Southwest Orthopaedic & Reconstructive Specialists
southwestortho.com

DATE: _____

Name: (Last) _____**(First)**_____**(MI)**_____**(Nickname)**_____

Date of Birth: _____/_____/_____ **Age:** _____ **Sex:** ☐ **M** ☐ **F** **Marital Status:** ☐ **S** ☐ **M** ☐ **D** ☐ **W**

Phone: (_____**)** _____ **Cell: (**_____**)**_____-_____ **SSN:**_____/_____/_____

Address: _____**City:**_____**ST:**_____**Zip:**_____

Email Address: _____

Employer: _____ **Phone: (**_____**)**_____-_____

School if Student: _____ ☐ **Full time** ☐ **Part time**

Primary Care Physician: _____

Referred by: _____

☐ **Physician** ☐ **Hospital** ☐ **Family/Friend** ☐ **Advertisement** ☐ **Coach** ☐ **Other**

IN CASE OF EMERGENCY, I GIVE PERMISSION TO NOTIFY:

Name: _____ **Home: (**_____**)**_____-_____

Relationship:_____ **Cell: (**_____**)**_____-_____

HEALTH INSURANCE INFORMATION: **Please give information about the primary policy holder of insurance**

Primary
Insurance Company: _____

Insured Name: _____

Relationship to patient: _____

SSN: _____ **DOB:** _____

Policy or ID number: _____

Group number: _____

Employer: _____

Secondary
Insurance Company:_____

Insured Name: _____

Relationship to patient:_____

SSN: _____ **DOB:** _____

Policy or ID number: _____

Group number: _____

Employer: _____

If patient is a minor please give parental or guardianship information

Parent or Guardian_____

Relationship_____**SSN:**_____ **DOB:**_____

Demographic Information:

Preferred Language: _____

Race: ☐ **White** ☐**Black** ☐**Asian** ☐**Native American** ☐ **Hispanic** ☐**Native Hawaiian** ☐**Unknown**
Ethnicity: ☐**Hispanic** ☐**Non-Hispanic** ☐ **Unknown**

☐**Decline to answer the above**

Patient name_____ **DOB** _____

Is This A <u>Work-Related</u> Accident?δ YES δ NO

If **<u>Yes</u>**, list Employer and/or Adjuster's name and phone:

_____

Is This An <u>Auto-Related</u> Accident? δ YES δ NO

If **<u>Yes</u>**, list responsible party and insurance company, adjustor's name, claim number and phone. If unknown, write 'Unknown':

_____

_____

_____

_____

_____

If **<u>Yes</u>**, please indicate how your account will be billed:

☐ **MVA (Self-Pay)** ☐ **Health Ins.**

<u>NOTE</u>: Be advised all MVA(Self-Pay) accounts require lien filing process on accounts with charges over $200. MVA Liens will not be filed for medical charges if you are a Medicare/Medicaid recipient.

Are you represented by an attorney? δ YES δ NO

If **Yes**, list attorney's name and phone:

_____

Please list how you would like to be contacted, for <u>appointment reminders</u>:

☐Text Message ☐ Voicemail at (_____) _____ - _____ This is my: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Please indicate which phone number we may leave a voicemail with <u>clinical information</u>:

(_____) _____ - _____This is my: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Who may we talk to on your behalf?

_____**By initialing, I permit Southwest Orthopaedic and Reconstructive Specialist to discuss health information in person or by phone with the following family members or friends. Release of information under this document is limited to verbal discussion with my Health Care Provider. This document does not permit release of any written health information to the individuals named below.**

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____

_____**By initialing, I understand that I will be treated by one or more SOS physicians who may refer me for further procedures, imaging, surgery and/or other related services to OCOM hospital (Oklahoma Center for Orthopaedic and Multi-Specialty Surgery). I further understand that the following physicians have an ownership interest in the OCOM hospital: Bradley Reddick, DO, Derek West, DO, Kristopher Avant, DO, Brian Levings, DO, RJ Langerman, DO, Matthew Diesselhorst, MD, Mehdi Adham, MD, Kyle McGivern, DO, Daniel Jones, MD.**

I attest that the information stated on this document is true and correct to the best of my knowledge, and agree to contact and inform SOS of any changes to the information stated herein.

X_____ _____

Signature of patient, parent or legal guardian/ relationship is required **DATE**

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DATE: _____

Patient name_____ **DOB** _____

Height _____ Weight _____ Do you currently have Active Tuberculosis (TB)? δ **YES** δ **NO**

Are you in Pain Management? ☐Yes ☐No If Yes, Dr. _____

Do you have a Cardiologist? ☐Yes ☐No If Yes, Dr. _____Phone_____

Last Influenza Vaccination (date): _____ Last Pneumonia Vaccination (date): _____

COMPLAINT/INJURY

Today I Expect to Be Seen For:

☐Right ☐Left ☐Both

☐Head ☐Neck ☐Shoulder ☐Elbow ☐Wrist ☐Hand ☐Finger ☐Back ☐Hip ☐Knee ☐Ankle ☐Foot
☐Toes ☐Ribs ☐Face ☐Abdomen ☐Breast ☐Other_____

☐Work – Related Injury

☐Motor Vehicle – Related

Date of Injury or Date Illness Began: _____

REGARDING CURRENT INJURY:

Were you treated at a hospital or by another physician? δ YES δ NO

If **YES**, by Whom and When? _____

Have you had ☐X-ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐
Other(_____)?

