SOUTHWEST
Orthopedic Group, L.L.P.

Dear:

We are glad you have chosen us to help you with your healthcare needs. Your appointment is scheduled for _____am/pm on _____.
Our clinic is located on the 10th floor of Scurlock Tower, ***6560*** Fannin, Suite 1016. Scurlock is located directly across from The Methodist Hospital in the Texas Medical Center, Scurlock Tower offers self and valet parking facilities.

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.

Directions to Medical Center Office (Scurlock Tower)

Scurlock Tower is located across from The Methodist Hospital on Fannin Street and opposite the Smith Tower on University Blvd. The building occupies the entire block at the intersection of S. Main, University, Fannin, and Dryden. We do not validate any parking tickets.

- Self-parking areas can be accessed through any of the building's entrances. Self-Parking rates range from $2.00 (up to 30 minutes) to $9.00 (3.5 hours to 24 Hours).
- To Valet Park, enter the "Valet Entrance" on the Fannin side of the building. Valet Parking rates range from $10 (up to 2 hours) to $13 for 24-hour parking.

From The West:
Follow Interstate 10 East toward Houston; Exit 610 South (past the Galleria). Then merge onto 59 North (toward downtown Houston). Follow 59 North to the Main Exit, take the Main Exit. Turn Right onto Main. Continue down Main Street (stay to the right of the Water Fountain); continue through approximately 5 lights and Turn Left on University Blvd. Turn Right on Fannin. The entrance to Valet and Self-parking in on the Right side of the street. There is an additional entrance on S. Main.

From The East:
Take Interstate 10 West toward Houston; Exit onto 59 South toward Victoria. Follow 59 South to the Fannin Street Exit. Then follow Fannin South approximately 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman (Baylor Plaza) on your left). Scurlock Tower is on the Right side of the street after the light at University. There is an entrance to Valet and Self-parking on Fannin. There is an additional entrance on S. Main.

From The North:
On Interstate 45, head South to 59 South toward Victoria. Follow 59 South to the Fannin Street Exit. Then follow Fannin South approximately 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman (Baylor Plaza) on your left). Scurlock Tower is on the Right side of the street after the light at University. There is an entrance to Valet and Self-parking on Fannin. There is an additional entrance on S. Main.

From the Northeast:
Follow 290 Southeast toward 610 South. Go past the Galleria and then merge onto 59 North (toward downtown Houston). Follow 59 North to the Greenbriar/Shepherd Exit. Turn Right onto Greenbriar (first intersection); follow Greenbriar heading South several blocks to University (Rice Stadium will be on the Left); turn left onto University; follow University to Fannin Street. Turn Right on Fannin. Enter the Scurlock Tower Garage on the Right side of the street. There is an additional entrance on S. Main.
Additional Route: Take I-10 to 610 South. Take 59 North (Follow same directions above).

From The South:
Take 288 North to 610 West. Follow 610 West to S. Main Exit. Turn Right on S. Main approximately three miles to Scurlock Tower parking entrance, which is on the Right between Dryden and University Street. Turn Right into the Scurlock Tower Garage. There is an additional entrance on Fannin.

From The Southwest:
Take 59 North toward Houston; Exit Greenbriar/Shepherd Exit. Turn Right onto Greenbriar (first intersection); follow Greenbriar heading South several block to University (Rice Stadium will be on the left) Turn left onto University, follow University to Fannin Street. Turn Right on Fannin. Enter the Scurlock Tower Garage on the Right side of the street. There is an additional entrance on S. Main.

From The Southeast:
On Interstate 45 head North to 610 West. Follow 610 West to S. Main Exit. Turn Right on S. Main and proceed approximately three miles to Scurlock Tower parking entrance, which is on the right between Dryden and University. Additional entrance is on Fannin.

DAVID R. LIONBERGER, M.D.

