SOS Southwest Orthopaedic & Reconstructive Specialists
Easy Access to Healthcare Excellence
southwestortho.com

Today's Date: ____________________

Name: (Last, First, Middle) ____________________ Preferred Name: ____________________

SSN: ____________ Date of Birth: ____/____/____ Age: ______ Sex: ☐ M ☐ F

Address: ____________________ City: __________ State: __________ Zip: __________

Phone: (____) __________ Cell: (____) __________ Marital Status: ☐ S ☐ M ☐ D ☐ W

Employer: ____________________ Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Unemployed

Emergency Contact: ______________ Relationship: __________ Phone: ______________

Email: ____________________ Primary Care Physician: ____________________

Referred by: ☐ Physician ______________ ☐ Hospital ☐ Family/Friend ☐ Ad ______________

Where did your injury occur? ☐ Home ☐ Auto ☐ School ☐ Work ☐ Other ______ ☐ No Known Injury

**Auto related injury? ☐ Yes ☐ No Date of Injury: ______________

Insurance Company: ____________________ Phone: ____________________

Claim Number: ____________________ Adjuster: ____________________

** Work Related Injury? ☐ Yes ☐ No Date of Injury: ______________

Insurance Company: ____________________ Phone: ____________________

Claim Number: ____________________ Adjuster: ____________________

Employer: ____

Are you represented by an Attorney? ☐ Yes ☐ No

Attorney Name: ____________________ Phone: ____________________

<u>Health Insurance Information</u>

Primary Insurance: ____________________ Policy Holder: ____________________

Relationship to Patient: ______________ SSN: __________ DOB: ______________

ID Number: ______________ Group Number: __________ Employer: ______________

Secondary Insurance: ____________________ Policy Holder: ____________________

Relationship to Patient: ______________ SSN: __________ DOB: ______________

ID Number: ______________ Group Number: __________ Employer: ______________

Person Responsible for Bill: (If the patient is a minor)

Name: ________________________________ Relationship to Patient: ________________________________

Address: ______________________________ City: ______________ State: _____________ Zip: _______________

DOB: ______________ SSN: _______________Employer: ____

_______ **By initialing, I understand that I will be treated by one or more SOS physicians who may refer me for further procedures, imaging, surgery and/or other related services to OCOM hospital (Oklahoma Center for Orthopaedic and Multi-Specialty Surgery). I further understand that the following physicians have an ownership interest in the OCOM hospital: Bradley Reddick, DO, Derek West, DO, Kristopher Avant, DO, Brian Levings, DO, RJ Langerman, DO, Mehdi Adham, MD, & Steven Sands, DO.**

I attest that the information stated on this document is true and correct to the best of my knowledge and agree to inform SOS of any changes to the information stated herein.

______________________________________ ______________________________

Signature of Patient or Guardian Date

Patient Responsibilities and Expectations

1. I will comply with facility rules and regulations, which have been developed to protect patients and ensure safety of patients and staff.
2. I will conduct myself in a manner that is respectful and considerate of staff members and other patients.
3. I will be respectful to all providers, staff and other patients.
4. I will follow the instructions and recommendations of my physician and accept full responsibility for the consequences of failing to do so.
5. I will inform medical staff of any health problems, changes in medications or concerns of medical treatment.
6. I will take an active part in my treatment plan and establish long-term treatment goals.
7. I will inform the staff or physician if instructions or explanations given are not understood or will not be followed.
8. I will take any prescribed medications ONLY as prescribed by my physician.
9. I understand that any lost or stolen pain medications or prescriptions will not be refilled for any reason.
10. I will offer cooperation and understanding to my provider and staff members.
11. I understand that I am responsible for the behavior of any guests that accompany me in the clinic or who participate in communication of my treatment with the provider or staff.
12. I will respect the privacy and confidentiality of other patients.
13. I will refrain from using obscene language, making threats or using any type of assaulting behavior.
14. I will arrive on time for appointments and give advanced notice of cancellation when possible.
15. I will inform the clinic office staff of any changes in my medical coverage and pay for services rendered and needed.

By signing this agreement, I understand my responsibilities and expectations as a patient of Southwest Orthopaedics. I also understand that any breach of this agreement could result in termination of my relationship as a patient.

