Patient Name: _____

Date of Birth: _____ Chart #: _____

PATIENT HISTORY FORM (please completely fill this form out)

Height: _____ Weight: _____ Sex: ☐M ☐F Hand Dominance: ☐Left ☐Right ☐ Ambidextrous

MEDICAL STAFF USE ONLY: **Encounter: ☐Initial ☐Subsequent ☐Sequelae**

BMI: _____ BP: _____/ _____ Temp: _____ Pulse: _____ Resp: _____ Pulse Ox: _____

CHIEF COMPLAINT TODAY ☐Left ☐Right ☐Bilateral Body Part (s): _____

FOR INJURIES ONLY: **Date of injury: _____**

Describe **how** and **where** the injury occurred:_____

Did injury occur **on the job**? ☐Y ☐N

Did injury occur in an **auto accident**? ☐Y ☐N

If yes what **STATE** did the injury occur? _____ If yes to on the job **EMPLOYER** name:_____

Referring Physician/ Source: _____

Who is your Primary Care Physician? _____/ City, State/ Ph#: _____

Do you have a Cardiologist? ☐Y ☐N Physician Name: _____/ City, State, Ph#: _____

Do you have any other Specialists? ☐Y ☐N Physician Name: _____/ City, State, Ph#: _____

What is the reason for your visit today? _____

_____

Have you been to the emergency room or seen another physician/ provider prior to your visit today? ☐Y ☐N

Have you had previous? ☐ X-rays ☐ MRI ☐ CT SCAN ☐ DEXA ☐ Other _____

Describe your pain: ☐Achy ☐Burning ☐Sharp/ Shooting ☐Throbbing ☐Other:_____

What makes the pain worse? _____What makes the pain better? _____

What is your pain level on a scale of 1-10? _____

What treatments or modalities have you tried? (i.e. medications, injections, physical therapy, etc.)

_____

Social History: ***Marital Status:*** **☐Single ☐Married ☐Divorced ☐Widowed**

☐Current Every Day Smoker ☐Former Smoker
☐Current Some Day Smoker ☐Never Smoker

Do you drink alcohol? ☐Y ☐N If yes, how much?
☐0-1 drinks/day ☐1-2 drinks/day ☐3 or more/day

Type of Tobacco _____

Are you employed? ☐Y ☐N Are you retired? ☐Y ☐N

☐Cigarettes ☐Chewing Tobacco
☐Cigars ☐Vapor/ E-Cigarettes
☐Pipe ☐Snuff/ Smokeless Tobacco/ Other

Type of Occupation? _____
Do you use or ever used illicit drugs? ☐Y ☐N
If yes, type/ frequency? _____

☐ Marijuana medical card

Do you have or have you ever had any of the following medical conditions:

******Any unchecked boxes will be assumed negative*****

☐ ***None of the below***

☐ **Abnormal Chest X-ray**
☐ **AIDS**
☐ **Anemia**
☐ **Anticoagulant Therapy**
☐ **Anxiety**
☐ **Arthritis, Osteoarthritis**
☐ **Arthritis, Rheumatoid**
☐ **Asthma**
☐ **Atrial Fibrillation**
☐ **Blood Disorders**
If yes type of blood disorder? _____
☐ **Cancer** ***If yes type of***
Cancer:_____
☐ **Cerebral Palsy?**
☐ **Chronic Obstructive Pulmonary Disease**
☐ **Congestive Heart Failure**
☐ **Deep Vein Thrombosus (blood clots)**

☐ **Depression**
☐ **Diabetes**
If yes ☐ Type I ☐ Type II
Date of last HbgA1C/ result _____/ _____
☐ **Eczema**
☐ **Emphysema**
☐ **Epilepsy**
☐ **Esophageal Reflux**
☐ **Eyesight problems**
☐ **Gallbladder Disease**
☐ **Glaucoma**
☐ **Gout**
☐ **Headache**
☐ **Heart Attack**
☐ **Heart Disease**
☐ **Heartburn/ GERD**
☐ **Hepatitis Type**_____
High Blood Pressure ☐**Y** ☐**N**
☐ **High Cholesterol**
☐ **HIV Infection**
☐ **Hyperlipidemia**
☐ **Immunological Disorders**

☐ **Kidney Disease/ Dialysis**
☐ **Liver Disease**
☐ **Low Blood Pressure**
☐ **Mental Illness** ***If yes type of illness:*** _____
☐ **Migraines**
☐ **Multiple Sclerosis**
☐ **Muscular Dystrophy**
☐ **Neuro Illness**
☐ **Osteomyelitis**
☐ **Peripheral Vascular Disease**
☐ **Are you Pregnant?**
☐ **Prostate Problems**
☐ **Pulmonary Embolism**
☐ **Seizure Disorder**
☐ **Sickle Cell Anemia**
☐ **Sleep Apnea**
☐ **Stomach Ulcer**
☐ **Stroke**
☐ **Thyroid Disease**
☐ **Tuberculosis**

