

**SOUTHWEST ORTHOPEDIC  
GROUP, LLP**

Dear Patient:

We are glad you have chosen us to help you with your healthcare needs. Our clinic is located on the 10<sup>th</sup> floor of Scurlock Tower, 6560 Fannin, Suite 1016. Scurlock is located directly across from The Methodist Hospital in the Texas Medical Center, Scurlock Tower offers self and valet parking facilities.

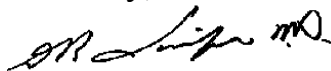
Please fill out the enclosed new patient information form and bring it with you to your visit. Please also bring your insurance card so that we can make a copy. If your insurance company requires a referral, it is your responsibility to obtain this prior to your visit. Please be aware if you have not met your yearly deductible it will be collected at the time of your office visit.

If you need to cancel or reschedule your appointment, please contact our appointment desk as soon as possible at 713-333-4100.

If you would like to obtain more information about our office prior to your visit, you may visit my website at [www.dlionbergermd.com](http://www.dlionbergermd.com).

We look forward to seeing you soon.

Sincerely,



David R. Lionberger, M.D.

DATE: \_\_\_\_\_

DR. NAME: \_\_\_\_\_

**PATIENT DATA**

\_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_  
Last Name First Name Middle  
\_\_\_\_\_ MALE OR FEMALE Marital Status: M S W D  
Date of Birth Age  
\_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
Home Address Apt. No.  
\_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
City State Zip Code  
Occupation: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_  
Referred By: \_\_\_\_\_ OFFICE NO.: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

\_\_\_\_\_ PHONE NO.: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
NAME

**EMPLOYER INFORMATION:**

\_\_\_\_\_ PHONE NO.: \_\_\_\_\_  
EMPLOYER NAME  
\_\_\_\_\_ City State Zip Code  
Address

**GUARANTORS INFORMATION:**

\_\_\_\_\_ Social Security Number Date of Birth  
Last Name First Name Middle  
Patient's Relationship to Policy Holder: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
\_\_\_\_\_ City State Zip  
Home Address Apt. No.

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**

\_\_\_\_\_ Customer Service No: \_\_\_\_\_  
Name of Primary Insurance  
\_\_\_\_\_ GROUP NO.  
ID NUMBER

**SECONDARY INSURANCE:**

\_\_\_\_\_ Customer Service No: \_\_\_\_\_  
Name of Secondary Insurance  
\_\_\_\_\_ GROUP NO.  
ID NUMBER

**AUTHORIZATION TO PAY BENEFITS OF PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.**

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

**DAVID R. LIONBERGER, M.D.**  
ORTHOPEDIC SURGEON  
SOUTHWEST ORTHOPEDIC GROUP

**(PLEASE FILL OUT COMPLETELY INCLUDING BACK SIDE OF THIS SHEET)**

Date:	
Name:	
Date of Birth:	Age:
Height & Weight:	
Primary Care Doctor:	Phone #:
Referred by:	

**Chief Complaint:**

Describe in detail the reason for your visit include- **symptoms, location, onset, duration and severity**

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**Have you ever been treated with injections for this extremity?** No  Yes

If yes, what type and when? \_\_\_\_\_

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**Have you ever had a surgery on this extremity?** No  Yes

If yes, when? \_\_\_\_\_ Who was the surgeon? \_\_\_\_\_

**Medication allergies and reaction:** \_\_\_\_\_

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**Please list any other surgeries and corresponding dates:** \_\_\_\_\_

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# PATIENT HISTORY

## PAST MEDICAL HISTORY

Please list all past and current medical problems/concerns:

### General:

Fever No  Yes

Weight Loss/Gain No  Yes

### Respiratory:

Chronic cough No  Yes

Difficulty breathing No  Yes

### Cardiovascular:

Chest pain No  Yes

Shortness of breath No  Yes

Stroke No  Yes

High blood pressure No  Yes

### Gastrointestinal:

Liver Problems No  Yes

Hepatitis **A/ B/ C** No  Yes

Stomach Ulcers No  Yes

Colitis No  Yes

Diabetes: No  Yes

Thyroid: (↑/↓) No  Yes

Cancer: No  Yes

What type? \_\_\_\_\_

When? \_\_\_\_\_

Treatment? \_\_\_\_\_

### Musculoskeletal:

Weakness of muscles No  Yes

Osteoarthritis No  Yes

Rheumatoid Arthritis No  Yes

Radiating pain No  Yes

Scoliosis No  Yes

Gout No  Yes

Pain in calves/buttocks No  Yes

-Is pain relieved by rest? No  Yes

### Use of:

Alcohol use No  Yes

How much? How often? \_\_\_\_\_

Smoking No  Yes

Packs per day? \_\_\_\_\_

### Hematological:

Blood Clots No  Yes

Family history blood clots? No  Yes

Anemia No  Yes

Slow wound healing No  Yes

Lupus No  Yes

Other: \_\_\_\_\_

Notes: Office Use Only

# ***SOUTHWEST ORTHOPEDIC GROUP, LLP***

## **Review of Notice of Privacy Practices**

### **Acknowledgement:**

I acknowledge that 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 a copy of this document.

\_\_\_\_\_  
**Patient or Personal Representative  
Signature**

\_\_\_\_\_  
**Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: \_\_\_\_\_.

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### **Financial Policy Statement**

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_  
**Patient or Responsible Party**

\_\_\_\_\_  
**Date**

