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: ____________________

__Health Insurance Information__

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 & Blake Stepanovich, 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

Southwest Orthopaedic & Reconstructive Specialists

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

New Patient Medical History **Date:**

Patient Name: **DOB:**

What problem(s)/issue(s) brings you here today?	
How and when did it start?	
What makes it worse?	
What Makes it better?	

What diagnostic testing have you had for this problem? (Circle one)	**X-Ray**	**MRI**	**CT-Scan**	**EMG**	**Bone scan**
What treatments have you tried for this problem? (Circle one)	**Massage**	**Injections**	**Chiropractor**	**Physical Therapy**	**Psych evaluation**

Pain Score

0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like (circle any that apply):

Dull Achy Burning Stabbing Numbness Tingling Pulling Cramping Tightness

Please describe the time course of your pain (circle any that apply):

Constant Comes and Goes Worse in the morning Worse at night

Please list medications you are currently taking with doses:
(Include over-the-counter medications)

Please list other Medical Problems, Drug Allergies, and past Surgeries:

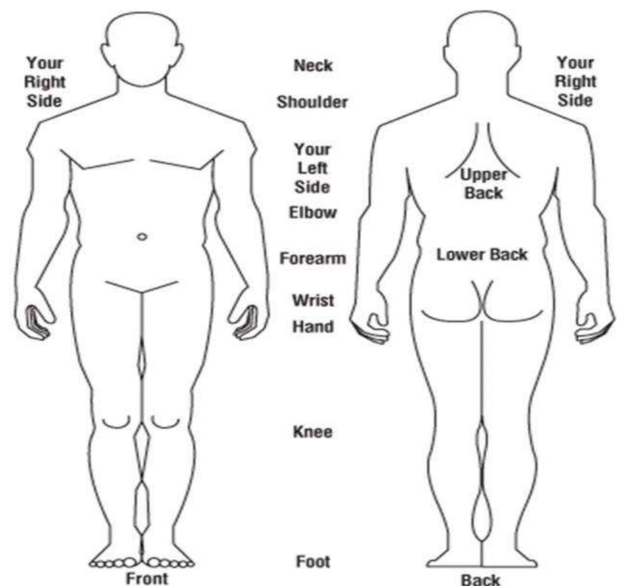
What exercise do you do?

Do you use Tobacco? If so, what kind and how long?

Illicit drug use? (Example: cocaine,heroin,meth)

Opioid use? (Example: Oxycodone, hydrocodone, tramadol)

What is your Occupation?
Number of hours worked per week?



Draw on the diagram where you have pain.

Review of systems:

GENERAL	**Night pain Headaches Fevers Unintentional weight loss**
VISION/RESP	**Vision Change Double vision Shortness of Breath Wheezing Coughing**
CARDIAC/NEURO	**Chest pain Palpitation Dizziness Weakness Numbness Tingling**
MUSC/SKEL	**Low Back Pain Joint pain Joint swelling Muscle Pain**
PSYCH	**Depressed mood Suicidal thoughts Sleep problems Anxiety**
DERM/URO	**New rash Psoriasis Urinary frequency/urgency Loss of control of urine**
GASTO/INTESTINAL	**Nausea Vomiting Black stool Loss of control of stool**

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The Roland-Morris Disability Questionnaire

Today's Date: ______________________________

Name: ____________________________________Date of Birth: ______________________

With your pain, you may find it difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some stand out because they describe you ***today*.**

As you read the list, think of yourself ***today***. When you read a sentence that describes you ***today***, circle the number of the sentence. If the sentence does not describe you, then leave it and go on to the next one.

Remember, only mark the sentence if you are sure that it describes you *today*.

1. I stay at home most of the time because of my pain.
2. I change position frequently to try and make myself comfortable.
3. I walk more slowly than usual because of my pain.
4. Because of my pain, I am not doing any of the jobs that I usually do around the house.
5. Because of my pain, I use a handrail to get upstairs.
6. Because of my pain, I lie down to rest more often.
7. Because of my pain, I have to hold on to something to get out of a chair.
8. Because of my pain, I ask other people to do things for me.
9. I get dressed more slowly than usual because of my pain.
10. I only stand up for short periods of time because of my pain.
11. Because of my pain, I try not to bend or kneel down.
12. I find it difficult to get out of a chair because of my pain.
13. My pain hurts most of the time.
14. I find it difficult to turn over in bed because of my pain.
15. My appetite is not very good because of my pain.
16. I have trouble putting on my socks (or stockings) because of my pain.
17. I only walk short distances because of my pain.
18. I sleep less because of my pain.
19. Because of my pain, I get dressed with the help of others.
20. I sit down for most of the day because of my pain.
21. I avoid heavy jobs around the house because of my pain.
22. Because of my pain, I am more irritable and bad tempered with people.
23. Because of my pain, I go upstairs more slowly than usual.
24. I stay in bed most of the time because of my pain.

