

**SOUTHWEST ORTHOPEDIC
GROUP, LLP**

Dear Patient:

We are glad you have chosen us to help you with your healthcare needs. Your appointment is scheduled for the Bellville Clinic in Bellville, Texas.

Please fill out the enclosed new patient information form and bring it with you to your visit. Please also bring your insurance card so that we can make a copy. If your insurance company requires a referral, it is your responsibility to obtain this prior to your visit. Please be aware if you have not met your yearly deductible it will be collected at the time of your office visit.

If you need to cancel or reschedule your appointment, please contact our appointment desk as soon as possible at 713-333-4100.

If you would like to obtain more information about our office prior to your visit, you may visit my website at www.dlionbergermd.com.

We look forward to seeing you soon.

Sincerely,



David R. Lionberger, M.D.

DATE: _____

DR. NAME: _____

PATIENT DATA

Last Name _____ First Name _____ Middle _____ SOCIAL SECURITY NO: _____

Date of Birth _____ Age _____ MALE OR FEMALE _____ Marital Status: M S W D

Home Address _____ Apt. No. _____ HOME PHONE: _____

City _____ State _____ Zip Code _____ WORK PHONE: _____

Occupation: _____ CELL PHONE: _____

Referred By: _____ OFFICE NO.: _____

EMERGENCY CONTACT INFORMATION:

NAME _____ PHONE NO.: _____ RELATIONSHIP: _____

EMPLOYER INFORMATION:

EMPLOYER NAME _____ PHONE NO.: _____

Address _____ City _____ State _____ Zip Code _____

GUARANTORS INFORMATION:

Last Name _____ First Name _____ Middle _____ Social Security Number _____ Date of Birth _____

Patient's Relationship to Policy Holder: _____ HOME PHONE: _____

Home Address _____ Apt. No. _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Name of Primary Insurance _____ Customer Service No: _____

ID NUMBER _____ GROUP NO. _____

SECONDARY INSURANCE:

Name of Secondary Insurance _____ Customer Service No: _____

ID NUMBER _____ GROUP NO. _____

AUTHORIZATION TO PAY BENEFITS OF PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE _____

DATE _____

DAVID R. LIONBERGER, M.D.
ORTHOPEDIC SURGEON
SOUTHWEST ORTHOPEDIC GROUP

(PLEASE FILL OUT COMPLETELY INCLUDING BACK SIDE OF THIS SHEET)

Date:	
Name:	
Date of Birth:	Age:
Height & Weight:	
Primary Care Doctor:	Phone #:
Referred by:	

Chief Complaint:

Describe in detail the reason for your visit include- **symptoms, location, onset, duration and severity**

Have you ever been treated with injections for this extremity? No Yes

If yes, what type and when? _____

Have you ever had a surgery on this extremity? No Yes

If yes, when? _____ Who was the surgeon? _____

Medication allergies and reaction: _____

Please list any other surgeries and corresponding dates: _____

PATIENT HISTORY

PAST MEDICAL HISTORY

Please list all past and current medical problems/concerns:

General:

Fever No Yes

Weight Loss/Gain No Yes

Respiratory:

Chronic cough No Yes

Difficulty breathing No Yes

Cardiovascular:

Chest pain No Yes

Shortness of breath No Yes

Stroke No Yes

High blood pressure No Yes

Gastrointestinal:

Liver Problems No Yes

Hepatitis **A/ B/ C** No Yes

Stomach Ulcers No Yes

Colitis No Yes

Diabetes: No Yes

Thyroid: (↑/↓) No Yes

Cancer: No Yes

What type? _____

When? _____

Treatment? _____

Musculoskeletal:

Weakness of muscles No Yes

Osteoarthritis No Yes

Rheumatoid Arthritis No Yes

Radiating pain No Yes

Scoliosis No Yes

Gout No Yes

Pain in calves/buttocks No Yes

-Is pain relieved by rest? No Yes

Use of:

Alcohol use No Yes

How much? How often? _____

Smoking No Yes

Packs per day? _____

Hematological:

Blood Clots No Yes

Family history blood clots? No Yes

Anemia No Yes

Slow wound healing No Yes

Lupus No Yes

Other: _____

Notes: Office Use Only

Patient Name _____
Date _____

KNEE EVALUATION
Dr. David Lionberger, M.D.

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR KNEE/KNEES:
Circle one of the following choices for each category.