Other illness or conditions: _____

_____

Have you had a BONE DENSITY SCAN? ☐Y ☐N If yes date or year of scan _____
Where was the scan done? _____ / City or State _____

List All Previous Surgery/ Procedures	Date/ Year of Surgery/ Procedure

Preferred Pharmacy (please list)_____ Phone #_____
Street and City_____

List All Current Prescription and Over-the-Counter Medications ☐ Check if **None**

Medication	Strength	Frequency	Medication	Strength	Frequency

List All Allergies and Reactions (include meds, food, latex) ☐ **No Known Allergies**

Medication/ Other	Reaction	Medication/ Other	Reaction

Date of last FLU shot? _____ ☐Never Date of last PNEUMONIA shot? _____ ☐Never

Family Medical History- Check all boxes that apply- *Please indicate: M= mother, F= Father, B= Brother, S= Sister*

Alcoholism ☐M ☐F ☐B ☐S	Heart Disease ☐M ☐F ☐B ☐S	Pulmonary Embolism ☐M ☐F ☐B ☐S
Autoimmune Disorder ☐M ☐F ☐B ☐S	High Blood Pressure ☐M ☐F ☐B ☐S	Rheumatoid Arthritis ☐M ☐F ☐B ☐S
Birth Defects ☐M ☐F ☐B ☐S	High Cholesterol ☐M ☐F ☐B ☐S	Seizure Disorder ☐M ☐F ☐B ☐S
Blood Disorders ☐M ☐F ☐B ☐S	Liver Disease ☐M ☐F ☐B ☐S	Stomach Disorders ☐M ☐F ☐B ☐S
Cancer ☐M ☐F ☐B ☐S	Lung Disease ☐M ☐F ☐B ☐S	Stroke ☐M ☐F ☐B ☐S
Diabetes ☐M ☐F ☐B ☐S	Kidney Disease ☐M ☐F ☐B ☐S	
Drug Abuse ☐M ☐F ☐B ☐S	Mental Illness ☐M ☐F ☐B ☐S	
Eye Disorders ☐M ☐F ☐B ☐S		

Review of Systems: Please check here if you are NOT experiencing any of the below symptoms: ☐

Please check all that apply. Any unchecked boxes will be assumed to be negative.

Musculoskeletal	Endocrine	Gastrointestinal	Skin
☐ Joint pain/ stiffness	☐ Excessive thirst	☐ Nausea/ vomiting	☐ Rashes
☐ Joint swelling	☐ Excessive urination	☐ Constipation	☐ Dryness
☐ Back pain	☐ Heat/ cold intolerance	☐ Diarrhea	☐ Open sores
☐ Difficulty walking			
Cardiovascular	☐ **Heme/ Lymph**	**Genitourinary**	**Neurological**
☐ Chest pain/ tightness	☐ Easily bruised	☐ Incontinence	☐ Headaches
☐ Irregular heartbeat	☐ Bleeds easily	☐ Frequent urination	☐ Tremors
☐ Swelling of legs/ feet	☐ Swollen lymph nodes	☐ Painful urination	☐ Confusion
Respiratory	**Constitutional**	**Ears, Nose, Throat, Mouth**	**Psychiatric**
☐ Oxygen use at home	☐ Fever/ chills	☐ Difficulty hearing	☐ Depression
☐ Cough	☐ Fatigue/ weakness	☐ Difficulty swallowing	☐ Anxiety
☐ Wheezing	☐ Weight loss/ gain	☐ Dentures	☐ Nervousness
☐ Snoring		☐ Ringing in ears	
☐ Shortness of breath			

Completed by: (please print): _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

Relationship to Patient (please print): _____

OSSO
AN HPI AFFILIATE

OKFootMD
ORTHOPEDIC SPECIALISTS

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 ☐ Unemployed ☐ 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:**
If the patient is a minor, please list both parent names and employees	

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 your 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:**

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 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 SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including my 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 or 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 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 and Orthopaedics
Authorization to Release Information via phone / Family / Friends

Patient Name: _____ **DOB**: _____ **Chart #:**_____

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: _____ **Work**: _____ **Cell**: _____

