

Today's Date: _____

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

SSN: _____ Date of Birth: ____/____/____ Age: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Employer: _____ Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Unemployed

Emergency Contact: _____ Relationship: _____ Phone: _____

Email: _____ Primary Care Physician: _____

Referred by: ☐ Physician _____ ☐ Hospital ☐ Family/Friend ☐ Ad _____

Where did your injury occur? ☐ Home ☐ Auto ☐ School ☐ Work ☐ Other _____ ☐ No Known Injury

****Auto related injury?** ☐ Yes ☐ No Date of Injury: _____

Insurance Company: _____ Phone: _____

Claim Number: _____ Adjuster: _____

**** Work Related Injury?** ☐ Yes ☐ No Date of Injury: _____

Insurance Company: _____ Phone: _____

Claim Number: _____ Adjuster: _____

Employer: _____

Are you represented by an Attorney? ☐ Yes ☐ No

Attorney Name: _____ Phone: _____

Health Insurance Information

Primary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ SSN: _____ DOB: _____

ID Number: _____ Group Number: _____ Employer: _____

Secondary Insurance: _____ Policy Holder: _____

Relationship to Patient: _____ SSN: _____ DOB: _____

ID Number: _____ Group Number: _____ Employer: _____

Person Responsible for Bill: (If the patient is a minor)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

_____ 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, Mehdi Adham, MD, & Steven Sands, DO.

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

Signature of Patient or Guardian

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



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 a copy of the Notice of Privacy Practices for SOS. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is available upon request and on SOS's web site.

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

PATIENT HEALTH HISTORY & INFORMATION

PATIENT NAME: _____ **DATE:** _____

Are you in pain management? ☐ Yes ☐ No If Yes, Dr. _____ Phone: _____

Do you have a cardiologist? ☐ Yes ☐ No If Yes, Dr. _____ Phone: _____

Do you have a pacemaker? ☐ Yes ☐ No If Yes, when? _____

What do you expect to be seen for today? _____

❖ Which side? ☐ Right ☐ Left ☐ Both

❖ Which body part? ☐ Head ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Finger ☐ Back ☐ Hip ☐ Knee ☐ Ankle
☐ Foot ☐ Toes ☐ Ribs ☐ Face ☐ Abdomen ☐ Breast ☐ Other _____

❖ Was this injury/illness due to an accident? ☐ Yes ☐ No
 If Yes, what type? ☐ Work Related Injury? ☐ Motor Vehicle Related Injury?

Date of Injury/Illness Began: _____

REGARDING CURRENT INJURY/ILLNESS:

Have you been treated at a hospital or by another physician for this injury/illness? ☐ Yes ☐ No

If YES, by Whom and When? _____

Have you had a/an: ☐ X-ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG

If yes, list where and when: _____

Have you had surgery for current injury? ☐ Yes ☐ No

If yes, list date and Doctor: _____

What is your current: Height _____ Weight _____

OB/GYN (Females Only):

Are you currently pregnant? ☐ Yes ☐ No

ALLERGIES:

Do you have any drug allergies? ☐ Yes, Name: _____ ☐ No known Drug Allergies

Do you have any allergies to these? ☐ Latex ☐ Adhesive Tape ☐ Iodine ☐ Metal ☐ Other _____

PHARMACY INFORMATION:

What is your preferred pharmacy?

Name: _____ Location: _____

CURRENT MEDICATIONS: (attach list as needed)

_____	mg _____
_____	mg _____
_____	mg _____
_____	mg _____
_____	mg _____

PATIENT NAME: _____ DATE: _____

MEDICAL HISTORY: (Check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> GERD | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis (ACTIVE TB) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Obesity | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Otitis Media | <input type="checkbox"/> Vision impairments |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Seizure | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> IBS/IBD | <input type="checkbox"/> Sickle Cell Anemia | |

SURGICAL HISTORY: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Umbilical Hernia |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Lymph Node Biopsy | <input type="checkbox"/> VP shunt |

Other: _____

FAMILY HISTORY : (List relatives with conditions. For example mother, father, brother, sister, paternal grandmother, paternal grandfather, maternal grandmother, or maternal grandfather)

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol abuse _____ | <input type="checkbox"/> Drug Abuse _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Early Death _____ | <input type="checkbox"/> Miscarriages _____ |
| <input type="checkbox"/> Birth Defect _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hyperlipidemia _____ | <input type="checkbox"/> Suicide Attempt _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Vision Loss _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Learning Disabilities _____ | |

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes - How often? _____ ☐ No

Do you Smoke? ☐ Every day ☐ Some Days ☐ Never Smoker ☐ Former Smoker - Quit in _____

Use Smokeless Tobacco? ☐ Yes ☐ No ☐ Never ☐ Former Smokeless Tobacco - Quit all tobacco in (year): _____

By signing this medical history form, I attest that the information stated within is true and current medical history to the best of my knowledge and I agree to contact/inform Southwest Orthopaedic Specialists medical staff or my provider of any medical changes to the information stated herein.

X _____
Signature of patient – Parent or Legal Guardian

Date

Print Name of Parent or Legal Guardian, if patient is a minor: _____