PRINTED NAME PATIENT/GUARDIAN SIGNATURE DATE

AUTHORIZATION FOR MEDICAL TREATMENT AND ACKNOWLEDGEMENT OF SOUTHWEST ORTHOPAEDIC SPECIALISTS' HEALTH INFORMATION AND FINANCIAL POLICIES, DISCLOSURES, TERMS AND CONDITIONS

The undersigned hereby:

Grants authorization for medical treatment; agrees to full and final financial responsibility, including: If filing a claim with my health insurance company, I understand I am responsible for any co-pays, co-insurance, deductibles, and non-covered services; If I do not have health insurance or if I have an open third party liability claim (e.g., Motor Vehicle Accident), I understand I am required to pay the initial evaluation fee and a deposit on any surgery ordered prior to services being rendered, and I agree to keep my account in current good standing for all other services rendered and balances accrued; If I have an open third party liability claim (e.g., Motor Vehicle Accident), I understand my account will be considered "Self Pay" (as if I have no health insurance), and I understand that any charges accruing beyond any amounts I pay will be filed as a Lien against me with Oklahoma County Court Clerk and that no Lien will be released without full and final settlement of my SOS account.

I understand SOS utilizes an outside, third party service for management and handling of insurance eligibility, verification and collections, and that SOS does not control the actions of the third party service.

I understand SOS is not required to offer discounts for any amounts which may be due from me.

I understand any amount due from me is payable at or before the time of service, and that SOS is not required to offer payment arrangements of any kind. I understand SOS may refuse to provide service if I fail to pay any amount currently due from me. I understand that any amount due from me is considered a legitimate and lawful debt obligation and that SOS may use any lawful means to collect; I understand that regardless of insurance, if I fail to keep my account current (no more than 30 days overdue), my account will be turned to an outside collection agency.

Acknowledges that I have been provided a copy of the Notice of Privacy Practices for SOS. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is available upon request and on SOS's web site.

I authorize SOS to access and utilize my medical records in the course treatment from other medical providers and/or a Health Information Exchange(s) ("HIE"); I authorize SOS to record my medical information and utilize it on HIE(s) for use by other medical providers utilizing HIE(s), and I acknowledge that such use is outside the dominion and control of SOS and therefore I will address any questions or issues regarding such use with the HIE(s) and/or other related medical providers or third parties. I understand that should I wish to opt-out from participation in the Coordinated Care Oklahoma (CCO) HIE, I am responsible for doing so pursuant to the procedure set forth on the CCO website, *http://coordinatedcarehn.com/patients/;*

I authorize SOS and/or contracted third parties to utilize my primary phone number or email address I have provided to contact me about my care, treatments, insurance, or payments due for services rendered, including leaving voicemail information;

I authorize SOS to utilize secure electronic verification of filled prescription medications, to maintain current medication history and as is required by the Oklahoma Bureau of Narcotics and Dangerous Drugs.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties as described below:
Description of the specific information to be discussed: ☐Appointment Dates/Times ☐Diagnosis ☐ Diagnostic Results
☐Medications ☐Care Plan ☐Other: ______________________
Information above may be given to the following individual(s):

Name: ___________________________________ Relationship: ______________________ Phone: ______________________

Name: ___________________________________ Relationship: ______________________ Phone: ______________________

Name: ___________________________________ Relationship: ______________________ Phone: ______________________

Name: ___________________________________ Relationship: ______________________ Phone: ______________________

________ ________________________ ____
Date **Patient Name** **Signature of patient, parent or legal guardian**

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PATIENT HEALTH HISTORY & INFORMATION

PATIENT NAME: ______________________________ **DATE:** ____________________

Are you in pain management? ☐ Yes ☐ No If Yes, Dr. ____________________ Phone: ______________

Do you have a cardiologist? ☐ Yes ☐ No If Yes, Dr. ____________________ Phone: ______________

Do you have a pacemaker? ☐ Yes ☐ No If Yes, when? ________________

What do you expect to be seen for today? ____

- Which side? ☐ Right ☐ Left ☐ Both
- Which body part? ☐Head ☐Neck ☐Shoulder ☐Elbow ☐Wrist ☐Hand ☐Finger ☐Back ☐Hip ☐Knee ☐Ankle ☐Foot ☐Toes ☐Ribs ☐Face ☐Abdomen ☐Breast ☐Other ______________________
- Was this injury/illness due to an accident? ☐ Yes ☐ No
  If Yes, what type? ☐ Work Related Injury? ☐ Motor Vehicle Related Injury?

