Patient Information

Name:

Date of Birth:	Social Security Number:	Sex:

Address:

City:	State:	Zip:

Home Phone:	Business/Cell:

E-mail Address:

Primary Care Physician:

Address:

Phone:

Guarantor (If minor child or if other than insurance provider):

SSN:	Date of Birth:

Relationship to Patient:

Insurance Information	
Primary Insurance Company:	
Subscriber:	
SSN:	Date of Birth:
Employer:	Phone
Policy/ID#:	Group:
Secondary Insurance Company:	
Subscriber:	
Employer:	Phone:
Policy/ID#:	Group:
I understand that, regardless of insurance coverage, I am responsible for all fees for services rendered to the above named patient. I hereby authorize Ronald G. Morton, MD, to furnish my health insurance company or other third party payers or their designated agents all the information, which the above named entities may request concerning treatment of the patient named above. I hereby assign to Ronald G. Morton, MD, the medical benefits to which I or my dependents are entitled under my health insurance plan.	

_____

Signature of Patient/Legal Guardian Date

New Patient Registration AND Questionnaire

New Patient Questionnaire

Please list your current problems and concerns with the reason for today's visit listed first:

Please list all prior surgeries/hospitalizations:

Please list all disorders/diseases (example, diabetes):

Please list all your medications. (If you have a list, we can make a copy.)

Medication **Dosage** **How Often**

_____
_____
_____
_____
_____
_____

Preferred Pharmacy: **Phone:**

Please list any non-prescription substances, including over-the-counter medications, herbal supplements, vitamins or recreational drugs:

Are you allergic to any medications: Yes __ No__ If yes, please list:

Your age:	Number of Children:	Occupation:
Alcohol use? Yes ☿☿ No __ If yes, how often/much:	Tobacco use? Yes ☿☿ No__ If yes, how many packs per day:	

Family History			
Relative	Living	Age (now or at death)	Medical Problems
Mother	Yes__ No__		
Father	Yes__ No__		
Brother	Yes__ No__		
Sister	Yes__ No__		
Son	Yes__ No__		
Daughter	Yes__ No__		

_____

Signature of Patient/Legal Guardian Date

New Patient Registration AND Questionnaire

Emergency Notification
Name:
Address:
Phone:
Relationship:

Medical Consent
Medical Information Can Be Released To:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

Can messages be left on your answering machine/voicemail? Yes___ No___
Can we contact you via e-mail? Yes___ No___

Consent for Treatment
I consent to treatment as necessary or desired the care of the above named patient. This includes, but not limited to whatever drugs, medicine, lab tests, x-rays, or other studies that may be used by Ronald G. Morton, MD, or his nurse or qualified designee at his direction. I have read and understand the above information. I also understand this consent can be revoked in writing at any time.

Acknowledgement of Receipt of Privacy Practices
Ronald G. Morton, MD, reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the privacy practices for Ronald G. Morton, MD.

_____

Patient Name (Please Print) Date

_____

Signature of Patient/Patient Representative Relationship

MEDICAL RECORDS RELEASE REQUEST

Medical Records Can Be Released From
Name:
Address:
Phone:
Fax:
Patient Name:
Date of Birth:

_____

Patient Name (Please Print) Date

_____

Signature of Patient/Patient Representative Relationship

Ethnicity and Race Questionnaire

In order to meet Electronic Health Record (EHR) Meaningful Use Measures, The Center for Medicare and Medicaid Services (CMS) requires us to collect demographic information from out-patients. Specifically, these five items are: *date of birth, gender, race, ethnicity* and *preferred language*. Options are available if you choose not to answer the questions.

