



**PATIENT INFORMATION**  
CONTACT INFORMATION

LAST NAME	FIRST NAME	MI
ADDRESS	CITY	STATE ZIP
HOME PHONE:	WORK PHONE:	EXT: EMPLOYED? YES NO
EMPLOYER'S NAME	PHONE #	
EMPLOYER'S ADDRESS (CITY/ST/ZIP)		
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	MARITAL STATUS:

EMERGENCY CONTACT:	PHONE #:
NEXT OF KIN:	PHONE #:
ADDRESS OF NEXT OF KIN:	

INSURANCE COMPANY:	PHONE #:
NAME OF INSURED:	SOCIAL SECURITY # OF INSURED:
DOB OF INSURED:	EMPLOYER OF INSURED:
ATTORNEY:	PHONE #:

**RELEASE AUTHORIZATION:**

I hereby authorize Lone Star Orthopedics to release any and all medical information, acquired in the course of my examination and/or treatment, including, but not limited to, information pertaining to the following: Mental Health; Alcohol & Substances; HIV/AIDS to my insurance carrier; my employer; other doctors treating or evaluating me; and/or my attorney.

This authorization includes verbal communication to my employer regarding my condition and ability to work, as well as verbal communication with agents of the insurance carrier for purposes of getting treatments/diagnostics approved.

I authorize payment directly to Lone Star Orthopedics. I authorize use of this form on all my insurance submissions. I authorize this practice to act as my agent to help me secure payment from my insurance companies.

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

Witness: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

This authorization is valid for 12 months

PATIENT NAME: \_\_\_\_\_

WHAT IS YOUR AGE? \_\_\_\_\_

WHAT DOCTOR REFERRED YOU HERE? IF YOU NEED THE REPORTS TO BE FORWARDED TO SOMONE PLEASE SPECIFY NAME.

PLEASE DESCRIBE THE SYMPTOMS WHICH BRING YOU TO THE OFFICE TODAY. PLEASE SPECIFY THE BODY PART INVOLVED AND WHETHER IT IS ON THE RIGHT OR LEFT.

IS THERE A DATE OF INJURY, IF SO WHEN?

WAS THIS WORK RELATED? Y N SCHOOL RELATED? Y N

WHEN WAS YOUR LAST DAY YOU WERE ABLE TO WORK/ATTEND SCHOOL?

PLEASE DESCRIBE YOUR JOB. IF YOU ARE NOT WORKING, WHAT ABOUT YOUR JOB AND INJURY PREVENT YOU FROM WORKING?

PLEASE GIVE THE DETAILS OF THE INJURY/ACCIDENT AND HOW IT OCCURRED, OR IF NO INJURY HOW DID YOU FIRST NOTICE YOUR SYMPTOMS:

HOW DO YOU THINK EACH OF THE BODY PARTS YOU MENTIONED EARLIER GOT HURT?

WHICH DOCTORS HAVE YOU SEEN SO FAR FOR THIS PROBLEM? PLEASE LIST THEM AND INDICATE IF THEY WERE SEEN FOR TREATMENT OR JUST AN OPINION:

DATE	DOCTOR'S NAME (PHONE # IF KNOWN)	TREATMENT / OPINION
		TREATMENT / OPINION
		TREATMENT / OPINION
		TREATMENT / OPINION
		TREATMENT / OPINION

PLEASE DESCRIBE ANY TREATMENT YOU HAVE RECEIVED FOR THIS PARTICULAR PROBLEM. (TO MAKE THINGS EASIER, SOME TREATMENTS ARE LISTED FOR YOU)

- PHYSICAL THERAPY/MANIPULATIONS HOW MANY WEEKS? \_\_\_\_\_ DID THEY HELP AT ALL? A LITTLE / SOME / A LOT
- INJECTIONS WHAT BODY PARTS? \_\_\_\_\_ HOW MANY TIMES? \_\_\_\_\_ DID THEY HELP AT ALL? A LITTLE / SOME / A LOT
- SURGERIES WHAT TYPE OF SURGERY \_\_\_\_\_ DID IT HELP AT ALL? A LITTLE / SOME / A LOT  
WHAT TYPE OF SURGERY \_\_\_\_\_ DID IT HELP AT ALL? A LITTLE / SOME / A LOT  
WHAT TYPE OF SURGERY \_\_\_\_\_ DID IT HELP AT ALL? A LITTLE / SOME / A LOT
- HAVE YOU HAD PAIN MANAGEMENT? YES / NO
- HAVE YOU DONE WORK CONDITIONING/HARDENING? YES / NO
- ANY OTHER TREATMENTS?

