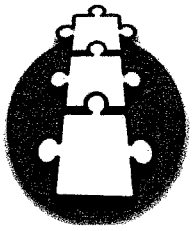


TEXAS**ORTHO**
SPINECENTER

12605 East Freeway, Suite 510
Houston, Tx 77015

Cancellation/No show fee

We understand that you may sometimes need to reschedule appointments. When you make your appointment please understand we are reserving time for you to see a provider. This courtesy makes it possible to give the service here at Texas ortho spine center. If you need to cancel an appointment or reschedule please notify us at least 24 hours in advance. **Failure to do so will result in charging the patient a $25 no show fee.**

We thank you for your trust in us here at TOSC.

Patient Signature

_____

TEXASORTHO SPINECENTER

THIS FORM REQUIRED FOR EACH VISIT

DATE: _____

PATIENT NAME _____ DATE OF BIRTH _____

ADDRESS: _____ DATE OF INJURY _____

CITY, STATE, ZIP: _____

Pain level on scale of 0-10: _____

What type of pain do you feel?

Itching	Aching	Locking	Swelling
Limping	Weakness	Tingling	Numbness
Giving-away	Burning	Stabbing	Throbbing

Other:

Where is the pain?
Please state right/left when referring to arm or leg

How often is the pain? Constant Occasional Seldom

When does the pain occur? Morning Afternoon Night

How is the pain brought on?

What other problems do you have that you feel are because of the pain?

Headaches	Bowel Problems
Blurring Vision	Bladder Problems
Erectile Dysfunction	

Other:

What relieves your pain?

Rest	Elevation of body part
Medications	Physical therapy

Other:

What makes your pain worse?

Bending	Standing	Running
Riding in Vehicle	Walking	Stooping
Changes in weather		

Other:

Have you seen any other doctors since your last visit?
Yes **No**
If Yes, Doctor/Clinic Name:
Date:
Reason:

Have you had any tests since your last visit?
Yes **No**
If Yes, Test Name:
Date:
Location:

List Any Allergies you have?

Current Medications:

Preferred Pharmacy:

Pharmacy Phone Number

Since your last visit, please note any changes to marital status, job, smoking or drinking history

TEXAS**ORTHO**
SPINECENTER

PATIENT INFORMATION / *INFORMACION DEL PACIENTE*				Date/*Fecha*:
In case of emergency call: *En caso de emergencia llamar a:*		Relationship: *Relacion:*		Phone: *Telefono:*
Patient Name: *Nombre de Paciente:*				Ph#: *Telefono:*
Address: *Direccion:*		Referring Doctor Phone/ *Numero de Doctor de Referencia*		
City State Zip: *Ciudad, Estado, Codigo Postal:*				Email:
DOB/ *Fecha de Nacimiento*	Age/ *Edad*	Sex/ *Sexo*		Marital Status S M W D *Estado Marital*
Place of Employment: *Lugar de Trabajo:*		Occupation: *Ocupacion:*		Emp. Phone *Telef. De Trabajo*

PERSON(S) AUTHORIZED TO SHARE MEDICAL INFORMATION/*AUTORIZADO PARA RECIBIR INFORMACION MEDICO*		
Name/*Nomre*	Phone Number/*Numero de Telefono*	Relation/*Relacion*

INSURANCE INFORMATION/INFORMACION DE LA ASEGURANZA	
Name of Insurance Company Nombre de la Compania de Seguro	
Address including zip code *Direccion incluyendo codigo postal*	
ID# *Numero de Identificacion*	Phone/ *Telefono*
Name of Insured *Nombre del asegurado*	If patient is a dependent, give name of insured person
Authorization to pay benefits to the physician. I hereboy authorize payment directly to the undersigned physician of 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	
SIGNED (Patient or parent, if minor) FIRMA (Paciente o padre si paciente es un menor) DATE/FECHA	SIGNED (Insured person) FIRMA DEL ASEGURADO DATE/FECHA

REVIEW OF YOUR BODY SYSTEMS *REVISION DE LOS SISTEMAS DEL CUERPO*

Please circle Y (Yes/Si) or N (No)

Do you have now or have you ever had any of the following? ¿Tiene o ha tenido cualquiera de las siguentes condiciones?