ORTHOPEDIC SURGEON
SOUTHWEST ORTHOPEDIC GROUP

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

Chief Complaint: **PLEASE CIRCLE ALL THAT APPLY**

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

1. The patient's chief complaint is pain in the: ***Right—Left Knee—Shoulder—Hip***
2. This has been a problem for _____ ***Days—Weeks—Months—Years?***
3. Associated symptoms include ***—weakness—popping— or grinding—restricted motion—stiffness—swelling—night pain—instability or giving way?***
4. The pain or discomfort can be described as: ***Burning—aching—sharp—dull***?
5. The pain is ***Constant—Intermittent—periodic, localized—random—radicular?***
6. Most frequently, the patient's pain is: ***Mild—Moderate—Severe?***
7. The most significant pain is located on the ***Front—Back—Inside—Outside*** of the joint?
8. The pain can be improved by: ***Ice—Heat—Rest—Elevation—Medications—Nothing?***
9. The pain is exacerbated by ***Activity—ROM—Everything, walking—getting into or out of a chair—sports—traveling—dressing—bathing —or grooming?***
10. Previous medications include _____***?***
11. Previous treatments include ***Surgery —Brace—exercise and or Physical Therapy—Nothing.***

Have you ever been treated with <u>injections</u> for <u>this extremity</u>? No ☐ Yes ☐
If yes, what type and when? _____

_____

_____

Have you ever had a <u>surgery</u> on <u>this extremity</u>? No ☐ Yes ☐
If yes, when? _____ who was the surgeon? _____
What type of Surgery was performed?_____

Please list <u>any other surgeries</u> and corresponding dates:

_____

_____

PATIENT HISTORY

PAST MEDICAL HISTORY
Please list all past and current medical problems/concerns:

<u>General:</u>

Fever No ☐ Yes ☐

Weight Loss/Gain No ☐ Yes ☐

<u>Respiratory:</u>

Chronic cough No ☐ Yes ☐

Difficulty breathing No ☐ Yes ☐

<u>Cardiovascular:</u>

Chest pain No ☐ Yes ☐

Shortness of breath No ☐ Yes ☐

Stroke No ☐ Yes ☐

High blood pressure No ☐ Yes ☐

Other: _____

<u>Gastrointestinal:</u>

Liver Problems No ☐ Yes ☐

Hepatitis **A/ B/ C** No ☐ Yes ☐

Stomach Ulcers No ☐ Yes ☐

Colitis No ☐ Yes ☐

<u>Diabetes:</u> No ☐ Yes ☐

<u>Thyroid</u>: (↑/↓) No ☐ Yes ☐

<u>Cancer:</u> No ☐ Yes ☐

What type?_____

When?_____

Treatment?_____

<u>Musculoskeletal:</u>

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 ☐

<u>Use of:</u>

Alcohol use No ☐ Yes ☐

How much? How often?_____

Smoking No ☐ Yes ☐

Packs per day?_____

<u>Hematological:</u>

Blood Clots No ☐ Yes ☐

Family history blood clots? No ☐ Yes ☐

Anemia No ☐ Yes ☐

Slow wound healing No ☐ Yes ☐

Lupus No ☐ Yes ☐

Other:_____

_____

Please list any other physicians and contact information (pulmonary,oncology,nephrology,etc)

Doctor:	Specialty:	Phone #:

Doctor:	Specialty:	Phone #:

Doctor:	Specialty:	Phone #:

Doctor:	Specialty:	Phone #:

Notes: Office Use Only

Patient Name: _____DOB:_____

Allergies: _____

Pharmacy Name: _____ Phone #:_____

Alt. Pharmacy Name: _____ Phone #:_____

PLEASE LIST **ALL** MEDICATIONS YOU ARE CURRENTLY TAKING ON A REGULAR BASIS INCLUDING **DOSAGE** AND **FREQUENCY**

Medication	Dosage	Times/day	**Reason for taking this medication**

Physician Name: David R. Lionberger, 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:** _____

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 **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, LLP, 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, LLP, you recognize an obligation to promptly remit payment to Southwest Orthopedic Group, L.L.P.

The above does not apply to those patients that are considered Workers' Compensation. However, be advised as a Workers' 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, LLP, 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.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature

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: _____