J. ANDREW HURST, M.D.
PINEY WOODS ORTHOPEDICS
3816 NORTH UNIVERSITY
NACOGDOCHES, TEXAS 75965

PATIENT INFORMATON

DATE: _____

PATIENT'S NAME: _____ AGE: _____ SEX : M ( ) F ( )

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

ADDRESS: _____
STREET CITY, STATE ZIP CODE

HOME PHONE: ( )_____ CELL PHONE : ( )_____

CIRCLE MARITAL STATUS: M S D W email _____

PHARMACY (To be used for Prescriptions) _____

RACE_____ ETHINTICITY: HISPANIC_____ NON HISPANIC_____ LANGUAGE_____

PATIENT'S EMPLOYER INFORMATION

EMPLOYER: _____ OCCUPATION: _____

EMPLOYMENT STATUS: FULL TIME ( ) PART-TIME ( ) SELF ( ) RETIRED ( ) ACTIVE MILITARY ( )

EMPLOYER ADDRESS: _____ PHONE : ( ) _____ EXT. ____
STREET CITY/ST ZIP CODE

PATIENT'S SPOUSE INFORMATION

SPOUSE'S NAME: _____ OCCUPATION: _____

SPOUSE'S SOCIAL SECURITY#: _____ SPOUSE'S DATE OF BIRTH: _____

SPOUSE'S EMPLOYER: _____ PHONE: ( )_____ EXT. _____

ACCIDENT/ILLNESS INFORMATION

COMPLETE DATE OF ACCIDENT: _____

WERE YOU INJURED: ON THE JOB ( ) AUTO ACCIDENT ( ) SCHOOL INJURY ( ) OTHER ( )

BRIEFLY DESCRIDE ACCIDENT: _____

IF NOT AN ACCIDENT, GIVE DATE OF FIRST SYMPTOM: _____

HAVE YOU HAD THIS SAME OR SIMULAR ILLNESS? YES ( ) NO ( )

IF YES, PLEASE DESCRIBE: _____

_____

***WE DO NOT FILE LIABILITY CLAIMS. UPON PAYMENT A RECEIPT WILL BE PROVIDED SO YOU CAN**

FILE FOR REIMBURSEMENT. IF YOU HAVE ANY QUESTIONS PLEASE SPEAK WITH THE FRONT DESK.

OTHER PATIENT INFORMATION

PERSONAL /FAMILY PHYSICIAN: _____ REFERRED BY: _____

PARENT / GUARDIAN INFORMATION

PLEASE COMPLETE THIS SECTION IF YOU ARE A COLLEGE STUDENT OR UNDER 21 YRS OLD

FATHER'S NAME: _____ OCCUPATION: _____

EMPLOYER: _____ PHONE ( ) : _____ EXT. ____

MOTHER'S NAME: _____ OCCUPATION: _____

EMPLOYER: _____ PHONE ( ): _____ EXT. ____

PARENT'S HOME ADDRESS: _____
STREET CITY/STATE ZIP CODE

PARENT'S HOME PHONE: ( ): _____

PLEASE COMPLETE THE INSURED'S INFORMATION BELOW

INSURED = PERSON WHO CARRIES THE INSURANCE IN THEIR NAME

INSURED'S NAME: _____ RELATION TO PATIENT: _____

INSURED'S DATE OF BIRTH: _____ INSURED'S SOCIAL SECURITY #: _____

INSURED'S EMPLOYMENT STATUS: FULL TIME ( ) PART TIME ( ) RETIRED ( )

INSURED'S EMPLOYER: _____

PLEASE READ AND SIGN BELOW

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. J. Andrew Hurst to release any information acquired in the course of my examination/treatment to my insurance carrier. I also authorize Dr. Hurst to release information to any hospital and physician I may be referred to by this office. In work- related injury cases, I authorize Dr. Hurst to release information to my employer.

MEDICARE / MEDICAID / SECONDARY INSURANCE ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dr. J. Andrew Hurst for all medical services rendered.