TOTAL: [ ]

Mental Health and Substance Abuse History **Date:**

Patient Name: **DOB:**

For the following table, circle the number in all boxes that apply to you. For instance, regarding **"Family History of Alcohol Abuse,"** if you are Female and you have this in your family, you should circle the **"1"** in the corresponding box. If you are Male, you should circle the **"3"** in the corresponding box. Next, add the total of the numbers that you circled at the bottom.

	Female	Male
FAMILY HISTORY OF SUBSTANCE ABUSE		
Alcohol	1	3
Illegal Drugs	2	3
Prescription Drugs	4	4
PERSONAL HISTORY OF SUBSTANCE ABUSE		
Alcohol	3	3
Illegal Drugs	4	4
Prescription Drugs	5	5
MENTAL HEALTH HISTORY		
ADD, OCD, Bipolar, Schizophrenia	2	2
Depression/Anxiety	1	1
Your age is between 16 and 45 years	1	1
History of Preadolescent Sexual Abuse	3	0

Add columns: ______________ + ______________

TOTAL:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) **Date:** ____________

Name: ______________________ DOB: ______________________

Over the last two weeks, how often have you been bothered by any of the following problems?
(Circle your answer for each question)

	Not at all	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure doing things.	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling, staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as, reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed - Or the opposite - being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or thoughts of hurting yourself.	0	1	2	3

Office use only: Add columns _______+ _______+ ________

Total: ______________

If you checked any problems, how difficult have these problems made it for you to do your work, take care of things at home or have a good relationship with other people? (Circle one of the following)

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

SOS

Spine, Pain & Wellness Institute

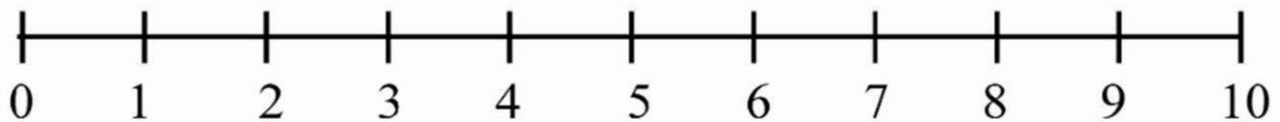
Visual Analog Pain Scale

Date:

Name: **DOB:**

0	**Pain Free**
1	**Very minor annoyance – occasional minor twinges**
2	**Minor annoyance – occasional strong twinges**
3	**Annoying enough to be distracting**
4	**Can be ignored if you are really involved in your work, but still distracting**
5	**Can't be ignored for more than 30-minutes**
6	**Can't be ignored for any length of time, but you can still go to work and participate in social activities**
7	**Makes it difficult to concentrate, interferes with sleep. You can still function with effort.**
8	**Physical activity is severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.**
9	**Unable to speak. Crying out or moaning uncontrollably – disorientation**
10	**Unconscious. Pain makes you pass out.**

No Pain | Moderate Pain | Worst Pain



No Pain	Mild	Moderate	Severe	Very Severe	Worst Pain
0	1– 3	4 – 6		7 – 9	10

Acknowledgement & Consent to Drug Testing

Drug Testing is a critical component included in the treatment plan for all patients under the care of our SOS physician, provider, and/or medical team, especially to those who are prescribed controlled substances. As directed by the agreement between SOS and individual patients receiving care for various conditions, vital information necessary for the monitoring of these patients is obtained through regular, periodic and random drug screening. Drug testing ordered by SOS providers functions to protect patients, protect providers, protect access to therapy, protect the community and protect the health care resources.

I understand that my refusal to provide for urine, saliva and/or blood specimen, tampering with, or providing false information through the specimen's chain of custody shall be grounds for termination from the medical practice.

I understand that all information disclosed by and acquired by SOS as derived from this test shall be kept confidential and shall solely be used for the purpose of continuing medical treatment only.
I also understand that SOS reserves the right to obtain an external Rx history and randomly verify past medications through the Prescription Monitoring Database in order to be prescribed any pain medications.

I hereby release, indemnify, and hold harmless SOS, its employees, directors, and its agents from any liability, loss, or expenses, injury, damage, or claims whatsoever on or about this drug test.
By signing this form, I hereby give my consent to providing collection of drug specimen by SOS Spine, Pain & Wellness Institute or it's designated medical representative as ordered or directed.

Patient name (print): ______________________________

Patient Signature: ______________________________ Date: ______________

Witness name (print): ______________________________

Witness Signature: ______________________________ Date: ______________