



Bruce E. Douthit, M.D.

Steven W. Michelsen, D.O

4461 Coit Road, Ste. 101 Frisco, TX 75035

Phone: 972-335-8455 Fax: 972-335-7560

Patient History Questionnaire

The following questions are to provide the doctor with additional medical information.

Name: _____ Age: _____ Date: _____

What are you seeing the doctor for? _____

Date of injury: _____ ER or Urgent Care treatment? Y / N Where? _____

How is your general health? (circle one) Excellent Good Fair Poor

Previous surgeries (procedure, date, doctor, complications): _____

Hospitalization aside from surgery (reason, date, doctor): _____

Any excessive bleeding from a cut, surgery, pulled teeth or other? Y / N Date: _____

Any blood transfusion? Y / N Date and reason: _____

Current medications: _____

Any medication or drug allergies? Y / N List: _____

Are your immunizations up to date: Y / N If not, why? _____

Do you have any physical disabilities? _____

Family history: How is their health, if deceased, what was the cause?

Mother: _____

Father: _____

Siblings: _____



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Have you had, or are you currently experiencing any of the following: (check those that apply)

Yes ___ No ___ Tuberculosis

Yes ___ No ___ Paralysis

Yes ___ No ___ Anemia

Yes ___ No ___ Neuritis (numbness or tingling in limbs)

Yes ___ No ___ Diabetes

Yes ___ No ___ Hernia

Yes ___ No ___ Mumps

Yes ___ No ___ Blood in urine

Yes ___ No ___ Measles

Yes ___ No ___ Blood in stool

Yes ___ No ___ Whooping cough

Yes ___ No ___ Frequent indigestion or ulcers

Yes ___ No ___ Hay fever

Yes ___ No ___ Hepatitis

Yes ___ No ___ Skin rash or irritation

Yes ___ No ___ HIV positive

Yes ___ No ___ Asthma

Yes ___ No ___ Sexually Transmitted Disease

Yes ___ No ___ Goiter or thyroid trouble

Yes ___ No ___ Cancer What kind: _____

Yes ___ No ___ Blindness

Yes ___ No ___ Rheumatoid Arthritis

Yes ___ No ___ Cataracts

Yes ___ No ___ Osteoporosis

Yes ___ No ___ Eye Infection

Yes ___ No ___ Osteoarthritis

Yes ___ No ___ Frequent or severe headaches

Yes ___ No ___ Swollen or painful joints

Yes ___ No ___ Gum disease

Yes ___ No ___ Bone disease

Yes ___ No ___ Pain or pressure in chest

Yes ___ No ___ Swelling in feet

Yes ___ No ___ High blood pressure

Yes ___ No ___ Recent weight loss Amount: _____

Yes ___ No ___ Low blood pressure

Yes ___ No ___ Recent weight gain Amount: _____

Yes ___ No ___ Emphysema

Yes ___ No ___ Epilepsy

Other: _____

Yes ___ No ___ Stroke



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Patient Acknowledgement

I authorize Orthopedic and Sports Injury Specialists (OASIS) to release medical information that may become necessary to request reimbursement by my insurance company to whom I have submitted claims. I understand I am responsible for all medical fees during my treatment with OASIS. If surgery is required I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to OASIS. This assignment will remain in effect until revoked by me in writing. A photocopy or assignment is to be considered as valid as the original. I understand any overpayment on my account will be promptly refunded.

Disclosure of interest:

Bruce E. Douthit, M.D., has an ownership interest in Baylor Medical Center at Frisco and as a result he may financially benefit from the referral of services to the hospital in the form of increased dividends or distributions. You have the option of using an alternative health care facility. Please let us know if you have any concerns regarding the financial relationship between Dr. Douthit and Baylor Medical Center at Frisco.

Documentation of Good Faith Efforts

Patient Name: _____

Date: _____

The patient presented for treatment on this date and was provided with a copy of the provider's **Notice of Privacy Practices** for review. The patient's acknowledgment of being presented with this information is confirmed by a signature below:

Patient signature: _____

Date: _____

OR

A good faith effort was made to obtain a written acknowledgement of receipt of the **Notice of Privacy Practices**. However, an acknowledgement was not obtained because:

Patient refused to sign

Patient was unable to sign or initial due to: _____

There was a medical emergency and the provider will attempt to obtain acknowledgement at the next available opportunity

Other: _____



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Is your injury you are presenting to the office for today work related?

YES _____

NO _____

If you answered NO to the above question, please be advised that we only file on your personal health insurance. If at a later date you determine that this is in fact work related, we WILL NOT be able to file on Workman's Compensation on your behalf. So, please decide now if this injury is work related.

If you answered YES to the above question and have NOT informed our office prior to this visit, your appointment will be rescheduled until we have obtained all necessary information and approval to render treatment to you.

If you have answered YES to the above question and have already informed our office, please confirm with the receptionist that we have all necessary information on file.

Thank you for your cooperation.

Patient Signature: _____

Date: _____



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Social History:

Tobacco use: (circle one) Currently Previously Never

Year started: _____ Year stopped: _____

Cigarettes: Amount (packs per day) _____

Cigars: Amount (per week) _____

Smokeless/chewing: Amount (per day) _____

Alcohol use: (circle one) Currently Previously Never

Average amount of drinks per day: _____ Type: _____

Last time used: _____ Amount: _____

Drug use: (circle one) Currently Previously Never

Type: _____ Last use: _____

WOMEN ONLY:

Are you pregnant? (circle one) Yes No Unknown

Date of last menstrual cycle: _____ Do you use birth control? Y / N Type: _____

Number of children: _____ Number of miscarriages: _____

Pharmacy Information: (name, address and phone) _____



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Patient Preference-Communication of Health Information

I hereby give permission to Orthopedic and Sports Injury Specialists (OASIS) to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s) and/or personal friend(s):

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

____ I **DO NOT** wish to give permission for family member(s), other relative(s) and/or personal friend(s) to have access to any information related to my medical condition(s).

It is OK to leave detailed medical information on all phone numbers I have provided (circle one) Y / N

If not, please indicate which phone number(s) we can: Home Work Cell None

If none of the above, can we leave a call back number only: Y / N

On which number(s): Home Work Cell None



Financial Policy

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient representatives. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, checks and major credit cards.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we file your insurance claims for you if you assign benefits to the physician. If your insurance company does not pay within a reasonable period, we will look to you for payment.
- We have made prior arrangements with many health plans to accept an assignment of benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the co-payment or coinsurance due at the time of service.
- All health plans are not the same. Some may not be able to find you under your insurance identification number and require a social security number of the policy holder in order to find the patient. Therefore, we require your social security number for two reasons. First of all as a back up for insurance companies and secondly, collection agencies require a social security number in order to collect on delinquent accounts. If you do not wish to supply us with your social security number, we will not be able to file on your insurance on your behalf. You will be a private pay patient and pay in full for services rendered. If you do not wish to pay for those services, your appointment will be cancelled.
- In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you **read your insurance booklet** or a copy of the contract your policy falls under to determine your benefits.
- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable in full immediately.
- Be prepared to present your insurance card and proof of identity at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs.
- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowable, for scheduled surgical procedures. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.
- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

When you are charged a "global" fee for surgery or office care of a fracture, laceration repair, etc., that fee not only includes the service on the day it is performed, but includes routine follow up care as well. The global period ranges from 10-90 days depending on the procedure and your health plan. X-rays and supplies, such as casting or dressing materials, splints, durable medical equipment, etc., are not included in the "global" period and charges will be made for these items. Services related to complications are also not included in the "global" period.

Patient Signature: _____

Date: _____