Nationality or Ethnic Background
Please indicate below which most accurately identifies your ethnic background.
___ Hispanic/Latino
___ Not Hispanic/Latino
___ I (patients legal name) Refuse to Answer the Question

Race		
Please indicate below which most accurately identifies your ethnic background.		
__ African American	__ Japanese	__ Native Hawaiian
__ Asian	__ Filipino	__ Pacific Islander
__ Caucasian	__ Hispanic	__ Other
__ Chinese	__ Native American	__ Unknown

Preferred Language		
__ English	__ Spanish	__ Other

_____

Patient Name (Please Print) Patient Date of Birth

_____

Signature of Patient/Patient Representative Date

Fall Prevention, Balance, and Dizziness Questionnaire

To help determine if you may be headed for a fall or have a balance disorder, take the Balance Self-Test below. If you answer yes to one or more of the questions, you could be at risk. The best way to determine if you have a problem is to share with the doctor any fears or concerns you have regarding falling, dizziness or vertigo, so that he or she may help determine the cause of your symptoms.

Please read each question and check the box that best describes your answer	**Yes or Often**	**Sometimes**	**No or Never**
1. Do you ever lose your balance or feel dizzy or unsteady?	—	—	—
2. Have you continued to experience dizziness after an injury or accident?	—	—	—
3. Do you feel unsteady when you are walking or climbing stairs?	—	—	—
4. Do you feel dizzy while sitting down or rising from a seated or lying position?	—	—	—
5. Does walking down the isle of a supermarket or stopping next to moving traffic make you dizzy?	—	—	—
6. Does moving your head quickly make you dizzy or cause you to feel nauseous?	—	—	—
7. Are you dizzy or unsteady when you first get up in the morning?	—	—	—
8. Do you ever fall or feel like you are about to fall for no apparent reason?	—	—	—
9. Do you use a walker, cane or any other form of assistance for your mobility?	—	—	—

10. Have you had a recent loss of, or decrease in, your vision or hearing?	—	—	—
11. Do you fear falling?	—	—	—
12. Have you experienced dizziness, vertigo or serious imbalance in the past six months?	—	—	—
13. Has your balance problem caused problems in your social life?	—	—	—
14. Have you fallen more than once in the past year without an obvious cause?	—	—	—
15. Does dizziness or imbalance interfere with your job or your household responsibilities?	—	—	—

_____

Signature of Patient/Legal Guardian Date

Pre-ENG-VNG Instructions

At Texas Therapeutic Medical Specialties, we will perform state of the art testing on all components of our centers of balance. This testing will take an hour to an hour and a half, so if for any reason you cannot keep your appointment, please call (903) 212-4399 as soon as possible.

If you tend to become dizzy with movement, ear, or visual stimulation, you will most likely experience those symptoms at some time during your testing. For this reason, it is recommended that you have someone accompany you and drive you to the clinic on the day of testing.

It is important that your ears are not obstructed, therefore Dr. Morton will need to have examined your ears recently, and if there is any question about this, your ears can be checked again before you test. Also do not forget to remove any (in the ear) hearing devices.

Certain medications may also alter the results of inner ear tests; therefore it is best to discontinue any nonessential medications 48 hours before you undergo testing. If you have any questions about essential vs. non-essential medications, please call your prescribing physician or the clinic.

The medications most important for you to discontinue before your inner ear testing include:

- "Inner ear" or "dizzy" pills—these include antivert or meclizine, Dramamine, scopolamine and Phenergan.
- Antihistamines—any medications for colds and allergies, such as Benadryl, Zyrtec cough medications, etc.
- Aspirin—if not medically necessary.
- Sleeping pills.
- Sedatives and tranquilizers—Valium, Ativan, Xanax, etc.
- Pain medications, muscle relaxers, or narcotics of any kind.
- Alcoholic beverages.
- Caffeine.
- Diuretics—fluid pills, prescribed for dizziness.
- Certain herbal remedies—gingko, valerian, St. John's Wort, etc.
- Any medications that may contain any of the above.

This list in not all-inclusive, so if you have any questions, again, please calls the clinic or your prescribing physician. It is best not to eat or drink within 2 hours before your test is to begin. Do not apply creams, lotions or make-up, especially eye make-up to your face before your test. This can interfere with electrical and video recordings. Dress comfortably. Consider wearing loose fitting jeans or slacks. Wear shoes that are easy to slip on and off for balance testing. Remember, if you have any questions feel free to call at (903) 212-4399 so Dr. Morton and his staff can help.