Dennis R. Gutzman, MDPA

Certified by the Board of Orthopaedic Surgeons

PATIENT INFORMATION FOR ON THE JOB INJURIES

PLEASE PRINT

Patient's Name: _____Age_____ DOB: _____Male ____Female_____

Home Address: _____City _____ State____Zip_____

Home Phone_____ 2nd phone (Cell)_____Patient's Social Security_____

Email Address: _____

Patients Drivers License Number : _____ If other than Texas what State?_____

Spouse's Name: _____ Spouse Work #_____

Name of a Neighbor, Friend or Relative we might contact in case of Emergency:

Name: _____Phone _____ How Related _____

DATE OF INJURY/ ACCIDENT: _____

EMPLOYER INFORMATION AT THE TIME OF YOUR INJURY

Employer (Business Name) _____

Address of Employer: _____City/ST _____Zip_____

Phone Number: _____ Fax #_____

Place of Injury: _____Time: _____am . pm. Was the injury reported to your Employer? _____

If yes, to whom did you report your injury to? _____

Have you lost time from work for this injury? Yes _____ No _____If yes, how much time? _____
Have you attempted to return to work following your injury? Yes _____No _____
If you returned to work are you, or were you, able to do your job requirements in relation to your injury?
Yes _____No_____
If NOT what happened that you could not complete your job requirements? _____
_____
Are you working now? No____ Yes____ Light Duty with restrictions _____Same employer?_____ Different Employer ____

If you are doing light duty, what restrictions are you on? _____

What was your occupation when you were injured? _____
Briefly, describe your job duties. (lifting, bending, climbing, sitting, standing, etc.)
_____

_____

This information is true to the best of my knowledge.

_____ Today's Date _____
Patient's Signature/ or legal guardian

Interpreter _____

Dennis R. Gutzman, MD, PA
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2424 Babcock Rd., Ste 201
San Antonio, TX 78229
210-616-0462/ f: 210-616-0467

Release of Information

Unless you give written permission we will not release your medical information according to the HIPPA guidelines.

Patients Name: _____ Date of Birth _____

Who do you want us to contact in case of an Emergency:

Name: _____Phone _____ How Related _____

If you have someone who you want us to release medical information to such as a Spouse, Child, or Parent please list below.

Name _____ Relationship to You _____

Name_____ Relationship to You_____

"I give permission for the above person(s) to receive my medical information".
This Authorization is good for one year.

_____ _____
Patient's/Guardian's Signature Today's Date

Your referring physician will have a report faxed to their office.

If you have an Attorney on this case that we need to release information to please fill out the following.

Attorney _____ Phone: _____ Fax:_____

Patient's Signature_____

Date: _____ (*Authorization Good for 1 year from date signed*)

This is acknowledgement that you received our Notice of our Privacy Practices required by law to maintain the privacy of our patients with respect to protected health information.

_____
Signature of the Patient/Guardian

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PAST MEDICAL/SOCIAL/FAMILY HISTORY

Patient's Name: _____ Date of Birth _____SSN:_____

Have you ever had the same or similar problems in the past? _____. If so, when? _____
Do you use Tobacco products: Yes ____ No _____
Do you drink Alcohol: Yes ____ No _____ Occasionally _____ Socially _____
Are you Allergic to any Medications: Yes___No ____
Please list the medications you are allergic to : _____
_____

Please check off whether you have had or your family has had any of these types of illnesses:

	Self	Which family member has/had this illness: Father	Mother	Brother	Sister	Controlled	Treatment
High Blood Pressure	____	____	_____	____	____	_____	____
Diabetes	____	____	_____	____	____	_____	____
Heart Disease	____	____	_____	____	____	_____	____
Lung Disease	____	____	_____	____	____	_____	____
Kidney Disease	____	____	_____	____	____	_____	____
Liver Disease	____	____	_____	____	____	_____	____
Intestinal Disease	____	____	_____	____	____	_____	____
Seizures	____	____	_____	____	____	_____	____
Hepatitis	____	____	_____	____	____	_____	____
Stroke	____	____	_____	____	____	_____	____

Explanation of any illness above or other illness not mentioned:
_____

Your Past Surgical History (Operations)

1) _____ Year _____
2) _____Year_____
3) _____Year _____
4) _____Year _____

Check off any of the following if you have had within the past 6 months.