If **Yes**, list Where and When: _____

Have you had surgery before for this? δ YES δ NO

If **Yes**, list Date and Type: _____

Who performed the surgery? _____

MEDICAL HISTORY: (Check all that apply)

☐Anemia
☐Anxiety Disorder
☐Asthma
☐Bladder Infections
☐Blindness
☐Blood Clots/Embolism
☐Blood Disorders
☐Cancer
☐Cardiac Cath
☐Cerebral Palsy
☐Chest Pain
☐Coagulopathy
☐COPD
☐Coronary Arterial Bypass
☐Crohn's Disease
☐Deafness
☐Depression
☐Diabetes
☐Dialysis
☐Other
_____

☐Emphysema/Chronic Bronchitis
☐Fibromyalgia
☐GERD
☐Gout
☐Heart Attack
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Cholesterol
☐HIV
☐High Blood Pressure
☐Intestinal Ulcers
☐Kidney Disease
☐Liver Disease
☐Lupus
☐Lyme Disease
☐Memory Loss
☐Mentally Disabled
☐MRSA
☐Other
_____

☐Migraines
☐Mitral Valve Prolapse
☐Mute
☐Nerve Disorder
☐Neuropathy
☐Osteoarthritis
☐Pacemaker/Defibrillator
☐Paraplegia
☐Peripheral Vascular Disease
☐Prostate Disease
☐Psychological Disorder
☐Quadriplegia
☐Rheumatoid Arthritis
☐Seizures
☐Shortness of Breath
☐Sleep Apnea
☐Stroke
☐Stomach Ulcers
☐Thyroid Disease
☐Other
_____

☐Transient Ischemic Attack
☐Tuberculosis (TB)
☐Vancomycin Resistant

SOCIAL HISTORY:

- Have you ever been addicted or dependent on drugs or pain medicine? ☐Yes ☐No
- Smoke: ☐Every Day ☐Some Days ☐Never Smoker ☐Former Smoker Quit in _____
- Drink: ☐Yes ☐No How many per month?_____

SURGICAL HISTORY: (Continue on back if needed) **Date of Surgery:**

_____

_____

_____

_____

_____

_____

FAMILY HISTORY: (List relatives with conditions)

Medical Condition	Relative (mother, brother…)	Medical Condition	Relative (mother, brother…)
☐Diabetes	_____	☐Lung Disease	_____
☐Hemophilia	_____	☐Kidney Disease	_____
☐Rheumatoid Arthritis	_____	☐Malignant Hypothermia	_____
☐Cancer	_____	☐Anesthetic Reaction	_____
☐Stroke	_____	☐Other_____	_____
☐Heart Disease	_____	☐Other_____	_____

CURRENT REVIEW OF SYSTEMS: (Check all that apply within the last year)

☐Abdominal Pain	☐Difficulty Swallowing	☐Headaches	☐Night Sweats	☐Skin Problems
☐Bleeding	☐Easily Bruising	☐Increased Thirst	☐Poor Balance	☐Urinary Retention
☐Chest Pain	☐Emotional Disturbances	☐Increased Hunger	☐Persistent Cough	☐Weakness
☐Convulsions/Seizures	☐Eyes or Vision Problems	☐Insomnia	☐Rash	
☐Decreased Motion	☐Fecal Incontinence	☐Joint Pain	☐Shortness of Breath	
☐Depression	☐Fever/Chills	☐Nausea/Vomiting	☐Shortness of Breath while lying down	

CURRENT MEDICATIONS AND ALLERGIES: (use back of form if needed)

_____mg_____ How often? _____

_____mg_____ How often? _____

_____mg_____ How often? _____

_____mg_____ How often? _____

Allergies to Drugs:_____ **☐No Known Drug Allergies**

Allergies to: ☐Latex ☐Adhesive Tape ☐Iodine ☐Other _____

Are you Pregnant? ☐Yes ☐No

What pharmacy do you use? _____ Location _____

I attest that the information stated on this document is true and correct to the best of my knowledge, and agree to contact and inform SOS of any changes to the information stated herein.

X_____ _____

Signature of patient, parent or legal guardian/ relationship is required DATE

Patient Responsibilities and Expectations

1. I will comply with facility rules and regulations, which have been developed to protect patients and ensure safety of patients and staff.
2. I will conduct myself in a manner that is respectful and considerate of staff members and other patients.
3. I will be respectful to all providers, staff and other patients.
4. I will follow the instructions and recommendations of my physician and accept full responsibility for the consequences of failing to do so.
5. I will inform medical staff of any health problems, changes in medications or concerns of medical treatment.
6. I will take an active part in my treatment plan and establish long-term treatment goals.
7. I will inform the staff or physician if instructions or explanations given are not understood or will not be followed.
8. I will take any prescribed medications ONLY as prescribed by my physician.
9. I understand that any lost or stolen pain medications or prescriptions will not be refilled for any reason.
10. I will offer cooperation and understanding to my provider and staff members.
11. I understand that I am responsible for the behavior of any guests that accompany me in the clinic or who participate in communication of my treatment with the provider or staff.
12. I will respect the privacy and confidentiality of other patients.
13. I will refrain from using obscene language, making threats or using any type of assaulting behavior.
14. I will arrive on time for appointments and give advanced notice of cancellation when possible.
15. I will inform the clinic office staff of any changes in my medical coverage and pay for services rendered and needed.

By signing this agreement, I understand my responsibilities and expectations as a patient of Southwest Orthopaedics. I also understand that any breach of this agreement could result in termination of my relationship as a patient.

PRINTED NAME PATIENT/GUARDIAN SIGNATURE DATE