M. Brandon Johnson Intake From

Patient name: ________________________ DOB: __________ Today's date: _____________

What body part/extremity are we seeing you for today? : _______________ Right/ Left/ Both

Did another doctor refer you to us? Yes/ No. If yes, Who? ______________________

If no, how did you hear about us?____

How did you injury yourself:

- ☐ NO injury, just started hurting
- ☐ Sports (which sport?) ________
- ☐ Motor vehicle accident
- ☐ Work/Job, is there a work comp claim? Yes/ No, Date of injury: ______________

How long have you had symptoms? ____

Please describe your symptoms:____

How would you rate your pain, on a scale 1-10? (10 being the greatest pain) _______
Do you have pain at night? Yes / No
Does it waken you from sleep? Yes / No
Is the pain getting: Better Worse Same

Have you had any of the following imaging studies:

X-rays	Yes / No	Date:_______
MRI	Yes / No	Date:_______
CT scan	Yes / No	Date:_______

Past Medical History

☐ Anesthetic Complications
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Fibromyalgia
☐ GERD/Reflux Disease
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Hepatitis
☐ High Blood Pressure
☐ Hyperlipidemia
☐ Kidney Stone
☐ MRSA
☐ Osteoarthritis
☐ Phlebitis
☐ Rheumatoid Arthritis
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ Ulcers

Height: _________ **Weight:** __________

When did you last have your flu vaccine?: (month & year) ________ Pneumonia vaccine?: _______

List all **ALLERGIES** to any **medications, LATEX or TAPE and the reactions**:

 No Known Drug Allergies

Medication	Reaction

What is your preferred pharmacy (Please include name and cross streets:

____

CURRENT MEDICATIONS: (Please include over the counter medication and food supplements.)

Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
Drug Name: ______________________Dose: _______________How Often: ________________
 None

Past Surgical History

Please list all of the SURGERIES you have had:

Type of Surgery	Year	Type of Surgery	Year

Social History

Tobacco: Never a Smoker
Current Smoker: Cigarettes Yes No Amt:_______pck/day Has been smoking for?
Smokeless Tobacco: Yes No Amt:_____per day. Cigars: Yes No Amt:_____# week
 Quit Smoking: Year last smoked _________
Alcohol use: Yes No _____# drinks per day / week / occasional / social
Exercise: Yes No Times per week: ______ Type of exercise: ____________________

Occupation: ___________________

*****If you are not here for your hip, you can stop here*****

Hip Intake Form

Please check all that apply:

- ☐ Pain with long sitting?
- ☐ Pain with long driving/travel?
- ☐ Cycling?
- ☐ Putting on shoes and socks?
- ☐ Walking?
- ☐ Running?
- ☐ Pivoting/Twisting?
- ☐ Squatting?

Do you have any of the following:

- Giving way or giving out? Yes / No
- Catching sensation? Yes / No
- Painful popping? Yes / No
- Popping that is not painful? Yes / No

Pelvic Floor Questions:

1. Do you have pain or discomfort from intercourse? Yes / No
2. Do you have bladder problems, such as incontinence or urinary urgency? Yes / No
3. Do you have difficulty or hip pain with bowel movements? Yes / No
4. Females: Have you had children: Yes / No
5. In addition to your hip pain do you have a deep pain near the sit bone area? Yes / No
    a. To the lower back area? Yes / No

Please circle all the areas where you are having pain:

Groin or bikini line   Side of hip   Buttock   Front of thigh   Other:__________

Have you had any injections:

1. Into the side of the hip or bursa? Yes / No
   If yes, how long was it helpful? ______________________
   What percentage of your symptoms did it take away? ___________________
2. Into the joint by using xray? Yes / No
   If yes, how long was it helpful? ______________________
   What percentage of your symptoms did it take away? __________________

Physical Therapy:

Have you done Physical therapy for this? Yes / No
Where did you go? __________________________________
How long did you attend? ____________________________
Did it completely fix the problem? Yes / No   Did it help at all? Yes / No
Have you had massage or chiropractic treatment? Yes / No If so, where? _____________________

9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.424.5417

PATIENT INFORMATION
(Please print – Fill in ALL blanks)

Patient's Legal Name: Last First M.I.	Sex:	DOB:	Age:

Social Security Number:	Marital Status: ____Single ____Married ____Widowed ____Divorced ____Separated
Patient's Address:	Employment Status: __Employed __Full-time Student ___Part-time Student ___ Retired

City:	State:	Zip Code:	Email:	Referring Physician:

Home Phone:	Work Phone:	Cell Phone:

Ethnicity: ___Hispanic ___Non-Hispanic___Declined	Race: _____White _____Asian _____Black _____Pacific _____Native American _____Multiple _____Other	Preferred Language:

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim

Name of Primary Insurance Company:	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Policyholder Employer:	
Secondary Insurance (if applicable):	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Policyholder Employer:	

EMPLOYMENT INFORMATION

Patient's Employer:	Phone Number:
Insured Employer:	Phone Number:

If the patient is a minor, please list both parent names and employers

Mother	Employer:	Phone Number:
Father	Employer:	Phone Number:

NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to patient:

WHO REFERRED YOU TO OUR OFFICE (circle one)