Muscoloskeletal : Joint pain/Stiffness ___, Weakness ___
Nervous System: Nervousness ___, Numbness ____, Paralysis ____, Dizziness____, Convulsions ___ ,Epilepsy ____, Cold/Tingling extremities ___
Respiratory: Shortness of Breath ____ Pneumonia ____, Influenza ___, Tuberculosis ____ Pleurisy ____,Whooping Cough ____
Cardiovascular System: Chest Pain ___, Rheumatic Fever ____
General: Fatigue ___, Fever ___, Headaches ___, Allergies ____, Difficulty Sleeping ___, Forgetfulness ____, Confusion ___,
Gastrointestinal: Black/bloody stools ___, abdominal cramps ___
Genitourinary: Bladder trouble ___, Painful/Excessive Urination ___, Discolored urine____, Difficulty urinating ____
EENT System: Vision Problems ___ Dental Problems ___, Sore throat ___, Hearing problems ___ Difficulty swallowing ___, Heartburn ___
Hematologic/Lymphatic/Immunologic: Anemia ___, HIV/AIDS ____, Clotting problems ____, Thyroid Disorder ___, Lymphatic disorders ___
Skin: Discoloration ___, skin cancer ____, Skin grafts,

Patient Signature: _____ Today's Date _____

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PATIENT MEDICAL QUESTIONAIRE

Please Print

Patient's Name: _____Date of Birth_____SSN:_____

Date of injury/Onset of illness: _____

***** PLEASE FILL OUT ALL QUESTIONS. IF IT DOES NOT APPLY TO YOU PLEASE MARK N/A OR NO.*****

What is your chief complaint today? Please specify right or left side.

_____

_____

If due to an accident or injury please describe how it happened:

_____

_____

If you are having **neck or back pain** are you, or have you had, any bowel or bladder problems? Yes or No

Have you been treated for this problem? _____ If so, by whom? (list all Doctors, Hospital ER, etc.) _____

_____

_____

What type of treatment have you had for this problem? Please indicate what facility and the date.

X-rays _____ MRI _____

Cat Scan _____ Discogram _____

Bone Scan _____ Myelogram _____

Physical Therapy _____

If you have had physical therapy, how much therapy have you had for this problem? Days _____ Weeks, _____ Months ____

EMG testing: _____Epidural Steroid Injections: _____ Pain Management program: _____

Have you had surgery for this injury or problem? If yes, when was the surgery done and what part of the body?

_____

Who did your surgery and where was it done at:

_____

Any Other treatment not listed above:

_____

Please list medications you are taking.

PARTIAL ASSIGNMENT OF CAUSE OF ACTION, ASSIGNMENT OF PROCEEDS, CONTRACTUAL LIEN AND TREATMENT AGREEMENT

Consideration: In order to facilitate the ability of the Office to collect its charges directly from various Payors and thereby to enhance the patient–provider relationship, I, the undersigned, as consideration for the Office's services agree to the following and direct all Payers as follows:

Partial Assignment of the Cause of Action, Assignment of Proceeds, and Contractual Lien. I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to the Office, as well as any and all causes of action that I might have now or in the future against any Payer to the extent of my Charges, the right to prosecute such causes of action either in my name or in the Office's name, and the right to settle or otherwise resolve such causes of action as the Office sees fit. I further assign my right to receive any Proceeds from any Payer to the Office and further grant a contractual lien to the Office **with respect to my charges.** I understand that these assignments of rights and contractual lien may effectuate, automatically or other wise, a secured interest under the applicable Uniform Commercial Code. I intend for this Agreement to effectuate such a lien and hereby authorize the Office to file the form(s) normally filed with the Secretary of State or other governmental agency in order to perfect such lien. Except as provided herein, nothing in this Agreement shall be construed as an election or waiver by the Office to a secured interest under any other statutory lien law. Consistent with these rights, I hereby direct any and all Payers, to pay the Proceeds directly and immediately to, and exclusively in the name of, the Office in the amount of my Charges.