Eyes		
Y N	Double vision	*Vision doble*
Y N	Dry eyes	*Ojos secos*
Y N	Blurry vision	*Vision borrosa*
Y N	Vision Change	*Cambios de vision*
Y N	Eye irritation	*Irritacion de ojos*
Ears		
Y N	Difficulty hearing	*Difficultad eschuchando*
Y N	Ringing in ears	*Tonido en las orejas*
Y N	Ear pain	*Dolor in las orejas*
Nose		
Y N	Nosebleeds	*Hemorragia nasal*
Y N	Sinus problems	*Problema sinusal*
Y N	Sputum	*Esputo*
Throat		
Y N	Sore throat	*Raspando de garganta*
Y N	Dry mouth	*Boca seca*
Y N	Hoarseness	*Ronquera*
Y N	Mouth ulcers	*Ulders de la boca*
Y N	Oral abnormalities	*Anomalias orales*
Y N	Difficulty swallowing	*Difficultad para tragar*
Y N	Bleeding Gums	*Hemorragia de las encias*
Skin		
Y N	Rashes	*Erupciones*
Y N	Itching	*Comezon*
Y N	Change in skin color	*Decoloracion de Piel*
Y N	Areas that will not heal	*Areas que no sanaran*
Gastrointestinal		
Y N	Vomiting blood	*Vomita sangre*
Y N	Indigestion	*Indigestion*
Y N	Abdominal pain	*Dolro abdominal*
Y N	Diarrhea	*Diarrea*
Y N	Constipation	*Estrenimiento*
Y N	Change in bowel habits	*Cambio de defecando*
Y N	Black/blood in stool	*Negro/Sangre en defecar*
Y N	Ulcers	*Ulceras*
Y N	Colitis	*Colitis*
Y N	Rectal bleeding	*Sangrando rectal*
Y N	GERD	*Reflujo "ERGE"*

Neurologic		
Y N	Stroke	*Apopejia*
Y N	Epilepsy	*Epilepsia*
Y N	Paralysis	*Paralisis*
Y N	Fainting spells	*Desmayos*
Y N	Dizziness	*Mareo*
Y N	Change in sensation	*Cambio de sensacion*
Musculoskeletal		
Y N	Neck pain	*Dolor de cuello*
Y N	Back pain	*Dolor de espalda*
Y N	Leg pain	*Dolor de pierna*
Y N	Painful joints	*Dolor de articulares*
Y N	Swollen joints	*Inflammacion de articulares*
Y N	Difficulty walking	*Difficultad con caminando*
Y N	Cramps	*Calambres*
Psychological		
Y N	Depression/Worry	*Tristesa*
Y N	Nervous Disorder	*Trastorno Nervioso*
Y N	Anxiety	*Ancia*
Y N	Memory loss	*Fallando de memoria*
Y N	Sleep Disturbances	*Alteracion de sueño*
Cardiovascular		
Y N	Chest pain or pressure	*Dolor de pecho o pression*
Y N	Palpitations	*Palpitaciones*
Y N	Irregular heartbeat	*Ritmo cardiac irregular*
Genitourinary		
Y N	Kidney stones	*Calculos renales*
Y N	Blood in urine	*Sangre en orina*
Y N	Painful urination	*Dolor con orinando*
Y N	Nocturia	*Orinando en la noche*
Y N	Pus in urine	*Pus en la orina*
Y N	Slow stream	*Orina despacio*
Y N	Difficulty urinating	*Difficultad con orinando*
Y N	Loss of urinary control	*Perdie control de orina*
Y N	Incomplete emptying	*Vaciando incomplete*
Respiratory		
Y N	Shortness of breath	*Difficultad de respirar*
Y N	Wheezing	*Chilido en el pecho*
Y N	Coughing	*Tos*
Y N	Bloody sputum	*Sangre con escupe*
Y N	Coughing blood	*Tosiendo sangre*

I acknowledge that I have reviewed this form in its entirety/*Soy de acuerdo que revise esta forma completamente.*

_____

Signature/*Firma*

Medical History Form *Forma de Historia Medica*	Name/*Nombre*	Date of Birth *Fecha de Nacimiento*	Date of Injury/ *Fecha de herido*

REASON FOR OFFICE VISIT

Where did the injury occur? Adonde occurio?
☐ At work/En el Trabajo ☐ Automobile ☐ Other/*Otro*

Describe if other?/Describe si es otro:

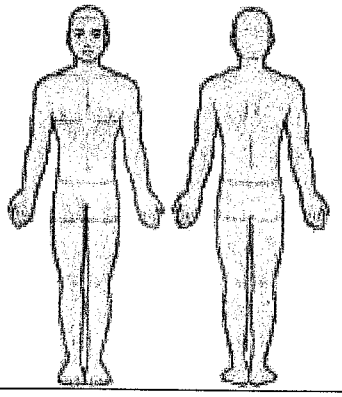
Present Symptoms/Sintomas presentes: ☐ Pain/*Dolor* ☐ Numbness/*Adormecido*
☐ Unable to bend/flex/lift/move without pain/no se puede estirar o doblar sin dolor