WHAT DIAGNOSTIC STUDIES WERE DONE SO FAR AND WHEN? (INCLUDE CT SCANS, BONE SCANS, MRI, NERVE TESTS)

CONSENT FOR TREATMENT

I, as a patient or on the patient's behalf, voluntarily consent to medical care including diagnostic, examinations, or surgical treatment under the general and special direction of Kenneth G. Berliner, M.D. and such associates or assistants as he may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of any treatment rendered by Dr. Berliner and such associates and assistants.

Signature \_\_\_\_\_

Date \_\_\_\_\_

PATIENT NAME:

PLEASE LIST YOUR CURRENT MEDICATIONS

Table with 4 columns: MEDICATION NAME, DOSE/STRENGTH, FREQUENCY (1X/DAY, 2X/DAY, 3X/DAY, 4X/DAY, MORE), and PRESCRIBING DOCTOR.

PLEASE LIST ANY MEDICATION OR MEDICAL TREATMENT YOU HAVE HAD A BAD REACTION TO:

PLEASE CHECK NEXT TO ANY HEALTH PROBLEMS YOU MIGHT HAVE HAD:

- DIABETES, HEART ATTACK, STROKE, HIGH BLOOD PRESSURE, ASTHMA, ULCERS, SEIZURES, TUBERCULOSIS, HEPATITIS. Includes checkboxes for YES/NO and a field for 'IF YES, WHAT TYPE? A / B / C'.

HAS ANYONE IN YOUR FAMILY HAD THOSE PROBLEMS? IF SO WHICH FAMILY MEMBER AND WHICH PROBLEM?

DID YOU EVER SMOKE? YES NO IF SO, HOW MANY PACKS PER DAY?
DO YOU EVER DRINK ALCOHOL? YES NO IF SO, HOW MUCH PER DAY?
HAVE YOU HAD ANY OTHER UNRELATED BONE OR JOINT INJURIES?
ANY MOTOR VEHICLE ACCIDENTS IN YOUR PAST?

Table with 3 columns: YEAR, BODY PARTS INJURED, MRI DONE? (checkboxes for NO/YES), FULL RECOVERY? (checkboxes for NO/YES SINCE).

- Series of health questions with checkboxes: HAVE YOU HAD ANY RECENT FEVER?, HAVE YOU HAD ANY RECENT WEIGHT LOSS?, HAVE YOU HAD ANY RECENT CHANGE IN VISION?, HAVE YOU HAD ANY RECENT COLDS OR FLU?, HAVE YOU EVER BEEN TOLD YOU HAVE A HEART MURMUR?, DO YOU GET SHORT OF BREATH EASILY?, DO YOU EVER GET CRUSHING CHEST PAINS?, DO YOU HAVE WHEEZING?, DO YOU HAVE A COUGH?, HAVE YOU EVER THROWN-UP BLOOD?, HAVE YOU RECENTLY HAD BLACK TARRY STOOLS?, DO YOU FEEL NAUSEOUS OR HAVE THROWN-UP RECENTLY?, DO YOU HAVE CONSTIPATION OR DIARRHEA?, DO YOU URINATING MORE OFTEN THAN USUAL?, DO YOU WAKE UP TO URINATE?, DOES IT HURT TO URINATE?, HAVE YOU NOTICED ANY RECENT RASHES?, HAVE YOU NOTICED ANY BREAST MASSES?, HAVE YOU HAD RECENT HEAD ACHES?, DO YOU HAVE A BLEEDING DISORDER?, HAVE YOU EVER TESTED POSITIVE FOR HIV?

COMPLIANCE AGREEMENT

I realize that Dr. Berliner and such associates or assistants are making medical decisions based on the assumption that the information given to him is truthful and accurate. I agree to be a truthful and accurate as is reasonably possible. I, also, understand that the outcome of treatment is partially based on my cooperation with Dr. Berliner's and such associates or assistants prescribed treatment plan. I agree to be as compliant as can reasonably be expected.