Other Terms. I understand that I remain personally responsible for my Charges. Consistent with law or contact, I agree to pay the full amount of my Charges to the Office upon their demand. Unless mutually agreed to in writing, the receipt and processing of partial payments by the Office shall not constitute a waiver of the Office's right to receive payment–in–full upon demand and shall not constitute an accord and satisfaction of my Charges, irrespective of any restrictions indicated on any payments. I understand that at any time, I can request a copy of my total Charges. I hereby waive any statute of limitations which may apply to the collection of my Charges.

In the event that I retain one or more attorneys to assist me in collecting any Proceeds, I direct each attorney to issue an irrevocable letter of protection to the Office regarding my Charges. I further direct (and the office hereby requests) each attorney to provide immediate notice to the Office regarding any proceeds received by the attorney(s), to promptly pay the Office in full out of such Proceeds, and to provide a full accounting of such Proceeds to the Office.

I authorize and direct the Office to submit my Charges to any and all Payers including, without limit, my health benefit plan. I understand, however that in the event that my Charges are submitted to more than one Payer, I hereby authorize and direct the Office to apply any Proceeds received from one Payer to any reductions, write–offs, or discounts, issued by another.

I authorize the Office to endorse or sign my name on any and all checks listing me as a payee which are received by the Office for payment of Charges incurred by me, my spouse, or my dependents. I further authorize the Office to apply any credit balance on my Charges to any other outstanding Charges still owed by me, my spouse, or my dependents, regardless of whether these other Charges are related to my condition.

This Agreement shall not be modified or revoked without the mutual written consent of the Office and myself. I hereby revoke the terms of any previously signed documents to the extent those terms conflict with the terms of this Agreement.

This Agreement shall be governed under the laws of the state where the Office is located, and is performable in the county where the Office is located. I hereby consent to personal jurisdiction and venue of any court in said county and waive all objections based on improper jurisdiction, venue, or forum non–conveniens.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of the Office and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and effect.

Definitions. For the purpose of this Agreement, the following terms shall have the following meaning: **"Office" shall refer to Dr.Dennis Gutzman** located at 2424 Babcock Rd., Ste 201, San Antonio, TX 78229; **"Payer"** shall refer to, without limit, any insurance carrier, health benefit plan administrator and fiduciary, health maintenance organization, preferred and independent provider organization, attorney, at–fault party, tortsfeasor, individual, and any other entity, which may elect or be obligated to pay or disburse Proceeds to me, either now or in the future, for any reason; **"Proceeds"** shall include, without limit, the proceeds from any settlement, judgment, or verdict, the proceeds from any promise to pay or reimburse, and the proceeds relating to the following benefits, plans, or coverages: individual and group health benefits, Medicare, Medicaid, Worker's Compensation, disability, and malpractice; **"Charges"** shall include, without limit, the full fees for the Office's services (including, without limit, treatment, medical equipment, supplies, supplements, narrative reports, depositions, and testimony), and Collection Costs incurred by the Office, 18% interest on outstanding Charges, and any other charges incurred by me at the Office; **"Collection Costs"** shall include, without limit, and pre– and post judgment court costs, filing fees, service of process charges, attorneys fees, and any other costs of collection incurred by the Office in any effort or action to collect my Charges either from me or from any Payer.

Patient Name (please print)_____ **Date of Birth**_____

Patient's Signature:_____ **Date:**___/___/____ **SSN:**_____

Name of Custodial Parent or Legal Guardian, on Behalf of the Patient (Please Print)_____

Parent/Guardian Signature:_____ **Date:** ___/___/____