HIGH PLAINS ORTHOPEDICS &SPORTS MEDICINE
DR. MEL HUEBNER

DATE:_____ REFERRED BY:_____

NAME_____ DOB:_____ AGE_____

**THE FOLLOWING INFORMATION PROVIDES BASIC INFORMATION ABOUT YOUR ORTHOPEDIC PROBLEM AND GENERAL HEALTH CONDITION. THIS INFORMATION IS VERY IMPORTANT AND CAN INFLUENCE YOUR ORTHOPEDIC DIAGNOSIS AND TREATMENT.**

PREFERRED PHARMACY: _____

**CURRENT MEDICATIONS: PLEASE LIST THE NAME OF THE DOCTOR WHO PRESCRIBES THIS MEDICATION**

_____ _____ _____

_____ _____ _____

_____ _____ _____

**DRUG ALLERGIES: PLEASE LIST REACTION TO THIS DRUG**

_____ _____ _____

**REVIEW OF SYSTEMS: DO YOU NOW, OR HAVE YOU IN THE PAST, HAD ANY OF THESE CONDITIONS? PLEASE CIRCLE AND LIST THE NAME OF THE DOCTOR WHO TREATS/TREATED YOU FOR THIS CONDITION.**

HYPERTENSION _____ ASTHMA _____ DIABETES _____
VASCULAR BLOCKAGE_____ EPILEPSY _____ HEPATITIS _____
TUBERCULOSIS _____ KIDNEY FAILURE_____ HEART DISEASE_____
CANCER (TYPE)_____ STROKE _____ BLOOD CLOT_____
THYROID _____

DO YOU HAVE A PROBLEM WITH SNORING OR SLEEP APNEA?_____
DATE OF LAST MENSTRUAL CYCLE_____

**PAST MEDICAL HISTORY:** PLEASE LIST LOCATON AND APPROXIMATE DATE.
FRACTURES OR OTHER SERIOUS INJRUES: _____
SURGERIES _____
HAVE YOU EVER HAD AN INFECTION FOLLOWING SURGERY? _____
HAVE YOU EVER HAD A PROBLEM WITH ASNESHESIA?? _____ DESCRIBE:_____

**SOCIAL HISTORY**: DO YOU, OR HAVE YOU IN THE PAST USED ANY OF THE FOLLOWING SUBSTANCES?
TOBACCO_____ How Much?_____ ALCOHOL _____ RECREATIONAL DRUGS_____ CAFFEINE _____

**FAMILY HISTORY**: HAS ANYONE IN YOUR IMMEDIATE FAMILY (MOTHER, FATHER, SIBLING) HAD ANY OF THE FOLLOWING CONDITIONS?
OSTEOARTHRITIS _____ RHEUMATOID ARTHRTIS _____ OSTEOPOROSIS_____

**WHAT PART OF THE BODY ARE WE SEEING YOU FOR TODAY?** _____ LEFT/RIGHT (CIRCLE)

HAVE YOUR RECIEVED ANY DIAGNOSTIC TESTS FOR THIS CONDITION PRIOR TO SEEING DR. HUEBNER, i.e. XRAY, MRI, ARTHROGRAM, EMG/NERVE CONDUCTION STUDY OR OTHER? PLEASE LIST WHEN AND WHERE.

_____
_____

PLEASE GIVE A BRIEF DESCRIPTION OF HOW YOUR INJURY HAPPENED AND/OR ONSET OF SYMPTOMS. PLEASE INCLUDE SEVERITY, WHAT RELIEVES YOUR SYMPTOMS AND WHAT ACTIVITIES MAKE THEM WORSE.
DATE OF INJURY/ONSET: _____ DESCRIPTION: _____
_____
_____

_____ _____
SIGNATURE DATE

**FOR OFFICE USE ONLY**

WT: _____ HT:_____ BMI: _____

NAME: _____

MAILING ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ CELL_____ WORK_____ EMAIL_____

SOCIAL SECURTY NUMBER: _____ EMPLOYER: _____ OCCUPATION_____

MARITAL STATUS (CIRCLE) M S D W MALE/FEMALE NAME OF SPOUSE: _____

PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT (PERSON NOT LIVING WITH YOUR) _____ PHONE _____