Date of Injury/Illness Began: ________________________________

REGARDING CURRENT INJURY/ILLNESS:

Have you been treated at a hospital or by another physician for this injury/illness? ☐ Yes ☐ No
If YES, by Whom and When? ____

Have you had a/an: ☐ X-ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG
If yes, list where and when: ____

Have you had surgery for current injury? ☐ Yes ☐ No
If yes, list list date and Doctor: ____

What is your current: Height__________Weight__________

OB/GYN (Females Only):
Are you currently pregnant? ☐Yes ☐ No

ALLERGIES:

Do you have any drug allergies? ☐Yes, Name: ____________________ ☐ No known Drug Allergies

Do you have any allergies to these? ☐ Latex ☐ Adhesive Tape ☐ Iodine ☐ Metal ☐ Other______________

PHARMACY INFORMATION:

What is your preferred pharmacy?

Name: ______________________________Location:______________________________

CURRENT MEDICATIONS: (attach list as needed)

______________________________ mg__________

______________________________ mg__________

______________________________ mg__________

______________________________ mg__________

______________________________ mg__________

PATIENT NAME: ______________________________ **DATE:** ____________________

MEDICAL HISTORY: (Check all that apply)

☐ADD/ADHD	☐Failure to thrive	☐Kidney Disease	☐Strep Throat
☐Allergic rhinitis	☐GERD	☐Lead Poisoning	☐Stroke
☐Anemia	☐Headache	☐Liver Disease	☐Tuberculosis (ACTIVE TB)
☐Arthritis	☐Hearing Loss	☐Lung Disease	☐UTI
☐Asthma	☐Heart Murmur	☐Obesity	☐Varicella
☐Cancer	☐Hepatitis	☐Otitis Media	☐Vision impairments
☐Clotting Disorder	☐High Blood Pressure	☐Pneumonia	☐
☐Diabetes Mellitus	☐High Cholesterol	☐Scoliosis	
☐Eating Disorder	☐HIV/Aids	☐Seizure	
☐Eczema	☐IBS/IBD	☐Sickle Cell Anemia	

SURGICAL HISTORY: (Check all that apply)

☐Appendectomy	☐Fracture Surgery	☐Small Intestine Surgery
☐Brain Surgery	☐Gastrostomy	☐Spine surgery
☐Cosmetic Surgery	☐Heart Surgery	☐Tonsillectomy
☐Ear tubes	☐Hernia Repair	☐Umbilical Hernia
☐Eye Surgery	☐Lymph Node Biopsy	☐VP shunt

Other: ______________________________

FAMILY HISTORY : (List relatives with conditions. For example mother, father, brother, sister, paternal grandmother, paternal grandfather, maternal grandmother, or maternal grandfather)

☐Alcohol abuse ____________	☐Drug Abuse ____________	☐Mental Illness ____________
☐Arthritis____________	☐Early Death ____________	☐Miscarriages ____________
☐Birth Defect ____________	☐Heart Disease ____________	☐Suicide ____________
☐Cancer____________	☐Hyperlipidemia ____________	☐Suicide Attempt ____________
☐COPD ____________	☐Hypertension ____________	☐Vision Loss ____________
☐Depression ____________	☐Kidney Disease ____________	☐Other ____________
☐Diabetes____________	☐Learning Disabilities ____________	

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes - How often? ____________ ☐ No

Do you Smoke? ☐Every day ☐Some Days ☐Never Smoker ☐Former Smoker - Quit in____________

Use Smokeless Tobacco? ☐Yes ☐No ☐ Never ☐Former Smokeless Tobacco - Quit all tobacco in (year): ________

By signing this medical history form, I attest that the information stated within is true and current medical history to the best of my knowledge and I agree to contact/inform Southwest Orthopaedic Specialists medical staff or my provider of any medical changes to the information stated herein.

X______________________________ ____________________

Signature of patient – Parent or Legal Guardian **Date**

Print Name of Parent or Legal Guardian, if patient is a minor: ______________________________