KNEE: **Right** | **Left** | **Right and Left**

1. Walking

- a. Unlimited
- b. More than 10 blocks
- c. 5-10 blocks
- d. Less than 5 blocks
- e. Housebound
- f. Unable

2. Supports

- a. None
- b. Cane
- c. Two canes
- d. Crutches or walker/ wheelchair

3. Ability to rise from chair

- a. Able to easily
(**no** arm support)
- b. Able to easily
(**with** arm support)
- c. Able to with difficulty
- d. Unable

4. Stairs

- a. Normal up and down
- b. Normal up; down with rail
- c. Up and down with rail
- d. Up with rail and unable down
- e. Unable

5. Stair Climbing

- a. Climb stairs normally with **NO** help from railing
- b. Climb stairs normally **WITH** help from railing
- c. Stop at each stair with **NO** help from railing
- d. Stop at each stair **WITH** help from railing
- e. Unable

6. Pain

- a. None
- b. Mild or occasional
- c. Stairs only
- d. Walking and stairs
- e. Moderate Occasional
- f. Moderate Continual
- g. Severe

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

**Patient or Personal Representative
Signature**

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

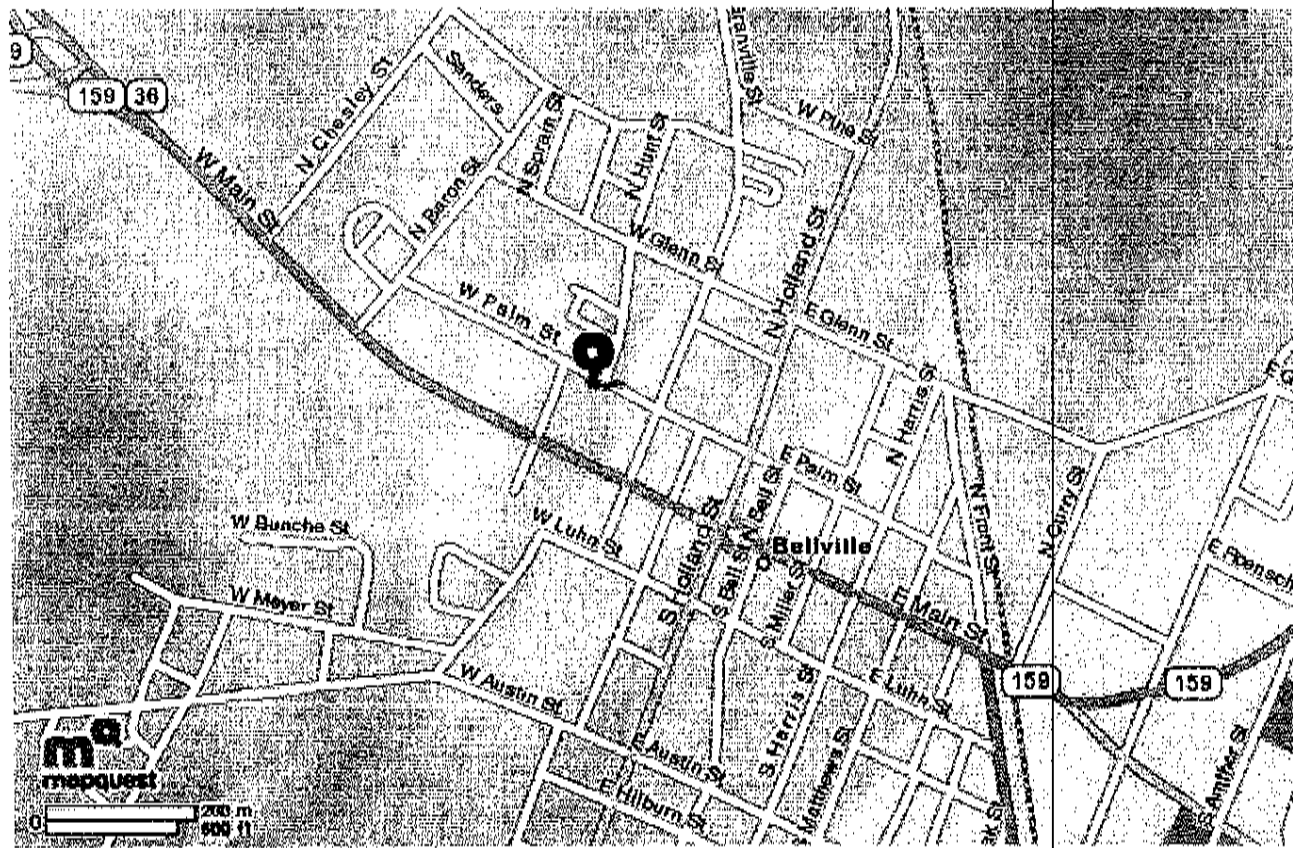
If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Patient or Responsible Party

Date



Bellville Clinic

235 W Palm St. Ste. 107
Bellville, TX 77418
Phone: 979-865-8858
Fax: 979-865-8325

The Bellville Clinic is attached to the Bellville General Hospital.

For questions regarding your appointment please contact the Houston office at 713-333-4100.

Thank You!