Have you suffered a previous injury of any kind to the same area of the body?
Ha sufrido cualquier otra clase de accidente en la misma parte del cuerpo? ☐ Yes/Si ☐ No

Have you suffered a previous injury? Ha sufrido accidentes previos? ☐ Yes/Si ☐ No

A previous automobile injury? Un accidente de automobile previo? ☐ Yes/Si ☐ No

Please mark with an "X" the areas which you feel pain or discomfort/Por favor marques con una "X" en areas en cuales siente dolor o malestar



PRESENT MEDICAL TREATMENT *TRATAMIENTO MEDICO PRESENTE*

Are you presently seeing a doctor? Actualmente esta viendo a un medico? ☐ Yes/Si ☐ No Name/*Nombre de Medico* _____

Date first seen/Fecha de la primera visita _____ Date last seen/*Fecha de la ultima visita* _____

Are you presently receiving medical treatment or physical therapy/*Esta usted recibiendo tratamiento medico or terapia fisica?* ☐ Yes/Si ☐ No

If yes, please indicate date of last treatment/ *Si su respuesta es afirmativa, indique la fecha de el ultimo tratamiento* _____

What type of treatment are you receiving?/*Describa la naturaleza de el tratamiento recibido* _____

PAST MEDICAL HISTORY *HISTORIA MEDICO*

☐	Cancer	☐	Lupus	☐	Blood Disease *Enfermedades de la sangre*
☐	Hepatitis	☐	Asthma *Asma*	☐	Veneral Disease *Enfermedades venereas*
☐	Anemia	☐	Emphysema *Inflamacion pulmonar*	☐	Thyroid Disease *Enfermedades de la Tiroides*
☐	HIV	☐	Lung Disease *Enfermedades pulmonares*	☐	Diabetes *Diabetis*
☐	AIDS	☐	Heart Disease *Enfermedad del corazon*	☐	Other

PREVIOUS SURGERY-HOSPITALIZATIONS *PREVIAS CIRUGIAS - HOSPITALIZACION*

Please list all surgeries or serious illnesses requiring hospitalization, starting with the last: *Favor enumere toda cirugias o enfermedades serias que haya requerdo hospitalizacion*	Date/*Fecha*	Injury/Illness *Herdido/Enfermedad*
	_____	_____
	_____	_____

PERSONAL HISTORY *HISTORIA PERSONAL*

YOUR CHILDREN/ SUS NINOS:
Number living Cuantos vivos _____ List any serious diseases in children Anote enfermedades serias de sus hijos _____

Number deceased/*Numero de fallecidos hijos*: _____ Cause/Causas: _____

		No	Yes/Si				No	Yes/Si
Regularly exercise (3 or 4 times/week) Hace ejercicios 3 o 4 veces a la semana					Were you ever a heavy drinker Ha sido usted alcoholic			
Use Illegal drugs *Usa drogas ilegales*					Smoke *Fuma*			
Use alcohol *Toma bebidas alcoholicas*					If ever, when did you stop? *Si alguna vez lo hizo cuando paro?*			

TEXASORTHO SPINECENTER

Texas Orthopaedic Spine Center
Rubin Bashir M.D.
P. 832-962-7493 F.832-962-7491
12605 East Freeway Suite 510 Houston, TX 77015

Medical Records Release Form / *Formulario de divulgación de registros médicos*

PATIENT /PACIENTE: _____ **DOB:** _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below: /
Al firmar este formulario, le autorizo a divulgar información confidencial de salud sobre mí, al entregar una copia de mis registros médicos, o un resumen o narrativa de mi información de salud protegida, a las personas o entidades que se enumeran a continuación:

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

Patient Initials _____ **Date** _____

Limitations on the information you may release subject to this Release Form are as follows:
Las limitaciones en la información que puede divulgar sujeto a este Formulario de divulgación son las siguientes:

_____

_____

The following person(s)/entity may release my protected health information to TEXAS ORTHO SPINE CENTER
La (s) siguiente (s) persona (s) / entidad pueden divulgar mi información médica protegida a TEXAS SPINE ORTHO CENTER.

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

The reason or purposes for this release of information are as follows:
El motivo o los propósitos de esta divulgación de información son los siguientes:

_____

_____

Patient Signature (or parent, guardian or legal representative)

_____

This Authorization Expires on: _____ 20 _____