

Patient Account# _____

Patient Name: _____

DOB: _____

Date: _____

Ashley C. Cogar, M.D.
Orthopedic Specialist for Hand/Wrist/Elbow

Chief Complaint / Reason For Visit Summary

What body part / extremity are you being seen for today? _____ RT / LT / BOTH

How long have you had this injury: _____

Height _____ Weight _____

What is your dominant hand? Right Handed Left Handed Ambidextrous

Is this injury a work-related injury? Yes NO

If yes, date of accident / injury: _____ has a claim been filed for this injury? _____

Is this injury due to a Motor Vehicle Accident? Yes NO

If yes, date of accident / injury: _____ has a claim been filed for this injury? _____

Please describe how you sustained your injury:

Please tell us about any other primary concerns you have that you would like to discuss with Dr. Cogar during your visit today.

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Ashley C. Cogar, M.D.
Orthopedic Specialist for Hand/Wrist/Elbow
Medical History Form

Review of Systems

Are you experiencing any of the following symptoms?

General:

- Chills
- Excessive Weight Gain/Loss
- Fatigue
- Fever
- Night Sweats
- Weakness

Skin:

- Discoloration
- Easy Bruising
- Hives
- Jaundice
- Rash

HEENT:

- Dizziness
- Lightheadedness
- Visual Changes
- Hearing Problems
- Ringing in the Ears
- Postnasal Drainage
- Sinus Pressure
- Snoring
- Hoarseness
- Sore Throat

Respiratory:

- Cough
- Coughing Up Blood
- Shortness of Breath
- Wheezing

Cardiovascular:

- Chest Pain
- Difficulty Breathing on Exertion
- Palpitations
- Swelling of Extremities

Gastrointestinal:

- Abdominal Pain
- Constipation
- Diarrhea
- Difficulty Swallowing
- Food Intolerance
- Nausea
- Vomiting

Genitourinary:

- Blood in Urine
- Frequency
- Groin Pain
- Incontinence
- Pelvic Pain
- Urgency

Musculoskeletal:

- Back Pain
- Joint Pain
- Muscle Pain
- Muscle Weakness
- Numbness
- Stiffness

Neurologic:

- Headaches
- Memory Loss
- Seizures
- Syncope
- Tingling
- Tremor
- Weakness

Psychiatric:

- Anxiety
- Depression
- Trouble Focusing

Endocrine:

- Excessive Thirst
- High Blood Sugar
- Low Blood Sugar

Hematology:

- Abnormal Bleeding
- Enlarged Lymph Nodes

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Past Medical History

Heart

- Heart Attack
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Irregular Heart Beat
- Atrial Fibrillation
- Other _____

Stomach

- Reflux
- Heartburn
- Ulcers
- Bleeding
- Irregular Bowel
- Diverticulitis
- Liver Disease
- Hepatic Failure
- Other _____

Endocrine

- Diabetes Type I
- Diabetes Type II
- Gestational Diabetes
- Thyroid
- Other _____

Lungs

- Asthma
- COPD
- Emphysema
- Other _____

Musculoskeletal

- Arthritis
- Gout
- Broken Bones
- Other _____

Neurologic

- Stroke
- Headache
- Migraine
- Dementia

Dermatology

- Skin Cancer
- Acne
- Rash

Urology

- Kidney Stones
- Prostate Issues
- Other _____

Gynecology

- Endometriosis
- HPV

Psychiatric

- Memory Loss/Confusion
- Anxiety
- Depression
- Bipolar

Other

- Anemia
- Sinus & Allergy
- Other _____

Cancer: List What Type

Social History

Tobacco: Never

- Current: Cigarettes No Yes Amount: _____ pack(s)/day
- Smokeless Tobacco No Yes Amount: _____ per day
- Cigars No Yes Amt: _____ # per week

Quit: Year last smoked _____ Amt: _____ pack/day How many years did you smoke? _____

Children: Secondhand smoke exposure? Yes No

Alcohol use: Yes No _____ # drinks per day / week / occasional / social (please circle)

Occupation: _____

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Family History

Have any of your family members had any of the following problems?

- | | | | | |
|---|---------------------------------|---------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Elevated Lipids | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prostate Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Uterine Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Cancer | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Diagnosis | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other Mental Illness | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |

List all **ALLERGIES** to any medications **and** the reactions: No Known Drug Allergies

Medication	Reaction

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Date: _____

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: _____
Drug Name: _____	Dose: _____	How Often: _____
Drug Name: _____	Dose: _____	How Often: _____

None

Past Surgical History

Please check or list all of the **SURGERIES** you have had:

