Patient Registration Sheet (*PLEASE PRINT*)

If you were referred to our office by another Doctor, please give us the name, address and phone number. We will send this doctor a thank you letter regarding your visit:

Doctor's Name: _____ **(MD, DO, DC)**
Phone #_____ **Address** _____

- **Today's Date:** _____ **Social Security #:** ____-____-_____ **Age:** _____
- **PATIENT's NAME:** _____ **Date of Birth:** ___/___/___
- Address: _____ City _____ ZIP_____
- Cell #: _____ Work#: _____ E-mail: _____
  Marital Status: (M/S/D/W) Circle One (M/F) Employer: _____
- Preferred Pharmacy: _____ Phone#: _____
- Responsible Party (for insurance purposes) _____ DOB: _____

PLEASE INDICATE AUTHORIZED CONTACT METHODS BELOW:

- **☐Text ☐Email ☐Voice Mail ☐Patient Portal**

***EMERGENCY CONTACT*:**

- Name _____ Relationship_____ Phone #_____

Due to insurances having multiple plans and policies, our office does our best to determine whether or not you may require an authorization or referral prior to your visit. **However,** it is **YOUR RESPONSIBILITY** to know whether or not **YOUR INSURANCE requires an authorization or referral to see Dr. Schauder.** If your insurance requires the authorization or referral and **YOU DO NOT** bring this with you to your visit **OR** if your insurance requires a referral/authorization and none is obtained you will be responsible for payment in full. **PLEASE NOTE:** Dr. Schauder is not a workers compensation provider and we cannot bill your healthcare insurance for a work-related injury. You will be responsible for payment at the time of service. It is considered fraud for us bill your private insurance for a work-related injury.

Please Initial Here _____

CONSENT FOR TREATMENT:
This consent provides us with your permission to perform reasonable and necessary medical examination, testing and treatment for the condition/conditions which has brought you to seek care at the practice. By signing below, you are indicating that (1) you consent to treatment at this office or any other satellite; (2) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain fully effective until it is revoked in writing. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding your treatment, we encourage you to ask questions. You have the right to discontinue services at any time.

AUTHORIZATION FOR PAYMENT:
I hereby authorize Dr. Keith Schauder or his agent to furnish any medical information to my medical representative, attorney, employer or other provider of service. I also agree that all payments made by insurance may be directed toward my physician's office. **I understand I am ultimately responsible for any balance on my account and payment in full is expected at the time of service.**

YOUR signature below confirms your agreement with the office policies above

***PATIENT SIGNATURE*:** _____

MEDICATIONS

Patient Name_____**DOB**_____ **Age**_____

Family Physician: _____**Phone#**_____

Current Medications	Date Updated	Drug Allergies

MEDICAL HISTORY FORM

- **REFERRING/FAMILY DOCTOR**_____ **DATE**_____
- **CARDIOLOGIST OR OTHER SPECIALIST** _____

PATIENT'S NAME_____**AGE**_____**DOB**_____**M/F**

What are we treating today? **Circle One:** Knee Shoulder Hip Neck Back Hand Wrist Ankle Foot Other: _____
RIGHT SIDE LEFT SIDE BOTH

Was this an **injury or accident**, such as a fall, automobile accident, sports injury? Yes ☐ No☐ Date of injury: _____
How did injury or accident happen? _____
_____
How long have you had symptoms if no injury or accident? _____

Have you **seen another physician** for this problem? Yes ☐ No☐ Name of physician_____

Are you seeing a **pain management physician**? Yes ☐ No☐ Name of physician _____

Pain level: Scale of 1-10 _____ **Height**: _____ **Weight:** _____ **Dominant hand:** Right ___ Left ___

Pain description: Aching - burning - stabbing - throbbing - sharp - dull - shooting - constant - unchanged - worsening

Symptoms: Swelling – Decreased Range of Motion – Weakness – Numbness – Tingling – Popping – Grinding – Locking
Instability – Radiation down leg – Radiation down arm
Helps? Ice – heat – rest – elevation – OTC medications **Makes Worse?** Walking – standing – sitting – range of motion

GENERAL HEALTH:

Good?	Yes ☐ No☐	Diabetes? Type I or II	Yes ☐ No☐
High blood pressure?	Yes ☐ No☐	Heart surgery?	Yes ☐ No☐
Pacemaker?	Yes ☐ No☐	Stents?	Yes ☐ No☐
Blood thinners?	Yes ☐ No☐	Reflux/gastritis/ulcers?	Yes ☐ No☐
History of DVT?	Yes ☐ No☐	Hormone therapy?	Yes ☐ No☐
Kidney or Liver Problems?	Yes ☐ No☐		

- Please list all **medical illnesses:**_____
_____

PREVIOUS SURGERIES Gallbladder Yes ☐ No☐ Tonsillectomy Yes ☐ No☐ Hysterectomy Yes ☐ No☐

Orthopedic surgeries Yes ☐ No☐ _____

Other surgeries_____

SOCIAL HISTORY:

- Do you smoke? Yes ☐ No☐ If yes, #packs per day _____, # years_____. Do you drink alcohol? Yes ☐ No☐

PATIENTS SIGNATURE: _____ ***Keith S. Schauder MD*** _____

INJURY/ACCIDENT REPORT

YOUR INSURANCE COMPANY REQUIRES US TO PROVIDE THEM WITH THE FOLLOWING INFORMATION ON ALL INJURY OR ACCIDENT CLAIMS:

PATIENT NAME: _____ DOB: _____ AGE: _____

WAS THIS AN **ACCIDENT** OR **INJURY**? Yes ☐ No ☐ **IF No – JUST SIGN AT BOTTOM OF PAGE**

WORK RELATED? Yes ☐ No ☐ **- IF YES - STOP AND NOTIFY THE FRONT DESK.**

ACCIDENT DETAILS: **Date of injury:** _____ **Place of injury:** _____

What happened? _____

_____

*Have you seen another **Physician/ER or Urgent Care for this injury/accident**? Yes ☐ No ☐

If yes who? _____ Phone # _____ Date: _____

*YOUR INSURANCE COMPANY WILL ONLY PAY FOR SERVICES THEY DETERMINE TO BE REASONABLE AND NECESSARY UNDER YOUR POLICY PROVISIONS.

IF YOUR INSURANCE COMPANY DETERMINES THAT A PARTICULAR SERVICE AND/OR SUPPLY, ETC. IS NOT REASONABLE AND NECESSARY UNDER THEIR POLICY STANDARDS, YOUR INSURANCE COMPANY MAY DENY PAYMENT FOR THAT PARTICULAR SERVICE.

*YOUR SIGNATURE BELOW WILL ACKNOWLEDGE THAT CERTAIN SERVICES MAY OR MAY NOT BE COVERED UNDER YOUR POLICY AND THEREFORE ***YOU WILL ACCEPT RESPONSIBILITY FOR PAYMENT*** OF THIS SERVICE REGARDLESS OF INSURANCE COVERAGE.

PATIENT/GUARDIAN SIGNATURE _____ ***DATE*** _____

DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

Please provide us a list of people (**husband, wife, children, other family, friends, attorneys, or other doctors**) we may share your Private Health Information with (**this also includes appointment times**). If you do not want us to speak with anyone please write **NONE.**

_____

_____

Effective December 1, 2017 a new Notice of Privacy Practices is posted in our office and on our website at www.dksmd.com for your review.

Disclosure of personal information to any affiliates will be to the minimum necessary in order to provide you with the utmost privacy and best medical care we are able to provide.

This notice is meant to inform you of how we safeguard your nonpublic personal information. Your trust and confidence are important to us and we strive to maintain your continued trust.

By signing this notice, you are stating that you are aware of our privacy practice, and by filling in the blanks above you are allowing us to disclose information to affiliates that you choose. This notice is effective December 1, 2017 and will remain in effect until revised or revoked.

_____ _____

PATIENT/GUARDIAN SIGNATURE ***DATE***

_____

WITNESS SIGNATURE

Compliance & Disclosure under Texas Occupations Code – Section 102.006

In compliance with the above code, Keith Schauder MD PA strives to provide the most personalized and up to date care for our patients. Dr. Schauder has partnered with several institutions in the area which share in this goal. We are pleased to inform you Dr. Schauder has made investments in Gulf Coast MRI and United Surgery Center. Referrals may be made to these specific facilities to insure our patients receive priority service; however you have the option to choose to go to any facility of your choice. You will not be treated differently by Dr. Schauder if you choose to use another facility other than United Surgery Center or Gulf Coast MRI.

By signing this Disclosure of Physician Ownership you acknowledge you have read and understand the foregoing notice of Dr. Schauder's ownership interests in Gulf Coast MRI and United Surgery Center

_____ _____

Patient/Guardian Signature ***Date***

STATE REQUIRED ETHNICITY AND RACE QUESTIONNAIRE

BACKGROUND INFORMATION

Texas law requires the Texas Health Care Information Collection Subunit to collect information on the race/ethnic backgrounds of hospital patients. Hospitals are required to ask patients to identify their own race and ethnic backgrounds.

The data obtained through this process will be used to assist researchers in determining whether or not all citizens of Texas are receiving access to adequate health care.

If patients fail to identify their own race and ethnic backgrounds, hospital staff will use its best judgment in making the identification.

Questions

Question #1: Ethnic Background
(Mark the box that the patient believes most accurately identifies his/her ethnic background)

Is the patient...?

- ☐ (1) Hispanic/Latino (21352)
- ☐ (2) Not Hispanic/Latino (21865)

Question #1: Race
(Mark the box that the patient believes most accurately identifies his/her race)

Is the patient...?

- ☐ (1) American Indian/Eskimo/Aleut (10025)
- ☐ (2) Asian or Pacific Islander (20289)
- ☐ (3) Black (20545)
- ☐ (4) White (21063)
- ☐ (5) Other *includes all other responses not listed above. Patients who consider themselves as multiracial or mixed should choose this category (21311)*