



EDMOND

1616 S. Kelly • Edmond, Oklahoma 73013 • (405) 330-0032 • FAX (405) 715-8808

NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST FIRST MIDDLE INITIAL SEX: BIRTH DATE: AGE
SOCIAL SECURITY NO.: MARITAL STATUS: SPOUSES NAME: RACE:
PATIENT'S ADDRESS: REFERRING PHYSICIAN: ETHNICITY:
CITY: STATE: ZIP CODE: Are You: EMPLOYED Full-Time Student Part-Time Student Retired PREFERRED LANGUAGE:
HOME PHONE: WORK PHONE: CELL PHONE:

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company
Name of the Person who carries the Insurance Policy Relationship to Patient
Carrier's DOB Carrier's SS#
Carrier's Employer
Secondary Insurance
Carrier Name Relationship to Patient
Not Applicable Carrier's DOB Carrier's SS#
Carrier's Employer

EMPLOYMENT INFORMATION

Patient's Employer Ph#
Insured Employer Ph#
If the patient is a minor, please list both parents names and employer
Mother Employer Ph#
Father Employer Ph#

NEXT-OF-KIN INFORMATION

NEAREST RELATIVE (OR FRIEND, NOT SPOUSE) NOT LIVING WITH YOU:
HOME PHONE: RELATIONSHIP TO THE PATIENT:

THIRD PARTY BILLING

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 Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I, acknowledge and agree that I have received a copy of the TPG Privacy Notice.

Signature

Date

Patient Name: _____ DOB: _____ Patient #: (office use only) _____

Today's date: _____

The Physician Group Edmond Medical History Form

Chief Complaint (Why did you come to see the doctor?): _____

Past Medical History

- | | | | |
|---|---|--|--|
| <u>Heart</u>
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Other _____ | <u>Gastrointestinal</u>
<input type="checkbox"/> Reflux
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding
<input type="checkbox"/> Irregular Bowel
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Crohn's/Ulc Colitis | <u>Endocrine</u>
<input type="checkbox"/> Diabetes Type I
<input type="checkbox"/> Diabetes Type II
<input type="checkbox"/> Gestational Diabetes
<input type="checkbox"/> Thyroid
<input type="checkbox"/> Other _____ | <u>Psychiatric</u>
<input type="checkbox"/> Memory Loss/Confusion
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Bipolar

<u>Other</u>
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sinus & Allergy
<input type="checkbox"/> Other _____ |
| <u>Lungs</u>
<input type="checkbox"/> Asthma
<input type="checkbox"/> COPD
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Other _____ | <u>Musculoskeletal</u>
<input type="checkbox"/> Arthritis (RA/OA)
<input type="checkbox"/> Gout
<input type="checkbox"/> Broken Bones
<input type="checkbox"/> Other _____ | <u>Neurologic</u>
<input type="checkbox"/> Stroke
<input type="checkbox"/> Headache
<input type="checkbox"/> Migraine
<input type="checkbox"/> Dementia | <u>Cancer</u>
<input type="checkbox"/> Cancer: List What Type

_____ |
| <u>Dermatology</u>
<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Acne
<input type="checkbox"/> Rashes | <u>Urology</u>
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Prostate Issues
<input type="checkbox"/> Other _____ | <u>Gynecology</u>
<input type="checkbox"/> Endometriosis
<input type="checkbox"/> HPV | |

Past Surgical History

Type of Surgery	Year/Age

Social History

Marital Status: _____
 Occupation: _____
 Household Members: _____
 Tobacco: Current Quit Never

Alcohol use: Yes No _____ # drinks/day
 Caffeine use: Yes No _____ # drinks/day
 Exercise: Yes No Times per week: _____
 Avg Hrs Sleep p/night: _____

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"/> Celiac Disease | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Crohn's Disease | <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 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"/> 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 _____ |

Patient Name: _____ DOB: _____ Patient #: (office use only) _____

Family History (Continued)

<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"/> Ulcerative Colitis	<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"/> Pancreatic Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Other _____

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

None

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

Medication	Reaction

IMMUNIZATIONS: (List Dates)

Hepatitis A: _____	Pneumococcal: _____
Hepatitis B: _____	TB Skin Test: _____
Tetanus: _____	Varicella: _____
Influenza: _____	_____

(List Dates)

Review of Systems

Are you experiencing any of the following symptoms?

