OKC ORTHOPEDICS
SPORTS & PAIN MEDICINE

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PATIENT INFORMATION

Patient's Last Name	First	Middle	Marital Status	Referring Physician
			❑ Single ❑ Married ❑ Widow	

Social Security Number	Daytime Phone	Cell Phone	Birth Date	Age	Gender
	( )	( )	/ /		❑ Male ❑ Female

Street/Mailing Address	City	State / Zip

Email Address	Spouse Name	Spouse Birth Date	Spouse Phone
		/ /	( )

Ethnicity	Race	Preferred Language
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White	❑ English ❑ Spanish ❑ Other:

Are you: (check one)	Employer	Employer Phone
❑ Employed ❑ Student ❑ Retired		( )

GUARANTOR (IF PATIENT IS A MINOR)

Person Responsible for Charges	Birth Date	Social Security Number	Phone
	/ /		( )

Address (if different)	Employer	Employer Phone
		( )

INSURANCE INFORMATION PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Is the patient covered by health insurance? ❑ Yes ❑ No ❑ This injury is covered by Worker's Compensation

PRIMARY Insurance Company Name: _____

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

If the Patient is NOT the Subscriber:

⇨ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____

SECONDARY Insurance Company Name: _____

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

If the Patient is NOT the Subscriber:

⇨ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone
		( )

HOW DID YOU HEAR ABOUT US?

❑ Doctor ❑ Attorney ❑ Family / Friend ❑ Hospital ❑ Internet Search ❑ Radio ❑ Yellow Pages ❑ Other _____

The above information is true to the best of my knowledge. I hereby authorize *Oklahoma City Orthopedics, Sports and Pain Medicine* to administer treatment to the above patient. I also authorize payment directly to *Oklahoma City Orthopedics, Sports and Pain Medicine* of the medical insurance benefits otherwise payable to me for medical services rendered. I understand I am financially responsible for any charges not covered by insurance. I have received a copy of and agree to the policies listed in the *Oklahoma City Orthopedics, Sports and Pain Medicine Policy Guide*.

X _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

OKC ORTHOPEDICS
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Patient Privacy Notice
(Summary)
Effective August 2, 2010

In accordance with the Federal Privacy Law (HIPAA), *Oklahoma City Orthopedics, Sports and Pain Medicine* keeps medical information and records confidential and will only use them for patient treatment, health care operations, and billing purposes.

TREATMENT:	Our physicians, clinicians, and staff will use your medical information to give you the best possible care.
HEALTH CARE OPERATIONS:	*Oklahoma City Orthopedics, Sports and Pain Medicine* will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.
BILLING PURPOSES:	*Oklahoma City Orthopedics, Sports and Pain Medicine* will use your medical information to bill the appropriate third parties for your care.

DISCLOSURE OF INFORMATION WITH EXTENUATING CIRCUMSTANCES

1. Health information may be given to family members and/or friends in case of an emergency.
2. Health information may be given to other physicians or institutions, at the discretion of the physician, to facilitate diagnosis and treatment.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.

I understand that if I have any questions I can speak to the *Oklahoma City Orthopedics, Sports and Pain Medicine* Privacy Officer. I also understand that a detailed version of the *Patient Privacy Notice* is available upon request.

I understand and agree to the above Privacy Policy:

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

OKC ORTHOPEDICS
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Release of Medical Information
To Others Involved in Your Healthcare

As stated in our *Patient Privacy Notice*, we cannot disclose to members of your family, your friends, or other acquaintances any protected health information that directly relates to your health care unless we have written permission from you. We request that you designate the individuals with whom we may discuss your protected health information. **Other persons calling about your appointment, billing, or direct health care issues will be refused access to this information.**

I give *Oklahoma City Orthopedics, Sports and Pain Medicine* permission to discuss my protected health information with the following persons:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that I may rescind or modify this permission at any time. Such changes must be in writing to *Oklahoma City Orthopedics, Sports and Pain Medicine*.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

I do not want my medical records, including appointment times, released to anyone including my work/school, spouse, family members, or attorney. _____initial

TODAY'S PROBLEM

Patient Name: _____

Date pain began: _____

Describe onset / event: _____

Description of Pain: _____

Using a Pain Scale of 0-10 (0 = No Pain, 10 = Excruciating Pain):
At its Worst: _____ At its least: _____ At its usual: _____ Today: _____

How do the following affect your pain? (B = Makes Better, W= Makes Worse, N = No affect)

Relaxation	___ B ___ W ___ N		Standing	___ B ___ W ___ N	
Heat	___ B ___ W ___ N		Walking	___ B ___ W ___ N	
Cold	___ B ___ W ___ N		Lying down	___ B ___ W ___ N	
Alcoholic Drinks	___ B ___ W ___ N		Exercise	___ B ___ W ___ N	
Medication	___ B ___ W ___ N		Sexual activity	___ B ___ W ___ N	
Sitting	___ B ___ W ___ N		Coughing/Sneezing	___ B ___ W ___ N	

