Physician Name: Jeffrey E. Budoff, M.D.

## PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Male or Female *(Please circle one)* | Marital Status: M S W D *(Please circle one)*

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: *(Please Check One)* Home Work Cell Mail | Email Address

Referred By: | Phone #:

## EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

## PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

## GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

## INSURANCE INFORMATION

| | | | | |
|---|---|---|---|---|
| Primary Insurance | Name of Primary Insurance | ID/Policy Number | Group Number | Customer Service No. |
| Secondary Insurance | Name of Secondary Insurance | ID/Policy Number | Group Number | Customer Service No. |
| Work Comp Insurance | Name of WC Insurance | Claim # | Adjuster Name | Adjuster Phone No. |

AUTHORIZATION TO PAY BENEFITS TO 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 OF TREATMENT.

Signature: | Date:

**JEFFREY E. BUDOFF, MD**

***(Nombre)*** ***(Fecha de hoy)***
Patient Name_____Today's Date_____

***(Edad)*** ***(Fecha de Nacimiento)***
Age_____ Birth Date: _____ Sex: M F

***(Mano Dominante) Derecha / Izquierda*** ***(Brazo Lastimado) Derecha / Izquierda***
I am: Right-Handed Left-Handed Injured Arm: Right Left

***(Ocupación)*** ***(Empleador)***
Occupation_____ Employer_____

**(¿Cuáles son tus pasatiempos?)**
Major Hobbies_____

***(Doctor que lo refirió)***
Referring Physician and **Phone Number** _____

**(¿Esto condición es el resultado de algún accidente?)**
Si:____ No:____ Personal: _____ Accidente en el trabajo: _____

***(Fecha de inico de la enfermedad)***
Date of Injury_____

***(Razón de la consulta de hoy)***
Reason for Your Visit Today_____
_____

***(Circule las condiciones que tenga o que ha tenido)***
**PMH**: Please Circle Any of the Following Conditions That You Have or Have Had:

| | | |
|---|---|---|
| ***(Diabetes-Insulinodependiente)*** Insulin Dependent Diabetes | ***(Hipertension)*** High Blood Pressure | ***(Enfermedad cardiaca/ infarto)*** Heart Disease |
| ***(Diabetes-no insulinodependiente)*** Non-Insulin Dependent Diabetes | ***(Coágulos de sangre)*** Blood Clots | ***(Infartos)*** Heart Attacks |
| ***(Hipotiroidismo)*** Hypothyroidism | ***(Desorden de la sangre)*** Bleeding Disorder | ***(Enfermedad de pulmones)*** Lung Disease |
| ***(Reacción a la anestesia)*** Reaction to Anesthesia | ***(Enfermedad de riñones)*** Kidney Disease | ***(Hepatitis)*** Hepatitis |
| ***(SIDA)*** HIV/AIDS | ***(Enfermedad de ulcera péptica)*** Peptic Ulcer Disease | ***(Enfermedad hepatica)*** Liver Disease |
| ***(Artritis Reumatoide)*** Rheumatoid Arthritis | ***(Abuso de drogas)*** Drug Abuse | ***(Alcoholismo)*** Alcoholism |
| ***(Asma)*** Asthma | ***(Desorden siquiátrico) ¿Que tipo?*** Psychiatric Disorder: What type?_____ | |

*(Cáncer) ¿Qué tipo?* *¿Está embarazada? Si / No*
Cancer: What Type?_____ Are You Pregnant: Y N

*(¿Otros problemas médicos?)*
Any Other Medical Problems?_____

**(Enumere todas las cirugías a las que se a sometido)**
**PSH**: Please List Each Surgery (Procedure and Date) That You Have Had:
_____
_____
_____

**(Alergias:) Enumere los medicamentos a cual es alérgico y los síntomas de alergia a cada medicamento?**
**Allergies**: Please List Any MEDICATIONS That You Are Allergic To, and What Happens When You Take Them:
_____
_____
_____