- General:** Chills Fatigue Fever Night Sweats Excessive Weight Gain/Loss 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:** Changes in Appetite Abdominal Pain Black, Tarry Stools Bloating Change in Bowel Habits Constipation Diarrhea Gas Hemorrhoids Indigestion Nausea Peptic Ulcer Rectal Bleeding Stomach Pain Vomiting Vomiting Blood
- 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:** Depression Anxiety Trouble Focusing
- Endocrine:** Excessive Thirst High Blood Sugar Low Blood Sugar
- Hematology:** Abnormal Bleeding Enlarged Lymph Nodes

Diagnostic Studies

Date of last Colonoscopy: _____ Date of last EGD (Upper Endoscopy): _____

Preferred Pharmacy (Name, Address and Phone): _____

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: _____

Email Address: _____

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: _____ |
| 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

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 _____

Oklahoma Sport Science & Orthopaedics

A Division of The Physicians' Group

Financial Policy

Thank you for choosing "Oklahoma Sport 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 you insurance policy provisions and coverage. Also, please note that we do not accept third party insurance (ie. Motor vehicle insurance.) You may still be seen today, but you will be seen as a self pay patient and must pay for services rendered on the day they were rendered and you will need to get reimbursed from the third party insurance accordingly.

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. Payments can be made by cash, check, money order, Visa, Discover card, American Express or MasterCard. If you have financial concerns regarding your bill or balance, please contact our billing department at (405) 419-8444. Please be aware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital or ambulatory surgery facilities and some radiology services may be billed separately. Payment on self pay accounts is due at the time of service.

There is a \$35.00 charge for any FMLA, disability or accidental forms that need to be completed. This charge is applicable per form completed and is payable prior to completion. Payments for these forms can be made by cash, check or money order only and are made out directly to the physician.

If you require surgery, diagnostic testing or other invasive procedures and are scheduled at Community Hospital, Community Hospital at St.'s North, Lakepointe Imaging Center, 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 Sport Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date: _____

Relationship if other than patient: _____

A. AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians', 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 Orthopedic & Sports Science Physicians'. I understand I am financially responsible for charges not covered by this assignment.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Orthopedic & Sports Science Physicians' 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 _____ WITNESS
(NEAREST RELATIVE OR TO SIGNATURE
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.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how The Physicians' Group, LLC or HPI Physicians, LLC, as applicable (the "Practice"), will use protected health information for the purposes of treatment, payment for treatment, and health care operations.
- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.
- The Practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient's Name (print): _____

Patient's Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.

If this form is signed by the patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patient:

Signature of Patient or Patient's Personal Representative

Date: _____

Current Contact Information for Patient or Personal Representative signing this form:

Name (print): _____

Address: _____

Telephone Number: _____

Email: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient's personal representative on this Acknowledgment but did not because:

_____ It was emergency treatment.

_____ I could not communicate with the patient.

_____ The patient refused to sign.

_____ The patient was unable to sign because _____

_____ Other: _____

Signature Practice Staff Member

Date

Name: _____

Title: _____

This form should be placed in the patient's medical record.

Appointment No Show and Late Policy

Appointment No Shows

A *NO SHOW* appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.
- The second no show will result in a call or email and a \$50.00 charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.
- The third no show will result in a dismissal from the practice.

Late Policy

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to your appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their scheduled appointment on time.
- Non Post-operative patients arriving 10-30 minutes late will be asked to reschedule.
- Any patient arriving more than 30 minutes late will be asked to reschedule.

Signature of Patient

Signature of Parent or Guardian (if applicable)

Print Name of Patient

Print Name of Parent or Guardian

Dated: _____