Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Today's date: _____

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

Past Medical History

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

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: _____
☐ None

Pregnancy and Birth

Date of Last Menstrual Period: _____ Age of First Period: _____
# of Days In Flow: _____ # of Days Between Cycles: _____
Are you Menopausal ☐ Yes ☐ No Age at Onset Of Menopause: _____
# of Pregnancies: _____ # of Live Births: _____ # of Abortions _____ # of Miscarriages _____
# of Living Children _____

Past Surgical History

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

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

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

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 ☐ Yes ☐ No Amt:_____pck/day Has been smoking for? _____
Smokeless Tobacco ☐ Yes ☐ No Amt:_____per day
Cigars ☐ Yes ☐ No Amt:_____# week
☐ Quit: Year last smoked _____ Amt: _____pck/day How many years did you smoke?_____
Children: Secondhand smoke exposure? ☐ Yes ☐ No
Alcohol use:☐ Yes ☐ No _____# drinks per day / week / occasional / social
Caffeine use: ☐ Yes ☐ No _____# drinks per day / week / occasionl / social
Seatbelt use: ☐ Yes ☐ No
Exercise: ☐ Yes ☐ No Times per week: _____ Type of exercise: _____
Occupation: _____
Have you ever used **street drugs**: ☐ Yes ☐ No Which ones: ☐ Marijuana ☐ IV drugs ☐ Cocaine
☐ Amphetamines ☐ Heroin ☐ Downers ☐ Inhalants ☐ other _____
Are you still using: ☐ Yes ☐ No Which ones: _____
Are you sexually active (in the last year)? ☐ Yes ☐ No ☐ Never
If yes check all that apply: ☐ 1 Partner ☐ Multiple Partner ☐ Male Partner(s) ☐ Female Partner(s)
☐ 5 or More Partners in your Lifetime
Which birth control do you use? ☐ None ☐ Condoms ☐ The Pill ☐ Vasectomy/Tubal ☐ Other_____
Is there concern for your safety? ☐ Yes ☐ No ☐ Emotional ☐ Physical ☐ Sexual Abuse

Family History

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

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

☐ Alcoholism	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Asthma	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Breast Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Colon Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Depression	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Elevated Lipids	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Attack	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Heart Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ High Blood Pressure	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Lung Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Migraines	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Osteoporosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Ovarian Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Prostate Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Skin Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Thyroid Disease	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Uterine Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Cancer	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Diagnosis	☐ Father	☐ Mother	☐ Sibling	☐ Other_____
☐ Other Mental Illness	☐ Father	☐ Mother	☐ Sibling	☐ Other_____

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

Medication	Reaction

IMMUNIZATIONS: **(List Dates)**

Hepatitis A: _____

Hepatitis B: _____

Td- Adult Tetanus Toxoid: _____

Influenza: _____

Pneumovax: _____

PPD – Tuberculin Skin Test (Include Results): _____

Gardasil (HPV): _____

Zostavax: _____

Patient Name: _____ DOB: _____ Entered by: _____ Audited: _____

Have you had any orthopedic complaints resulting in radiology procedures in the last year? (ex: Xray, MRI, CT scan)

Radiology Procedure	Year

Health Maintenance

Date of last Mammogram: _____(mo/yr) Date of last Bone Density: _____(mo/yr)
Date of last Colonoscopy: _____(mo/yr)
(Diabetic Patients) Date of last Eye Exam:_____(mo/yr) Where: _____
FOR WOMEN: Date of last Pap Smear: _____(mo/yr)
FOR MEN: Date of Last PSA level drawn (Prostate Cancer Screening):_____(mo/yr)

Please provide **first & last** names of all other physicians that you currently see and their specialty:

_____

_____

*What is your preferred pharmacy (Please include name and phone number and/or location):_____

_____

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

_____

OSSO
HEALTHCARE NETWORK
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: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	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 _____

Carriers DOB _____ Carriers SS# _____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient _____

Not Applicable ☐ Carriers DOB _____ Carriers SS# _____

Carriers 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 _____

Chart No. _____

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 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 additional 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 692-3700 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: _____

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', it agents and it 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.

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 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 TO SIGNATURE _____
(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 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.

The Physicians' Group, LLC
HPI Physicians, LLC

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: _____

_____

_____ Date: _____

Signature of Patient or Patient's Personal Representative

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.