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**: _____

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

PATIENT-PROVIDER AGREEMENT AND INFORMED CONSENT
ACUTE PAIN

1. Your treating physician has prescribed you opioid pain medication as part of your treatment plan to manage your acute pain. Your treatment plan also includes the following alternatives: _____.
2. The pain you are experiencing may be improved, but not eliminated, with the use of these opioid medications. Opioids are a type of powerful pain medication often called narcotics. They can be very useful in managing pain, but have a high potential for dependency and addiction.
3. Once opioid pain medications are prescribed, you will be required to have regular office visits to assess your pain status and monitor your compliance with this agreement. Your medications will not be phoned in should you be unable to keep these appointments.
4. Pain medications are strictly for your own use. The medication should not be given or sold to others because it may endanger that person's health and it is against the law.
5. 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.
6. Your treating physician is to be the only physician who prescribes opioid pain medications to you.
7. It is your responsibility to notify us of any other physician who is prescribing opioid pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing your opioid pain medications.
8. 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 opioid pain medications will not be refilled, and you will be dismissed as a patient.
9. 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.
10. Pain medication refill request are taken, and called in MONDAY through Friday from 8:30AM to 3:30PM ONLY. **PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON.**
11. Opioid medications carry a high potential for abuse and addiction. Therefore, federal and state law carefully regulates dispensed or written prescriptions for opioid medications. Forging or altering an opioid prescription, or distribution medications to others for their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and reported to appropriate authorities.
12. Lost, stolen or misplaced prescription medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility. You should store opioid medications in a secure location to prevent others from taking them and safely dispose of them when you are no longer using them.
13. There are several risks of opioid medications that your treating physician has discussed with you. Some of those risks include sleepiness or drowsiness, impaired mental or motor ability, slowing of breathing rate, skin rash, constipation, sexual dysfunction, sleep abnormalities, sweating, swelling, physical or psychological dependence, tolerance to analgesia (meaning you require more medicine to get the same pain relief), and addiction. Opioid medications are highly addictive even when taken as prescribed. Overdose of opioid pain medication can lead to breathing difficulty and even death. Taking more opioid medication than prescribed or

mixing opioid medication with alcohol, sedatives, benzodiazepines, and other central nervous system depressants is highly dangerous and can be fatal. It is your responsibility to inform your treating physician about all other medicines you are taking.

14. You should not drive an automobile or operate any machinery when taking opioid medications.
15. Your treating physician has discussed with you alternative pain management approaches that may be available to manage your pain instead of taking opioid pain medications and the risks and benefits of the alternatives.
16. If you break any of the rules described in this agreement, or your physician decides that the medicine is hurting you more than helping you, this medicine will be stopped by your physician in a safe way and no refills will be made. Further, your physician may dismiss you as a patient of the practice and ask you to select another physician. Any violation of this agreement or counseling received regarding violations will remain a part of your permanent medical record. This agreement will remain enforced during the entire course of your treatment plan.

INFORMED CONSENT

I, _____, have been informed and clearly understand the above listed issues regarding the treatment of pain with opioid pain medications. I have talked about this agreement with my doctor and I understand the above rules. I understand that this agreement will be filed in my chart as part of my permanent medical record.

Signature of Patient: _____ Date: _____

Signature of Physician: _____

If the patient is a minor, the patient's parent or guardian must consent by signing below.

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

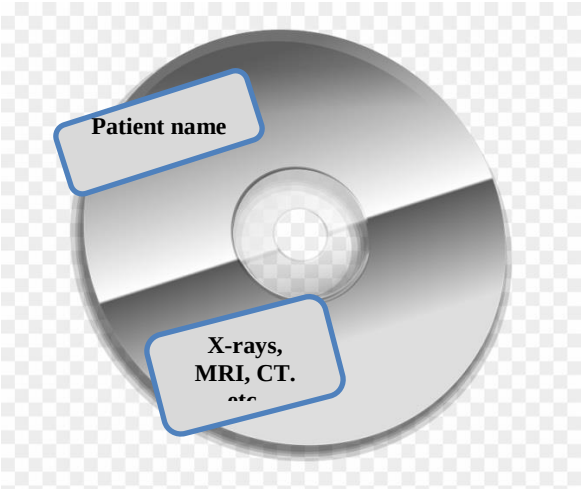
New **State Law** Regarding Narcotic Prescriptions
House Bill 2931
Effective January 1, 2020

Due to a new State of Oklahoma law, all narcotic medications MUST be sent to pharmacies in electronic form ONLY. Written narcotic scripts are no longer acceptable under this new law.
Please provide your pharmacy information below. **This is the only pharmacy we will use for your medications.**
If you need a refill, you will be required to contact our office 48-72 hours in advance. **NO REFILLS WILL BE GIVEN ON FRIDAYS**. Since our physicians are often in surgery and not in the clinic setting, same-day or next day refills **cannot** be guaranteed.

Pharmacy Name:_____
Pharmacy Address:_____
_____
Pharmacy Phone Number:_____

Confirm the above information is correct. As this is where you will be required to pick up your prescription.

Please bring your imaging disc with you to your appointment



Thank you,
OKFootMD

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, Foot & Ankle 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 provider’s 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, pre-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 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 claims.

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 Master Card. 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 files 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: ____

DISCLOSURE OF PHYSICIAN 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. Sheryl Smith, MD, Dr. Laura Luick, MD and Dr. Paul Kammerlocher, MD 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 or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Date:_____