WORKERS COMPENSATION

PATIENT DEMOGRAPHICS

Name: ____ Date: ______________

Age: ________ Date of Birth: ____________ S.S#: ______________ Email: ___________________

Address:____
Street Name & Number City State Zip

Home Phone #: _________________ Cellular #: ________________ Wk #: ________________

Marital Status: S M W D

HOW DID YOU HEAR ABOUT OUR OFFICE?

EMPLOYMENT INFORMATION

Employer Name: ____

Address: ____
Street Name & Number City State Zip

DATE OF INJURY: __________________ Hour _________am/pm

Your Current Title/Position: ____

Current Work status prior to injury: □ Full Time □ Part Time □ Temporary □ Contract □ Other

Are you off work? □ Yes □ No Last date worked: ______________________________

Length of time worked prior to accident: ________Years __________Months__________ Days________

Type of work being done at time of injury: ____

Location at time of injury including City & State:

____

In your own words, describe the accident: ____

____

____

Was Accident reported to employer? □ Yes □ No If yes Who: ______________________________
Name Title

Where you hospitalized due to this injury? □ Yes □ No

Which hospital were you admitted to? ____

How long was your stay? __________________ to_____________________
Admittance Date Discharge Date

Prior to this accident, have you ever had any of the physical complaints similar to what you have now? □ Yes □ No

If yes please Describe: ____

____

Were these similar complaints the result of a previous accident (s)? □ Yes □ No

If yes, please provide details of accident(s): ____

____

____

Have you returned to work since this accident? □ Yes □ No

If you have returned to work; Date returned ____________ □ Full duty □ Light duty / □ Full time □ Part time

Title/Position: ____

MEDICAL HISTORY

What treatment have you already received for your condition?

□ Surgery: Was your surgery ____Successful ____Unsuccessful/who preformed this surgery? ________________________________

□ Physical Therapy: Was your therapy ____Successful ____Unsuccessful/ where was it? ________________________________

□ Chiropractic Services: Was your treatment ____Successful ____Unsuccessful/ where was it________________________________

□ Other ____ □ None

Name and address of the other Doctor(s) who treated you for your condition:____

____

____

Date of Last: Physical Exam________________ Spinal X-Ray ________________ Blood Test________________

Spinal Exam ________________ Chest X-Ray ________________ Urine Test________________

Dental X-Ray________________ MRI, CT-Scan, Bone Scan__________ ________________________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	□ Yes □ No	Chicken Pox	□ Yes □ No	Liver Disease	□ Yes □ No	Rheumatoid Arthritis	□ Yes □ No
Alcoholism	□ Yes □ No	Diabetes	□ Yes □ No	Measles	□ Yes □ No	Rheumatic Fever	□ Yes □ No
Allergy Shots	□ Yes □ No	Emphysema	□ Yes □ No	Migraine Headaches	□ Yes □ No	Scarlet Fever	□ Yes □ No
Anemia	□ Yes □ No	Epilepsy	□ Yes □ No	Miscarriage	□ Yes □ No	Stroke	□ Yes □ No
Anorexia	□ Yes □ No	Fractures	□ Yes □ No	Mononucleosis	□ Yes □ No	Suicide Attempt	□ Yes □ No
Appendicitis	□ Yes □ No	Glaucoma	□ Yes □ No	Multiple Sclerosis	□ Yes □ No	Thyroid Problems	□ Yes □ No
Arthritis	□ Yes □ No	Goiter	□ Yes □ No	Mumps	□ Yes □ No	Tonsillitis	□ Yes □ No
Asthma	□ Yes □ No	Gonorrhea	□ Yes □ No	Osteoporosis	□ Yes □ No	Tuberculosis	□ Yes □ No
Bleeding Disorders	□ Yes □ No	Gout	□ Yes □ No	Pacemaker	□ Yes □ No	Tumors, Growths	□ Yes □ No
Breast Lump	□ Yes □ No	Heart Disease	□ Yes □ No	Parkinson's Disease	□ Yes □ No	Typhoid Fever	□ Yes □ No
Bronchitis	□ Yes □ No	Hepatitis	□ Yes □ No	Pinched Nerve	□ Yes □ No	Ulcers	□ Yes □ No
Bulimia	□ Yes □ No	Hernia	□ Yes □ No	Pneumonia	□ Yes □ No	Vaginal Infections	□ Yes □ No
Cancer	□ Yes □ No	Herniated Disk	□ Yes □ No	Polio	□ Yes □ No	Venereal Disease	□ Yes □ No
Cataracts	□ Yes □ No	Herpes	□ Yes □ No	Prostate Problem	□ Yes □ No	Whooping Cough	□ Yes □ No
Chemical Dependency	□ Yes □ No	High Cholesterol	□ Yes □ No	Prosthesis	□ Yes □ No	Other: ________________	
____________________		Kidney Disease	□ Yes □ No	Have you ever had any nervous or mental illnesses?	□ Yes □ No		