Adjustor	Attorney	Billboard	Case Manager	Doctor	Employer	Friend	Hospital	Insurance
Magazine	Neighbor	Phone Book	Physical Therapist	Coach	Radio	School	Trainer	Other

THIRD PARTY BILLING (circle one)

Is your injury work related	YES	NO
Is this injury due to an accident	YES	NO
If your injury is MVA related have you obtained an accident report?	YES	NO

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

DISCLOSURE OF PHYSCIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Brandon Johnson has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

____
Signature of Patient

____
Signature of Parent of Guardian
(if applicable)

____
Print Name of Patient

____
Print Name of Parent of Guardian

Dated:___________________________________

OKLAHOMA SPORTS SCIENCE & ORTHOPEDICS

Authorization to Release Information via Phone/Family/Friends

Patient Name:____ DOB:__________________

I hereby authorize confidential communications from the physicians or staff of OSSO regarding my health, care, treatments, appointments, prescriptions, etc…to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone: ________________________ Work Phone:________________________

Cell Phone: __________________________ Other: ___________________________________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: ______________________________ Relation: ___________________________
Name: ______________________________ Relation: ___________________________
Name: ______________________________ Relation: ___________________________
Name: ______________________________ Relation: ___________________________

I understand that this authorization will remain in effect until I revoke the authorization in writing.

____ ________________________
Patient Signature Date

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) your premier healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care. We specialize in adult and pediatric orthopedics, sports medicine, running injuries, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine surgery, and hand surgery.

In addition to accepting traditional insurance plans and Medicare, we are contracted with numbers Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring you current insurance care, or any other information that is required by your insurance company to each appointment. By maintaining updated information this endures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express, or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 419-8444 to make financial arrangements. Please be aware that charge for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

If your injury was due to a motor vehicle accident (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. Please note that not all OSSO Physicians will accept third party/MVA patients.

There is a $35 charge for any FMLA, disability, or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Oklahoma Sports Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this financial policy:

Signed____ Date___________________

(signature of person financially responsible for payment)

Relationship if other than patient____

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopaedics to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports Science & Orthopaedics to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Sports Science & Orthopaedics charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopaedics, its agents and its employees from liability in connection with the release of the information contained within.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Sports Science & Orthopaedics. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science & Orthopaedics from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand that a photocopy of this document is as valid as the original.

SIGNED____ DATE _________________________

(patient)

OR ____

(nearest relative or responsible party)

____________________________________ Policyholder's Signature_________________________

(relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

M. BRANDON JOHNSON, M.D.
AGREEMENT FOR SHORT TERM NARCOTIC PRESCRIPTIONS

Print Patient Name: ______________________________________ DOB: ________________________

The purpose of this Agreement is to prevent misunderstandings about certain medicines the patient will be taking for pain management. This is to help both the patient and their provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

The use of opioids may cause addiction and is only one part of a complete treatment plan.

I agree to the following:

1. I understand that as a surgical patient, I will receive narcotic pain medicine for a maximum of twelve (12) weeks post-surgery. If continued pain management is needed after this time, I will be referred to a pain management physician for further care.
2. I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take any medicine not prescribed to me.
3. Forging or altering a narcotic prescription or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated and I will be reported to law enforcement authorities.
4. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
5. I will not increase my medicine until I speak with my doctor or nurse.
6. My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
7. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
8. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
9. I agree to come to the office for a pill count at any time if asked by my doctor.
10. I will not use any illegal or controlled substances including marijuana, cocaine, amphetamines, etc.
11. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company might not cover the test and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given randomly through the course of my treatment.
12. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
13. I have been informed by my doctor about narcotic effects, including the normal physiological effects of tolerance (where I might need to take more medication to obtain the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly), and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patients with genuine pain.
14. I understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment such as an automobile.

Refills

1. I understand that refills of narcotic medication will be given only during my regularly scheduled appointment or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.

2. I understand that refills will be made only during regular office hours: Monday through Thursday, 8:00AM-4:30 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 72 business hours is REQUIRED.
3. I must keep track of my medications. No early or emergency refills may be made.
4. Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before a new prescription will be written.
5. I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of my pharmacy is ___________________________.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other doctor they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the Emergency Room, another doctor, etc.), I must notify my doctor. I am not to seek or accept medications from other providers without my doctor's permission, except in the event of a true medical emergency in which case, I must notify my doctor as soon as possible.

Termination of Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors, or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way and no refills will be made. Further, my doctor may dismiss me as a patient of the practice and ask me to select another doctor. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

72 HOURS NOTICE REQUIRED Initials: __________

NO REFILLS ON FRIDAY, SATURDAY, SUNDAY OR ON HOLIDAY REFILLS Initials: _______

DO NOT UNDER ANY CIRCUMSTANCES INCREASE YOUR MEDICATION DOSAGE WITHOUT DISCUSSING IT WITH THE OFFICE FIRST Initials: _______

DO NOT OBTAIN PAIN MEDICATION FROM ANY OTHER PHYSICIAN WITHOUT GETTING PERMISSION FROM DR. JOHNSON PRIOR. Initials: _______

Patient's signature ____ Date ____________________

Physician's signature _____________________________________