HUGH A. FREDERICK M.D., NEW PATIENT INFORMATION

Have you seen Dr. Frederick previously as a patient? ______________ If so, when? __________________

Patient's Full Legal Name:
(Last, first, middle, nickname)

Birthdate:	Age:	Social Security#	Drivers License # State:

Street Address: (*Street, City, State, Zip)*

Telephone & area code: Home:	Work:

Employer:	Occupation:

Male Female	Marital status S M W D S	Spouse	Bus. Telephone for Spouse

Email Address: (providing your email will allow you access to your medical record on line through our website; it will not be given out or used for any marketing)

If the patient is a minor, please complete the following.

Father's name	Street address, City, State, Zip	Telephone
Father's employer	Occupation	Bus. Telephone
Mother's Name	Street address, City, State, Zip	Telephone
Mother's employer	Occupation	Bus. Telephone
EMERGENCY CONTACT:	*Name and Phone of Relative, Friend or Neighbor*	

DEMOGRAPHICS: *Although this has nothing to do with the reason you are here and nothing to do with the treatment you will receive, this is now REQUIRED INFORMATION we must submit to the Federal Government. Please fill this out or just write decline on each line.*

Ethnicity: (Ex: Italian, French, Canadian)

Race: (Ex: Caucasian, Hispanic, Asian)

Preferred Language:

PREFERRED PHARMACY:

Pharmacy phone number and address:

PLEASE COMPLETE OTHER SIDE

PLEASE HELP US HELP YOU!

If you will write your answers to the questions below yourself, you can help Dr. Frederick cover routine matters of your medical history so he can spend his time with you on details of your hand or upper limb problem. *Thank You!*

I was referred to this office by Doctor ______________________________ Phone No. ______________________

I. CHIEF COMPLAINT

1. What is your major complaint? ____
   ____
2. How long has this been bothering you? ____
3. Which Side? Right _____________ Left _______________ Both _______________ (Check One)
4. Are you right or left handed? ____
5. Was an injury involved? Yes ___________________ No ___________________

   If so, date of injury: Month ____________________ Day __________________ Year _______________

   If so, did it happen at work? Yes ________________ No ___________________

CURRENT MEDICATIONS: Please include prescription and over the counter medicines -- including medication name, dose, and frequency. If you have a current medication list, we are happy to make a copy instead of having you fill out this portion of the form.

MEDICATION	DOSAGE	FREQUENCY

DRUG ALLERGIES / REACTIONS

Hugh Frederick, M.D.

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Hugh Frederick, M.D. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

____________________________ ________________________
(PATIENT'S NAME PRINTED) DATE

____________________________ ________________________
PATIENT'S SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)

____________________________ ________________________
WITNESS (Optional) DATE

Patient Consent and Acknowledgement of

DISCLOSURE OF PHYSICIAN'S OWNERSHIP INTEREST

IN

NORTH CENTRAL SURGICAL CENTER

Dr. Frederick, along with several other surgeons, has formed a partnership with North Central Surgical Center. By owning a small percentage of the hospital, Dr. Frederick can better control the quality of care provided at the facility. 51% of the hospital is owned by Baylor and 49% by the group of surgeons. The physician partners feel like this relationship keeps the hospital and medical staff on the same team working to provide the best care available. In the Baylor hospital system, the physician partnered hospitals routinely get the best ratings in patient exit surveys.

Dr Frederick's ownership interest in North Central Surgical Center does however mean that he may benefit from choosing to perform surgical procedures on you at this facility. Because of this, you have the right to choose to be treated at some other facility if you desire.

____ ______________________

Patient's Name Printed Date

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Patient's Signature (or Guardian, if a Minor)