Type of Surgery	Year
<input type="checkbox"/> Appendectomy	
<input type="checkbox"/> Arthroscopy (joint)	
<input type="checkbox"/> Back Surgery or <input type="checkbox"/> Neck Surgery	
<input type="checkbox"/> Cataract Surgery	
<input type="checkbox"/> Cesarean Section	
<input type="checkbox"/> Gallbladder Removal	
<input type="checkbox"/> Heart Surgery (Specify)	
<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Hernia (Specify)	
<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Knee Replacement or <input type="checkbox"/> Hip Replacement	
<input type="checkbox"/> Mastectomy or Lumpectomy (Specify)	
<input type="checkbox"/> Polyp Removal (Colon)	
<input type="checkbox"/> Tonsillectomy or <input type="checkbox"/> Adenoidectomy	
<input type="checkbox"/> Tubal Ligation or <input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Plastic Surgery (Specify)	
<input type="checkbox"/> Other (Specify)	
<input type="checkbox"/> Other (Specify)	
<input type="checkbox"/> Other (Specify)	

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Have you had any radiology procedures (ex: Xray, MRI, CT scan) specific to the reason you are here today? NO Yes (Please list)

Radiology Procedure	Year

What is your preferred pharmacy (Please include name and phone number): _____

What is your preferred mail order pharmacy (Please include name and phone number): _____

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9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.427.6776

PATIENT INFORMATION

(Please Print – Fill in All Blanks)

Patient's Legal Name:		Last	First	M.I.	Sex:	DOB:	Age:
Social Security Number:				Marital Status:			
				<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Patient's Address:				Employment Status:			
				<input type="checkbox"/> Employed <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student <input type="checkbox"/> Retired			
City:	State:	Zip Code:		Referring Physician:			
Home Phone:		Work Phone:		Cell Phone:			
Ethnicity:		Race:			Preferred Language:		
<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Declined		<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Pacific <input type="checkbox"/> Native American <input type="checkbox"/> Multiple <input type="checkbox"/> Other					

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:
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Chart No. _____

Oklahoma Sports Science & Orthopaedics

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 voice mail 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 plan, medications, and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _____ Relation: _____

Name: _____ Relation: _____

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

Patient Signature Date

OSSO STAFF ONLY:

Documented by:

Initials Date

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 organizations, workers compensation carriers, welfare funds, the Social Security Administration or its 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 KNOWN 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 therein.

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 for 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 a photocopy of this document is as valid as the original.

SIGNED _____ DATE _____
(PATIENT)

OR _____
(NEAREST RELATIVE OR RESPONSIBLE PARTY)

(RELATIONSHIP TO PATIENT) POLICYHOLDER'S SIGNATURE _____

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made a 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 health care 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 Department of Health, or by law.

Oklahoma Sports Science & Orthopaedics

A division of The Physicians' Group

Financial Policy

Thank you for choosing "Oklahoma Sports Science & Orthopaedics" as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care specializing in Adult & Pediatric Orthopedics, Sports Medicine, Running Injuries, Physical Medicine and Rehabilitation, Pain Management, Reconstructive & Orthopedic Spine Surgery and Hand Surgery.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous, 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 to each appointment your current insurance card, or any other information that is required by your insurance carrier. By maintaining updated information this ensures 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 Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 427-6776 to make payment arrangements. **Please be aware that charges 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 you will be set up on a self-pay account for any charges incurred up to \$500.00. If charges exceed \$500.00, 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 \$35.00 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 at Saints North 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 & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date _____
(Signature of person financially responsible for payment)

Relationship if other than patient: _____

Oklahoma Sports Science & Orthopaedics

- 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 phoned in should you be unable to keep these appointments.
- This office fills pain medications for surgical patients only. They are not filled indefinitely. After a period of time your doctor will taper your medications for discontinuation. If discontinuation is not possible or you are not a surgical candidate you will be referred for long-term pain management.
- 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 medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing you narcotic pain medications.
- Individuals must be aware that "doctor shopping" is viewed as narcotic drug seeking behavior and is not tolerated. Should this type of behavior occur, your narcotic pain medications will not be refilled and you will be dismissed as a patient.
- 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 taken and called in MONDAY thru FRIDAY from 8:30 am to 3:30 pm ONLY. PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS, OR AFTER HOURS FOR ANY REASON. We guarantee prescription refills will be processed within 48 hours of the request.
- Federal and state law carefully regulates dispensed or written prescriptions for narcotic medications. Forging or altering a narcotic prescription, or distributing medications to others of their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and be reported to the DEA, Police and FDA.
- Lost, stolen, or misplaced prescriptions or medications ARE NEVER REPLACED- NO EXEPTIONS. Your medications and prescriptions are your responsibility.
- Narcotic pain medications may cause sedation and dizziness. You should not drive an automobile nor operate any machinery when taking medications.

Informed consent: I, _____, have been informed and clearly understand the above listed issues regarding the treatment of pain with narcotic pain medications. I understand that this agreement will be filed in my chart as a part of my permanent medical record.

Signature _____ Date _____