) and type: _____
2. Have you taken oral contraceptives within the past 3 months? **Yes / No**
3. Hormone replacements medication(s): _____

Signature: _____ **Date:** _____
Patient/Guardian if Minor