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/20\_\_\_\_



KENNETH G. BERLINER, M.D.  
AMERICAN BOARD OF ORTHOPAEDIC SURGERY

### OFFICE MEDICATION POLICY

We are happy to refill medications for our patients. For your safety, we will have to monitor strict rules to decrease your risk from overdose and protect Dr. Berliner's medical license. By following these rules we will be able to refill your prescriptions while be treated by Dr. Berliner.

- If you are receiving medication from Dr. Berliner, please do not accept prescriptions for similar medications from the other doctors sharing in your care. This can potentially be hazardous or even fatal.
- It has been our experience that the huge number of phone calls we get regarding medication refills interferes with our ability to treat patients during the day. As a result, we may require up to 2 to 3 working days to refill medication requests. Please do not wait until you are completely out of medicine to call.

Do not call after hours, weekends, or holidays for medication refills. If there is an emergency, go to the emergency room.

Please do not call the office to find out the status of your medication before the 2 to 3 working days are up.

There will be no medicine replacements for lost, stolen, or excessive use of any narcotics, so be careful. DO NOT TAKE IT UPON YOURSELF TO INCREASE YOUR DOSE WITHOUT CONSULTING THE OFFICE.

If you feel your medication is not helping, please call the office and inform my medical assistants or my PA. If any narcotic medicine is changed, you will be required to bring in the unused portion of the discontinued medication so that we can dispose of it.

I have read the above and understand that there will be no exceptions under any circumstances.

A handwritten signature in black ink, appearing to read "K. Berliner".

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Kenneth Berliner, M.D.



PATIENT AUTHORIZATION
DISCLOSURE OR RECEIPT OF PROTECTED HEALTH INFORMATION

Name of Patient Medical Record #
Date of Birth Phone #
Patient Address

Soc. Sec. # (Providing your SS# is voluntary, but necessary to accurately identify your medical records. Failure to provide this information will likely delay the processing of your request).

Approximate Dates of Treatment

1. I authorize the following health care provider or facility TO DISCLOSE my patient information:
Outpatient Clinic(s):
Specific Provider(s):
Other: Name: Phone:
Address:

2. I authorize the following person or organization TO RECEIVE my patient information:
Name/Credentials: Kenneth G. Berliner, M.D Relationship: Orthopedic Surgeon
Address: 15769 North Freeway
Houston, TX 77090
Phone #: 281.875.0830 Fax #: 281.875.0316

Please disclose the following information: (circle to indicate your selection)

- History and Physical Psychological Evaluation Discharge Summary
Educational Reports Treatment Plans Psychosocial History
Radiology and Lab Reports Consultation Reports Immunizations
Outpatient Clinical Records

Other:

Information.

- 3. Please indicate the purpose of the disclosure of your patient records: Orthopedic Evaluation, or check here if it is for your own personal use
4. If applicable, I understand that based on the dates, providers, and information I have designated above, the disclosure Lone Star Orthopedics makes pursuant to this authorization may include information regarding my participation in a substance abuse treatment program.

5. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by federal privacy regulations, the information he/she receives will no longer be protected by these regulations and the recipient may re-disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
6. I understand that the Lone Star Orthopedics will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.
7. I understand that I may revoke this authorization in writing at any time by sending a written revocation of authorization to: **Lone Star Orthopedics**  
**c/o Medical Records**  
**15769 North Freeway**  
**Houston, Texas 77090**

I understand that my revocation is not effective to the extent that action has been taken in reliance on this authorization. This authorization expires (check one):

\_\_\_\_\_ 1 year from the date I sign below \_\_\_\_\_ one time disclosure only

\_\_\_\_\_  
 Patient's Name Signature of Patient or Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Name of Personal Representative (if applicable)

If signing as Personal Representative, describe authority to act for patient and submit documentation showing such authority: \_\_\_\_\_

\_\_\_\_\_  
 Name of Witness

\_\_\_\_\_  
 Signature of Lone Star Orthopedic Staff

\_\_\_\_\_  
 Date

(No notary is required if the patient appears personally to the Lone Star Orthopedic facility and presents identification.)

SUBSCRIBED AND SWORN before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

NOTARY PUBLIC

Residing in \_\_\_\_\_

My Commission expires: \_\_\_\_\_

**Authorization documented in HIPAA Management Application.  
 Lone Star Orthopedics staff, after processing place this form into the patient's medical record.**