OFFICE POLICY / ASSIGNMENT OF BENEFITS REGARDING PRIVATE INSURANCE AND PRIVATE PAY: If my funding is private insurance or private pay, then payment is expected at time of service, unless prior arrangements have been made. I understand filing my insurance is a courtesy, and I am responsible for all costs of treatment including those of charges that exceed or are not covered by my insurance. On assigned claims, I hereby authorize payment directly to Dr. J. Andrew Hurst for medical services rendered. I have read and understand the above statements. I agree to comply with the financial policies of this office.

SIGNATURE: (PATIENT, PARENT, OR GUARDIAN): _____ **DATE:** _____

PATIENT PERMISSION TO RELEASE INFORMATION

I, _____, give Dr. Hurst and his staff permission to release lab results, x-ray results, appointment information and other pertinent medical information, not including medical records, to the parties listed below. (Example: Parents, Spouse, Children, Guardian, Grandparents, etc.)
Dr. Hurst and his staff will not release medical information, even verbally, to anyone not named on this form.

Name	Relationship (Spouse, Child, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

EMERGENCY CONTACT INFORMATION
Please list 2 people (**not living in your household**) that we may contact in reference to appointment rescheduling if you are unable to be reached. No medical information will be discussed with them unless they are listed above.

NAME	**PHONE NUMBER**
_____	_____
_____	_____

I have reviewed the Notice of Privacy Practices of J. Andrew Hurst, M.D. that explains to me the use and disclosure of my medical information.

Signature_____ Date _____

J. ANDREW HURST, M.D.
PINEY WOODS ORTHOPEDICS
3816 NORTH UNIVERSITY
NACOGDOCHES, TX 75965

MEDICATION MANAGEMENT AGREEMENT

I, _____, understand that this agreement is between J. Andrew Hurst, M.D. and myself. It is designed to inform me fully of the manner in which my medications, especially narcotics, will be provided. It also outlines the criteria by which the doctor will determine whether or not to continue my medication. I understand that a reduction on the intensity of my pain and an improvement in my quality of life are the goals of this program.

1. Pain medications, especially of a narcotic type, will be provided only after it is determined that all reasonable alternatives for adequate pain control have been investigated/attempted.

2. I will agree to try other techniques as felt appropriate by the Doctor or Physician Assistant that may assist me in taking the lowest effective dose possible.

3. My "pain medications" will be prescribed by one doctor and one doctor only, and filled at one pharmacy. Any attempt, successful or not, to obtain additional medication without the permission of the doctor may result in discontinuation of medication therapy.

4. I agree to notify the doctor's office if I change my pharmacy for any reason.

5. Medications will be given at fixed intervals, and only if I keep my doctor appointments. The maximum length of medication refill will be six (6) weeks from the date of injury or surgery.

6. I understand no refills will be made after office hours or on weekend/holidays.

7. I agree that I will use my medication at a rate no greater than the prescribed rate and use of my medication at a greater rate will result in my being without medication for a period of time.

8. If your narcotics are lost or stolen, they will not be refilled until the due date.

9. Doctor and Patient agree that this agreement is essential for the Doctor's ability to treat the patient's pain effectively and that the failure of the patient to abide by the terms of this agreement may result in the withdrawal of my medication and the termination of the Doctor/Patient relationship.

10. If there is ever any issue with adequately controlling pain with prescribed "pain medications", the Doctor or Physician Assistant may decide on a referral to a pain management specialist.

I have read and understand each of the above statements. I realize that he doctor will assume the responsibility of assisting me in my therapy as long as I comply with the above.

_____ _____
Patient/Guardian Signature **Relationship to patient**

_____ _____
Witness Signature **Date**

J. Andrew Hurst, M.D.

Piney Woods Orthopedics
3816 North University
Nacogdoches, Texas 75965

Patient Name: _____ Appointment Date: _____
Age: _____ Sex: F / M Dominate Hand: R / L / Ambidextrous
Did you bring X-Rays: Yes / No Performed at: _____
Who requested that you visit our office: _____

Complaint: Please only check Main Issue (Patients will be seen for one issue per visit)

Body Part	Left	Right	Bilateral	Body Part	Left	Right	Bilateral
Shoulder				Elbow			
Hand				Wrist			
Finger(s)				Hip			
Upper Leg				Lower Leg			
Knee				Ankle			
Foot				Toes			