**(Medicinas:) Enumere todos los medicamentos que toma actualmente:Incluyendo Aspirina y Motrin**
**Medications**: Please List ALL Medications You Take, Including Aspirin, Motrin, etc:
_____
_____
_____

*(Síntomas) (Por favor circule las siguientes sintomas que tiene)*
***Review of Systems: Please Circle Any of the Following that You Have:***

*(Fiebre)*
Fever

*(Mareo)*
Dizziness

*(Frio en las puntas de los dedos)*
Fingertip Cold Intolerance

**(Sarpullido)**
Rash

(*Depresión)*
Depression

*(Ulcera en las puntas de los dedos)*
Fingertip Ulcers

*(Sangre en las heces)*
Blood in Stool

*(Tos )*
Productive Cough

*(Falta de Aire)*
Shortness of Breath

*(Hormigueo* **o adormecimiento de los pies***)*
Tingling or Numbness in Your Feet

*(Dificultad al orinar)*
Difficulty Urinating

*(Hormigueo o* **adormecimiento de las manos***)*
Tingling or Numbness in Your Hand

*(Dolor en el pecho*)
Chest Pain

*(Dolor en las articulaciones) ¿Aria de dolor?*
Joint Aches: Which Joints? _____

**(Historial Social:)**
**Social History:**

*(¿Fuma Cigarrillos?)* ***Si / No*** *¿Cuántos cigarrillos fuma por día?*
Do You Smoke? Y N How much do you smoke per day? _____

| | | |
|---|---|---|
| ***((¿Toma bebidas Alcohólicas?)*** | ***Si / No*** | ***¿Cuántas bebidas por día?*** |
| Do You Drink Alcohol | Y N | How Much? _____ |
| ***(Usa drogas?)*** | ***Si / No*** | ***¿Qué* clase de drogas*?*** |
| Do You Use Recreational Drugs | Y N | What Kind? _____ |

**Antecedentes Familiares: Circule los siguientes problemas médicos en su familia más cercana**
**Family History:** Please Circle Any of the Following Medical Problems in Your (Mediate Familia (Madre, Padre, Hermana, Hermano) Immediate Family (Mother, Father, Sister, Brother) :

| | | |
|---|---|---|
| ***(Reacción a la anestesia)*** | ***(Hipertensión)*** | ***(Artritis reumatoide)*** |
| Reaction to Anesthesia | Hypertension | Rheumatoid Arthritis |
| ***(Problemas de Sangrado)*** | ***(Problemas Cardiacos)*** | ***(Diabetes)*** |
| Bleeding Problems | Heart Problems | Diabetes |
| ***(SIDA)*** | ***(Enfermedad pulmonar)*** | ***(Cancer) ¿Qué tipo?*** |
| HIV/AIDS | Lung Disease | Cancer: What Type? _____ |

***(¿Otro tipo de enfermedades en la familia?)***
Other diseases that run in the family: _____

***(Incluya cualquier comentario o consulta adicional que considere importante con respeto a su condición y que no haya mencionado anteriormente en forma adecuada.)***
Please List Any Other Information That You Feel the Doctor Needs to Know:
_____
_____
_____

***Por favor indique el nombre y número de la farmacia que usted prefiere utilizar.***
**Please list the contact information for the Pharmacy you prefer to use:**

| | | |
|---|---|---|
| ***(Nombre de farmacia)*** | ***(Número de farmacia)*** | ***(Número de fax)*** |
| Pharmacy Name: _____ | Phone #: _____ | Fax #: _____ |
| ***(Nombre de farmacia)*** | ***(Número de farmacia)*** | ***(Número de fax)*** |
| Pharmacy Name: _____ | Phone #: _____ | Fax #: _____ |

# *SOUTHWEST ORTHOPEDIC GROUP, LLP*

## Notificación de prácticas de privacidad

**Nuestra Responsabilidad:**

Reconozco que he revisado el aviso de prácticas de privacidad en la oficina. Que explica como será utilizada y divulgada mi información medica. Entiendo que tengo derecho a recibir una copia de este documento.