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**TO BE FILLED OUT IF PATIENT IS A MINOR**

PARENT/GUARDIAN

FATHER'S NAME_____ MOTHER'S NAME _____

ADDRESS: _____ ADDRESS: _____

DATE OF BIRTH_____ EMPLOYER:_____ DATE OF BIRTH_____ EMPLOYER:_____

SOCIAL SECURTY NUMBER_____ SOCIAL SECURTY NUMBER_____

HOME PHONE_____CELL_____WORK_____ HOME PHONE_____CELL_____WORK_____

**********

**PLEASE READ THE FOLLOWING SECTION AND SIGN. IF PATIENT IS A MINOR, MUST BE SIGNED BY PARENT/GUARDIAN. THIS SECTION MUST BE SIGNED BEFORE YOU CAN SEE DR. HUEBNER.**

## AUTHORIZATON TO RELEASE INFORMATION

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO COMPLETE AND PROCESS INSURANCE CLAIMS. I FURTHER PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL..

_____ _____
SIGNATURE DATE

## AUTHORIZATION TO PAY BENEFITS

I HEREBY AUTHORIZE PAYMENT TO BE SENT DIRECTLY TO MELBURN K. HUEBNER, MD, OTHERWISE PAYABLE TO ME, BUT NOT TO EXCEEED THE CHARGES STATED. I UNDERSTAND THAT I AM FINAINCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVRERED BY THIS AUTHORIZATION.

_____ _____
SIGNATURE DATE

## CONSENT TO TREAT

I, KNOWING THAT I AM SUFFERING FROM A CONDITION REQUIRING MEDICAL DIAGNOSIS OR SURGICAL TREATMENT (IF DETERMINED NECESSARY AND BY MUTUAL CONSENT BY ME AND DR. HUEBNER) DO HEREBY VOLUNTARILY CONSENT TO SUCH PROCEDURES AND CARE AND TO SUCH MEDICAL, SURGIAL AND OTHER SERVICES UNDER THE GENERAL AND SPECIFIC INSTURCTION OF MELBURN K. HUEBNER, MD, HIS ASSISTANTS OR HIS DESIGNEE AS IS NECESSARY IN HIS JUDGMENT. I ALSO ACKNOWLEDGE THAT THE PRACTIE OF MEDICINE IS NOT AN EXACT SCIENCE AND NO GUARANTEES HAVE BEEN MADE AS TO THE RESULT OF TREAMENT OR EXAMINATION BY MELBURN K HUEBNER, MD. I FURTHER PERMIT COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

_____ _____
SIGNATURE DATE

MELBURN K. HUEBNER, MD
ORTHOPEDIC SURGERY
1901 MEDI-PARK, SUITE 10
AMARILLO, TX 79106

# PRIVACY AND PATIENT RIGHTS NOTICE

This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The HIPPA guidelines for patient privacy include several patient rights:

- The right to view their medical records.
- The right to obtain copies of all medical related information
- The right to have all errors corrected.
- The right to know who has access to their records.
- The right to review their providers policies and procedures on patient privacy and security.
- The right to know when corrections are made.
- The right to revoke authorizations to release protected health information (PHI)

Please list the family members or significant others, if any, whom we have permission to inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____

Name _____ Phone Number _____

Please print the telephone number where you want to receive calls about your appointments, lab or diagnostic test results or other health care information if other than your home phone number. I AM FULLY AWARE THAT A CELL PHONE IS NOT A SECURE AND PRIVATE LINE. _____

Can confidential messages (i.e. appointment changes) be left on your telephone answering machine or voice mail?_____

**MAY WE TAKE A PICTURE OF YOU IN ORDER TO PROTECT AGAINST UNAUTHORIZED USE OF YOUR PERSONAL AND MEDICAL INFORMATION TO HELP PREVENT IDENTITY THEFT AND FRAUD?_____**

## ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

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 copy of this document.

_____ _____
Signature of patient or Personal Representative Date

_____
Description of Personal Representative's Authority