Have you been hospitalized for your pain? If so, please list hospital, date, doctor, and details:
❑ Yes ❑ No
If Yes, details: _____

What time of day is your pain at its worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night

On average, how many hours do you sleep? _____

Has your appetite changed with your pain? ❑ Increased ❑ Decreased ❑ No change

If you have back and leg/arm pain, specify the percentage of each:
_____ % back/neck _____ % leg/arm

Back pain is located: ❑ Upper back ❑ Lower back ❑ No back pain
Leg pain is located: ❑ Right leg ❑ Left leg ❑ Both legs ❑ no leg pain
Arm pain is located: ❑ Right arm ❑ Left arm ❑ Both arms ❑ no arm pain

Previous Treatments:
❑ Injections or blocks Details: _____
❑ Physical/Occupational Therapy when: _____
❑ Chiropractor/Manipulation when: _____
❑ Acupuncture when: _____
❑ Hypnosis when: _____
❑ TENS unit when: _____
❑ Psychological therapy when: _____

Previous Tests:
❑ Lumbar MRI Where and when performed: _____
❑ Cervical MRI Where and when performed: _____
❑ Thoracic MRI Where and when performed: _____
❑ CT Scan Where and when performed: _____
❑ Myelogram Where and when performed: _____
❑ EMG Where and when performed: _____
❑ Bone Scan Where and when performed: _____
❑ Bone Density Where and when performed: _____
❑ Discogram Where and when performed: _____
❑ Rheumatoid Lab Panel
❑ Endocrine Lab Panel

Do you have or have you ever had: ❑ None of the below

❑ Arthritis	❑ Heart murmur	❑ Psychiatric disorder
❑ Glaucoma	❑ Hepatitis	❑ Abnormal EKG
❑ Cataracts	❑ Mononucleosis	❑ Anxiety
❑ Back trouble	❑ Fracture	❑ Abnormal muscle weakness
❑ Blood disease	❑ Diabetes	❑ High blood pressure
❑ Stroke	❑ Blood transfusion	❑ Fracture of facial bones
❑ HIV / AIDS	❑ Anticoagulant therapy	❑ Kidney disease
❑ Depression	❑ Lung disease	❑ Stomach disorder
❑ Cancer	❑ COPD/emphysema	❑ Asthma
❑ Epilepsy/Seizures	❑ Jaundice	❑ Muscular disorder
❑ High cholesterol	❑ Paralysis	❑ Bone disease
❑ Heart attack	❑ Thyroid	❑ Infection

Past Surgeries

❑ Appendectomy	❑ Carpal Tunnel	❑ Hysterectomy	❑ Thyroidectomy
❑ Back Surgery	❑ Cholecystectomy	❑ Tonsillectomy	

Hospitalizations in the last 12 months: ❑ Yes ❑ No

If yes, describe: _____

Family History ❑ None of the below

❑ Alcoholism	❑ Cancer	❑ High Cholesterol	❑ Renal failure
❑ Anemia	❑ Depression	❑ Hypertension	❑ Substance abuse
❑ Arthritis	❑ Diabetes	❑ IBS	❑ Thyroid disorder
❑ Asthma	❑ Heart Disease	❑ Migraines	❑ Other _____

Social History

Drink Alcohol? ❑ Never ❑ Occasionally ❑ Frequently ❑ Daily
Currently use street drugs, including marijuana? ❑ Yes ❑ No
Have a history of alcohol or drug addiction or abuse? ❑ Yes ❑ No
Use tobacco? ❑ Yes ❑ No Packs/day? _____ Smokeless tobacco? _____
Are you pregnant? ❑ Yes ❑ No
Number of children: _____
Marital status: ❑ Married ❑ Widowed ❑ Divorced ❑ Single ❑ Separated ❑ Unknown
Occupation: _____
Are you currently working? ❑ Yes ❑ No Last day worked: _____
Is your injury Workers Comp? ❑ Yes ❑ No If yes, list any other work comp injury: _____

Do you currently have:

❑ Fever	❑ Wheezing
❑ Coughing	❑ Muscle aches
❑ Hearing loss	❑ Heartburn
❑ Sore throat	❑ Sinus problems
❑ Chest pain	❑ Vomiting
❑ Headaches	❑ Paralysis
❑ Urinary pain	❑ Blood in urine
❑ Excessively dry skin	❑ Numbness
❑ Diarrhea/constipation	❑ Skin rash
❑ Joint pain/swelling	❑ Fatigue
❑ Irregular heartbeat	