_____ _____

**Firma de Paciente o Representante** **Fecha**

Si la firma de un representante personal aparece arriba, por favor describa la relación de Representante Personal del paciente: _____.

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### Declaración de política financiera

Es la política de fractura de Southwest Orthopedic Group, L.L.P. mandar la fractura a su compañía de seguros como cortesía hacia usted. Sin embargo usted es responsable de la fractura completa. Requerimos que los arreglos para el pago de su cuota estimada se haga hoy. El asegurado y el paciente es responsable de cualquier copago en el momento en que se realiza el servicio. Si su compañía de seguros no realiza el pago dentro de los sesenta (60) días, el balance se convierte en cien porciento responsabilidad de usted. Si su seguro paga más del total de la fractura, se le rembolsara el monto sobrante al paciente o a la compañía de seguros, según corresponda, dentro de un plazo razonable.

Si cualquier pago de los servicios brindado por Southwest Orthopedic Group, L.L.P. es hecho directamente a usted, reconoce su obligación de enviar de inmediato el pago correspondiente a Southwest Orthopedic Group, L.L.P.

Esta información no aplica a esos pacientes que son considerado Compensación de Workers'. Sin embargó si por algún motive o razón su caso de Compensación de Workers' no es aprobado o cancelado usted será responsable de los cargos adquiridos a la hora de la consulta.

Entiendo y acepto que si no llego a hacer cualquiera de los pagos de los que soy responsable en el tiempo requerido y acordado, su cuenta será transferida a una agencia de cobro. Usted será responsable por los cargos de la agencia de cobro y abogados que pueda adquirir Southwest Orthopedic Group, L.L.P.

La información anterior ha sido leída y explicada**. ENTIENDO QUE MI RESPONSABILIDAD POR EL PAGO DE MI CUENTA.**

_____ _____

**Nombre del paciente o persona responsable** **Fecha**

_____

**Firma del paciente o persona responsable**

# SOUTHWEST ORTHOPEDIC GROUP, L.L.P.

## ***AUTHORIZATION FOR COMMUNICATION OF MEDICAL INFORMATION***

*Patient Name:* _____ *DOB:* _____

*Address:* _____ *Telephone#*_____

***In order for our practice to respond promptly and accurately to your needs, Please list any person(s) whom you would like to have access to your medical information:***

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

*I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.*

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

# Informed Decision

In recent years, declining reimbursements have led to many hospitals resorting to significant cost cutting measures. One popular strategy for this has been to restrict the use of the latest, cutting edge surgical equipment and implants because, being new and often better, they are also usually more expensive. Other hospital strategies include decreasing the input surgeons have on the care their patients receive before, during, and after surgical procedures.

In response, some surgeons have established surgical centers for outpatient procedures. These are not only more convenient for patients, they are also associated with lower surgical infection rates and a much lower prevalence of multiple antibiotic-resistant bacteria. Having ownership of such centers gives surgeons much more input in the quality of care provided to their patients.

But, this can lead to increased costs to insurance companies, who have negotiated low payment rates with most hospitals. As a result, for profit insurance companies try to direct care towards in network surgical facilities with which they have contracted low rates of payment. If you and/or your employer have been paying higher health insurance premiums in order to have an insurance plan with out of network benefits, you have a choice to have your procedure at any facility your surgeon uses and feels comfortable with, regardless of whether or not it has a contract with your insurance company.

# Disclosure of Physician Ownership

Dr. Jeffrey Budoff has an ownership interest in *The Houston Center for Outpatient Surgery.*

Dr. Budoff believes that this interest allows him greater influence over the care provided to his patients.

In the event that you are referred for surgery at this center, you do have the option of using another health care facility if you choose. You will not be treated differently by Dr. Budoff if you choose a different facility.

If you have any questions or concerns, please feel free to discuss them with Dr. Budoff or his office staff.

**Acknowledgement of Disclosure**

Your signature on the bottom of this form signifies that you have read and understand this disclosure and that you know you can direct any questions and/or concerns regarding this disclosure to Dr. Budoff or his office staff.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Patient Name Time