SOS Southwest Orthopaedic & Reconstructive Specialists
southwestortho.com

DATE: _____

Name: (Last) _____(First)_____(Middle)_____(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 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:_____

The CMS Meaningful Use initiative requires we ask certain demographic information questions (below).

____Do Not Wish to Answer the Following Questions:

Language Choice _____

Race: ☐White ☐Black ☐Asian ☐Native American ☐ Hispanic ☐Native Hawaiian ☐Unknown

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Patient name_____ **DOB** _____

Is This A Work-Related Accident? ☐ **YES** ☐ **NO** If **Yes**, list Employer and/or Adjuster's name and phone:

_____

Is This An Auto-Related Accident? ☐ **YES** ☐ **NO**

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

_____

_____

_____

_____

_____

If **Yes**, please indicate how your account will be billed:

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

NOTE: 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? ☐ **YES** ☐ **NO**
If **Yes**, list attorney's name and phone:
_____

Please list how you would like to be contacted, for appointment reminders:

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

Please indicate which phone number we may leave a voicemail with clinical information:

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

Who may we talk to on your behalf?

_____ (Initial) 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
_____	_____	_____
_____	_____	_____

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 TB? ☐ **YES** ☐ **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? ☐ YES ☐ 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? ☐ YES ☐ 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

AUTHORIZATION FOR MEDICAL TREATMENT AND ACKNOWLEDGEMENT OF SOUTHWEST ORTHOPAEDIC SPECIALISTS' HEALTH INFORMATION AND FINANCIAL POLICIES, DISCLOSURES, TERMS AND CONDITIONS

The undersigned hereby:

Grants authorization for medical treatment; agrees to full and final financial responsibility, including: If filing a claim with my health insurance company, I understand I am responsible for any co-pays, co-insurance, deductibles, and non-covered services; If I do not have health insurance or if I have an open third party liability claim (e.g., Motor Vehicle Accident), I understand I am required to pay the initial evaluation fee and a deposit on any surgery ordered prior to services being rendered, and I agree to keep my account in current good standing for all other services rendered and balances accrued; If I have an open third party liability claim (e.g., Motor Vehicle Accident), I understand my account will be considered "Self Pay" (as if I have no health insurance), and I understand that any charges accruing beyond any amounts I pay will be filed as a Lien against me with Oklahoma County Court Clerk and that no Lien will be released without full and final settlement of my SOS account.

I understand SOS utilizes an outside, third party service for management and handling of insurance eligibility, verification and collections, and that SOS does not control the actions of the third party service.

I understand SOS is not required to offer discounts for any amounts which may be due from me.

I understand any amount due from me is payable at or before the time of service, and that SOS is not required to offer payment arrangements of any kind. I understand SOS may refuse to provide service if I fail to pay any amount currently due from me. I understand that any amount due from me is considered a legitimate and lawful debt obligation and that SOS may use any lawful means to collect; I understand that regardless of insurance, if I fail to keep my account current (no more than 30 days overdue), my account will be turned to an outside collection agency.

Acknowledges that I have been provided the SOS HIPAA Privacy Notice; I authorize the release of my medical and billing information to my insurance company or representing attorney; I authorize the assignment and payment of medical benefits or settlements to the physician and SOS. I understand that any request to change my medical record must be submitted in writing with specificity; I agree to notify SOS in writing of any requested restrictions on disclosure of my health information.

I authorize SOS to access and utilize my medical records in the course treatment from other medical providers and/or a Health Information Exchange(s) ("HIE"); I authorize SOS to record my medical information and utilize it on HIE(s) for use by other medical providers utilizing HIE(s), and I acknowledge that such use is outside the dominion and control of SOS and therefore I will address any questions or issues regarding such use with the HIE(s) and/or other related medical providers or third parties. I understand that should I wish to opt-out from participation in the Coordinated Care Oklahoma (CCO) HIE, I am responsible for doing so pursuant to the procedure set forth on the CCO website, *http://coordinatedcarehn.com/patients/;*

I authorize SOS and/or contracted third parties to utilize my primary phone number or email address I have provided to contact me about my care, treatments, insurance, or payments due for services rendered, including leaving voicemail information;

I authorize SOS to utilize secure electronic verification of filled prescription medications, to maintain current medication history and as is required by the Oklahoma Bureau of Narcotics and Dangerous Drugs.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties as described below:
Description of the specific information to be discussed: ☐ Appointment Dates/Times ☐ Diagnosis ☐ Diagnostic Results ☐ Medications ☐ Care Plan ☐ Other: _____
Information above may be given to the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

_____ _____ _____

Date **Patient Name** **Signature of patient, parent or legal guardian**

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PATIENT CODE OF CONDUCT

BEHAVIOR

I will offer cooperation and understanding to my provider and staff. I will be respectful of providers, staff and other patients. I will respect the privacy and confidentiality of other patients. I will ask questions and be actively engaged in my treatment and on-going care. I will adhere to the rules and policies of this facility. I will treat staff with respect and dignity at all times, whether in the clinic, over the phone or through secure messaging. I will use a normal tone of speech with staff. I will refrain from using obscene language, making threats of violence, name calling, and assaultive behavior. I will comply with my treatment plan and recommendations. I understand I am responsible for the behavior of any guests I bring into the office or who participate in communication with the provider or staff.

I understand if my or my guests' behavior becomes disruptive or in breach of this agreement, my relationship as a patient may be immediately terminated by my provider.

MEDICATION USE

I will take medication only as prescribed. I will not take any sedatives, alcohol or other pain medications without the prior approval of my doctor. I will not seek or accept any medications for pain other than those prescribed by my doctor. "Medications for pain" includes prescriptions from the doctors, medications borrowed or accepted from family or friends, and any illicit or street drugs. I understand if I do not keep my appointments, I will not receive refills. I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped. I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure any medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen narcotics or narcotic prescriptions. I understand that my doctor may require specialist evaluation of my treatment, and I agree to keep appointments when my physician refers me. My doctor will send a report of my care and a copy of this agreement when a referral is made. In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain any pain medication from a source other than my doctor.
2. I give, sell or in any way distribute prescribed medications to any other person(s).
3. I, in any way attempt to forge or alter a prescription.
4. My medical condition declines to the point at which, in the judgment of my doctor, continued therapy with this medication presents a danger to my well-being or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor determines that I am no longer a good candidate to continue the medication.

I understand that **refills of narcotic medication will be made only during business hours**. Narcotic refills are filled **Monday-Thursday 8:30am – 4:00pm**. **Refill requests will not be taken on Fridays after 1:00pm, unless as otherwise specified by your doctor.** When requesting refills please have your pharmacy fax a refill request to your doctor at 405-632-4549. Refills of narcotic medications will not be made after hours, on the weekends or on the holidays. The answering service will not contact your doctor for refills. It is my responsibility to contact the office 24-48 hours prior to using the last of my medicine, and during the business hours described above, to ensure that I do not run out. I understand that narcotic prescriptions may be required to be picked up in the office and a photo ID will be required before the prescription will be released. If a person other than me will pick up the prescription, that person will be required to bring his/her photo ID and a note from myself authorizing my medication to be released.

If I change pharmacies, I will contact my doctor's office and provide them with the name, address and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

_____	_____	_____
Printed Name	**Patient/Guardian signature**	**Date**

Southwest Orthopaedic & Reconstructive Specialists

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