Height: ____ feet _____ inches Weight: _____ pounds

ALLERGIES (Check all that apply) ***No allergies*** _____*initial*

✓		✓		✓		✓	
	Accupril (quinapril)		Demerol		Latex		Prevacid
	Acetaminophen/Tylenol		Depakote		Levofloxacin		Prilosec
	Acyclovir		DiaBeta (glyburide)		Lidocaine		Prinivil
	Advil (ibuprofen)		Diamox		Lipitor		Quinolones
	Altace (ramipril)		Dicloxacillin		Lodine		Ranitidine
	Ampicillin		Doxycycline		Lopressor (metoprolol)		Septra (sulfamethoxazole)
	Amaryl (glimepiride)		Egg		Lortab/Hydrocodone		Sulfa
	Augmentin (amoxicillin)		Erythromycin		Micronase (glyburide)		Tagamet (cimetidine)
	Aspirin		Famotidine		Minocin (minocycline)		Tegretol (carbamazepine)
	Bactrim (sulfamethoxazole)		Flagyl		Morphine		Tenormin (atenolol)
	Biaxin		Floxin		Motrin (ibuprofen)		Tetanus toxoid
	Carafate (sucralfate**)**		Glucotrol (glipizide)		Naprosyn (naproxen)		Tetracycline
	Ceclor (cefaclor)		heparin		Neptazane		Ticlid
	Celebrex		Ibuprofen		Niacin		Valium (diazepam)
	Cephalosporins		Inderal (propranolol)		Peanut		Vancomycin
	Cipro (ciprofloxacin)		Indocin (indomethacin)		Penicillin		Vasotec
	Clinoril (sulindac)		Insulin (animal**)**		Percocet (oxycodone)		Zestril
	Contrast media (ioversol)		Iodine or Shellfish		Persantine		Zithromax
	Codeine		Keflex (cephalexin)		Plavix		Zocor (simvastatin)
	Coumadin		Klonopin		Phenytoin		Zyloprim (allopurinol)
	Darvon		Lasix (furosemide)		Pravachol		
	Other:						

Medications

Please list **ALL** of your medications including medications not related to today's problem. (If you have a list of your medications, please allow the receptionist to make a copy.)

Medication	**Dose**	**Prescribed by**

I am taking no medications of any kind. _____*initial*

My Preferred Pharmacy

Pharmacy name: _____ Phone #: _____

Address (if known): _____ City: _____

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POLICY GUIDE

Effective July 21, 2014

Thank you for choosing *Oklahoma City Orthopedics, Sports and Pain Medicine* as your healthcare provider. We are dedicated to providing our patients with the highest quality of care.

Financial Policy

1. You are responsible for payment of all medical treatment and related services and supplies provided by Oklahoma City Orthopedics, Sports and Pain Medicine, PLLC.

2. As a service and out of consideration to you, this office will file insurance claims for all covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. You will be responsible for any deductible or co-payment amounts and any non-covered services incurred at the time of service.

3. **If you have insurance but did not bring your insurance ID card(s)** you will be set up on a self-pay account and you must pay for your visit at the time of service or your appointment will be rescheduled. Any overpayment on your account will be refunded after your insurance pays.

4. **If your injury was due to a Motor Vehicle Accident** you will be set up on a self-pay account. Patients are expected to pay up to $300.00 in charges incurred at the time of visit. Claims will be filed with third party insurance carriers on behalf of any patient who has provided complete and accurate billing information.

5. **There is a $25.00 charge for the completion of any patient-requested form such as *Family Medical Leave Act* (FMLA) forms, disability forms, etc.** This charge is applicable per form and is payable prior to completion.

6. If you need to re-schedule or cancel your appointment, please contact us 48 hours prior to your scheduled office visit or 72 hours prior to a scheduled procedure or surgery. If we are not notified **a no-show charge of $50.00 for office visits or $100.00 for procedures/surgeries will apply.**

In keeping with our commitment to serve our patients in need of financial assistance, we have secured arrangements for patient financing through Care Credit® for your convenience. Ask a staff member or visit www.carecredit.com for details.

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POLICY GUIDE

Effective July 21, 2014

Narcotics Policy

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be refilled if you are unable to keep these appointments.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you. It is your responsibility to notify us of any other physician who is prescribing narcotic pain medication to you. It is also your responsibility to inform other physicians that we are prescribing and managing your narcotic pain medications.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are handled Monday through Thursday from 8:30 AM to 3:30 PM ONLY. **PRESCRIPTION REFILL REQUESTS ARE NOT PROCESSED ON FRIDAY, SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON**. Prescription refills will be processed within 48 hours of the request.
- Lost, stolen, or misplaced narcotic prescriptions or medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility.

Thank you for allowing *Oklahoma City Orthopedics, Sports and Pain Medicine* to participate in your care.

Sincerely,

Oklahoma City Orthopedics, Sports and Pain Medicine Physicians and Staff