Have you had psychiatric care? □ Yes □ No Have you received a medical discharge from the Armed Forces □ Yes □ No

EXERCISE	**WORK ACTIVITY**	**HABITS**	
□ None	□ Sitting	□ Smoking	Packs/day________________
□ Moderate	□ Standing	□ Alcohol	Drinks/week______________
□ Daily	□ Light Labor	□Caffeine Drinks	Cups/Daily ______________
□ Heavy	□ Heavy Labor	□ High Stress Level	Reason ________________

Women Only: Are you pregnant? □Yes □No If yes Due Date: ________________ # of Pregnancies: ____________

Method of delivery: C-Section #______Vaginal #______Miscarriages #______Other Female Surgeries:________________

Injuries/Surgeries you have had Descriptions Date

Falls ____

Head Injuries ____

Broken bones ____

Dislocations ____

Surgeries ____

MEDICATIONS	**ALLERGIES**	**VITAMINS/HERBS/MINERALS**
________________________	________________________	________________________
________________________	________________________	________________________
________________________	________________________	________________________

Pharmacy Name:________________________________Phone #:____________________

Incase of an Emergency contact:

Name:____ Phone:________________________

Relation: ☐ Spouse ☐ Parent ☐ Sibling ☐ Other Relative ______________________

WORKERS COMPENSATION

JOB DESCRIPTION

(In terms of an 8-hour work day, "occasionally" means 33%, "frequently" means 34% to 66%, and "continuously" means 67% to 100% of the day)

In a typical 8-hour workday, I: (circle # of hours/activity)

Sit:	1	2	3	4	5	6	7	8	hours
Stand:	1	2	3	4	5	6	7	8	hours
Walk:	1	2	3	4	5	6	7	8	hours

On the job, I perform the following activities:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOULSY
Bend / stoop	□	□	□	□
Squat	□	□	□	□
Crawl	□	□	□	□
Climb	□	□	□	□
Reach over shoulder	□	□	□	□
Crouch	□	□	□	□
Kneel	□	□	□	□
Balancing	□	□	□	□
Pushing / Pulling	□	□	□	□

On the job I lift:

	NOT AT ALL	OCCASIONALLY	FREQUENTLY	CONTINUOULSY
Up to 10 pounds	□	□	□	□
11 to 24 pounds	□	□	□	□
25 to 34 pounds	□	□	□	□
35 to 50 pounds	□	□	□	□
51 to 74 pounds	□	□	□	□
75 to 100 pounds	□	□	□	□

Do you have to bend over while doing any lifting? □ Yes □ No

Are your feet used for repetitive movements, such as in operating foot controls? □ Yes □ No

Do you use your hands for repetitive actions, such as:

	SIMPLE GRASPING	FIRM GRASPING	FINE MANIPULATING
Right hand	□ Yes □ No	□ Yes □ No	□ Yes □ No
Left Hand	□ Yes □ No	□ Yes □ No	□ Yes □ No

Are you required to work on unprotected heights? □ Yes □ No

Describe: ____

____

____

Are you required to be around moving machinery? □ Yes □ No

Describe: ____

____

____

JOB DESCRIPTION Continued

Are you exposed to marked changes in temperature and humidity? □ Yes □ No
Describe: ____

____

____

Are you required to drive automotive equipment? □ Yes □ No
Describe: ____

____

____

Are you exposed to dust, fumes and/or gases? □ Yes □ No
Describe: ____

____

____

Please list any additional comments:

____

____

____

______________________________ ______________________
Signature Date

How did you hear about our office? ______________________________

TEXAS MEDICAL INSTITUTE

Patient Record of Disclosures

HIPPA Privacy rule: **III. Other Uses and Disclosures of Health Information** We will not use or disclose your health information for any purpose other than those identified in this written Authorization. We cannot take back any uses or disclosures already made with your permission.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone #: ______________________________

- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: ____________________________

☐ Work telephone #: _______________________________

- ☐ O.K to leave messages with detailed information
- ☐ Leave message with call-back number only
- ☐ Fax to this number#: ______________________

☐ **Written Communication**

- ☐ Mail to my home address
- ☐ Mail to my work/office

☐ Other ____________________________

____

_____________________________ _____________________ _____________________________

Patient Signature Date Print Name

Healthcare entities must keep records of PHI disclosures; information provided below, if completed properly, will constitute an adequate record. NOTE: Uses and disclosure for PHI may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to	Purpose	By Whom	1	2	3

1. Check this box if the disclosure is authorized
2. Print: T = Treatment Record; P = Payment Information; O = Other Healthcare provider
3. How was disclose made: F = Fax; P = Phone; E = E-mail; O = Other

Standard Authorization Form
To Use or Disclose Protected Health Information (PHI)

Patient Name:____ Date: ________________
Address: ____ SS#:xxx-xx- __ __ __ __
____ D.O.B: _____________

Receive Records From:

____

____

____

Release Records To:
Texas Medical Institute
6789 C amp Bowie Blvd

Fort Worth TX 76116

P: 817-731-2102 Fax: 817-731-
2157

Please send a copy of my records as indicated for date(s) of Treatment: ___________________

Specifically:
- ☐ History & Physical
- ☐ Nursing Notes
- ☐ EEG/EKG/CAT Scan
- ☐ Discharge Summary
- ☐ Social Serv. Notes
- ☐ MD Orders
- ☐ Operative Report
- ☐ Laboratory
- ☐ other please specify:
- ☐ MD Progress Notes
- ☐ Radiology

____

____

Purpose for releasing medical information

____

____

___________________________________ ___________________________________
Signature of Patient, Parent or Legal Guardian **Witness**

____
Date

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

___________________________________ ___________________________________
Signature of Patient, Parent or Legal Guardian **Witness**

____

Date

CONSENT TO TREATMENT

Date: ________________________

Patient Name: ____
(Print Name)

Omit any statement, which you do not wish to authorize by marking a line through the statement with your initial and date.

Consent to Treatment: I, as the patient or on behalf of the patient, do hereby consent to and authorize all medical, chiropractic and therapeutic treatment considered necessary or advised in the judgment of the physician on duty. I understand that no guarantees and/or assurances have been made as to the results which may be obtained.

Financial Agreement: I hereby guarantee payment for services at Texas Medical Institute located at 6789 Camp Bowie; Fort Worth TX and/or 3304 S.W. Loop 820 Fort Worth TX and/or 8100 John Carpenter FWY. Dallas TX. I understand that I will be held responsible for the court cost, legal fees, or agency fees which may be incurred in the collection of the account.

Assignment of Benefits: I hereby authorize all insurance companies to pay directly to Texas Medical Institute and any ancillary providers, any providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve any of my obligations to pay the account or any balance that is not covered or paid by the insurance company carrier which may be my responsibility.

Release of Medical Information: I hereby consent and authorize Texas Medical Institute's Physicians and any ancillary providers, to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefit from my health insurance carrier.

Teaching Facility: I understand that Texas Medical Institute is affiliated with medical schools, nursing schools, and other academic programs and therefore resident physicians, interns, and students may be involved with my care.

Nurse Practitioners/Physician Assistant: I understand that Texas Medical Institute provides care by Physicians, Nurse Practitioners, and Physician Assistants. Nurse Practitioners and Physician Assistants are not physicians, but function under the supervision of a physician either directly or via protocols established by the physician.

I HAVE READ THE AUTHORIZATION, CONSENT, AND AGREEMENT AND I ACCEPT THE TERMS DESCRIBED ABOVE.

Patient Name: ____________________________________ Date:_________________________

Signature of Patient or Responsible Party ________________________________

Relationship _____________________________________

Witness Signature _______________________________________ Date _____________