INJURY: YES / NO **DATE OF INJURY:** _____ **ONSET OF PAIN**: GRADUAL SUDDEN

MOTOR VEHICLE ACCIDENT DATE: _____ WEARING SEAT BELT: Yes/ No
Location in Car: _____ Air Bag Deployed: _____
Describe details of wreck: _____
Pursuing Legal Action: Yes / No
Medical Care Received / By Whom: _____

SIGNS/SYMPTOMS:
Sudden Burning Dull Sharp Stabbing Improving Unchanged
Getting Worse Bruising Swelling Limping Stiffness Weakness
Other: _____

TIMING OF PAIN: Constant Intermittent Night Pain

CURRENT PAIN: 1 2 3 4 5 6 7 8 9 10

HOW LONG HAVE YOU HAD YOUR PAIN: _____

METHODS USED TO TREAT PAIN:
No Treatment Brace Muscle Relaxers Tylenol Rest Ice Elevation
Aspirations Injections Physical Therapy Other: _____
Pain Medicine: Name_____ NSAID – Name and Dosage: _____

What actually relieves your pain: _____

DIAGNOSTIC IMAGING STUDIES:
Bone Scan Cat Scan MRI X-Rays Ultrasound No Imaging Studies
Performed at: _____

LIMITATIONS RELATED TO CURRENT CHIEF COMPLAINT:
_____

WHOM HAVE YOU SEEN FOR THIS PROBLEM:
Primary Care Physician: _____ Orthopedist: _____
Emergency Room:_____ Other: _____

Select any of the following medical conditions that you currently have

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Cardio: Ischemic Heart Disease
- ☐ Cancer _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis (Blood Clot)
- ☐ Depression
- ☐ Diabetes, Insulin or Non Insulin
- ☐ Renal Failure
- ☐ GERD
- ☐ Hepatitis Type_____
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Thyroid- Hyper or Hypo
- ☐ Hypertension
- ☐ Rheum: Fibromyalgia
- ☐ Rheum: Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

Past Surgeries

Have you had any surgeries on the following organs?

- ☐ None
- ☐ Appendix (Appendectomy)
- ☐ Breast : _____
- ☐ Gallbladder (Cholecystectomy)
- ☐ Gastric Bypass
- ☐ Heart :_____
- ☐ Ovaries: Tubal Ligation
- ☐ Prostate:_____
- ☐ Skin :_____
- ☐ Tonsillectomy
- ☐ Uterus: Hysterectomy
- ☐ Uterus (Hysterectomy): Cesearean Section
- ☐ Other_____

Gynecologic History

Last Menstrual Period_____

Family History

- ☐ None
- ☐ Diabetes
- ☐ Hypertension
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other_____

Orthopedic History

- ☐ None
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fracture Location:_____
- ☐ Gout
- ☐ Handedness – Ambidextrous, Right or Left
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vitamin D Deficiency
- ☐ Other_____

Orthopedic Surgery

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF, Bilateral, Right or Left
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression: Bilateral, Right or Left
- ☐ Cervical Spine Surgery:_____
- ☐ Wrist: Bilateral, Right or Left _____
- ☐ Lower Leg: Bilateral, Right or Left _____
- ☐ Upper Leg: Bilateral Right or Left_____
- ☐ Joint Replacement: Bilateral, Right or Left _____
- ☐ Knee Arthroscopy: Bilateral, Right or Left
- ☐ Lumbar: _____
- ☐ Rotator Cuff Repair: Bilateral, Right or Left
- ☐ Shoulder Arthroscopy: Bilateral, Right or Left
- ☐ Trigger Finger Release Right or Left, T 2 3 4 5
- ☐ Other_____
- ☐ NONE

Medications:

_____

_____

_____

_____

Allergies and Type of Reactions

_____

_____

SMOKER: Y / N **ORAL TOBACCO:** Y / N

PACKS PER DAY: _____ CANS PER DAY: _____

NUMBER OF YEARS: _____

PREVIOUS SMOKER: Y / N YEARS QUIT: _____

ALCOHOL USE: Y / N DAILY / WEEKLY /OTHER

OCCUPATION:_____

WORKPLACE_____

RETIRED / DISABLED / NOT WORKING

HEIGHT: _____ **WEIGHT:** _____