



8100 S. Walker Avenue, Building A  
Oklahoma City, OK 73139  
Phone 405-632-4468 Fax 405-632-0436

DATE: \_\_\_\_\_

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Nickname) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: S M D W

Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ SSN: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

School if Student: \_\_\_\_\_ Full time Part time

Primary Care Physician: \_\_\_\_\_

Referred by: \_\_\_\_\_  
Physician Hospital Family/Friend Advertisement Coach Other

**IN CASE OF EMERGENCY, I GIVE PERMISSION TO NOTIFY:**

Name: \_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**HEALTH INSURANCE INFORMATION: Please give information about the holder of insurance**

**Primary:** Insurance Company: \_\_\_\_\_ **Secondary:** Insurance: Company \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Policy or ID number: \_\_\_\_\_ Policy or ID number: \_\_\_\_\_

Group number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

**If patient is a minor please give parental or guardianship information**

Parent or Guardian \_\_\_\_\_

Relationship \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**What pharmacy do you use? \_\_\_\_\_ Location \_\_\_\_\_**

\_\_\_\_ (Initial) I agree that SOS may request and use my prescription medication history from other healthcare providers, third-party pharmacy benefit payors, or Health Information Exchanges for treatment purposes.

**The CMS Meaningful Use initiative requires we ask certain demographic information questions (below).**

\_\_\_\_ Do Not Wish to Answer the Following Questions:

- Language Choice \_\_\_\_\_
- Race: White Black Asian Native American Hispanic Native Hawaiian Unknown
- Ethnicity: Hispanic Non-Hispanic Unknown

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

**What are we seeing you for today?**

- Head Neck Shoulder Elbow Wrist Hand Finger Back Hip Knee Ankle Foot Toes
- Ribs Face Abdomen Breast Other \_\_\_\_\_ Right Left Both

Were you injured?  YES  NO If Yes, HOW? \_\_\_\_\_

Date your symptoms began? \_\_\_\_\_

Is This A Work-Related Accident?  YES  NO If Yes, list Employer and/or Adjuster's name and phone:

\_\_\_\_\_

Is This An Auto-Related Accident?  YES  NO

If Yes, please indicate how your account will be billed:

If Yes, list responsible party and insurance company, adjustor's name, claim number and phone. If unknown, write 'Unknown':

- MVA (Self-Pay)  Health Ins.

**NOTE: Be advised all MVA(Self-Pay) accounts require \$300 payment for initial evaluations and payment for further treatment is expected at date of service; any surgery deposits will be due prior to scheduling and will have liens filed to ensure payment after settlements.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you represented by an attorney?  YES  NO

If Yes, list attorney's name and phone: \_\_\_\_\_

**CURRENT MEDICATIONS AND ALLERGIES: (use back of form if needed)**

\_\_\_\_\_ mg \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_\_\_ mg \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_\_\_ mg \_\_\_\_\_ How often? \_\_\_\_\_

\_\_\_\_\_ mg \_\_\_\_\_ How often? \_\_\_\_\_

Allergies to Drugs: \_\_\_\_\_  No Known Drug Allergies

Allergies to:  Latex  Adhesive Tape  Iodine  Other \_\_\_\_\_

Are you Pregnant?  Yes  No

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

Please list how you would like to be contacted, for appointment reminders:

Text Message  Voicemail at (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ This is my:  Cell Phone  Home Phone  
 Work Phone

Please indicate which phone number we may leave a voicemail with clinical information:

(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ This is my:  Cell Phone  Home Phone  Work Phone

Who may we talk to on your behalf?

\_\_\_\_\_ (Initial) I permit Southwest Orthopaedic and Reconstructive Specialist to discuss health information in person or by phone with the following family members or friends. Release of information under this document is limited to verbal discussion with my Health Care Provider. This document does not permit release of any written health information to the individuals named below.

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____

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

X \_\_\_\_\_  
Signature of patient, parent or legal guardian/ relationship is required

**[THIS SECTION IS FOR STAFF USE]**

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Intake for:

Head Neck Shoulder Elbow Wrist Hand Finger Back Hip Knee Ankle Foot Toes  
Ribs Face Abdomen Breast Other \_\_\_\_\_ Right Left Both

Work – Related

Motor Vehicle – Related

Date of Injury: \_\_\_\_\_

**PATIENTS: PLEASE COMPLETE THE ALL THE QUESTIONS BELOW THIS LINE:**

Are you in Pain Management? Yes No If Yes, Dr. \_\_\_\_\_

Do you have a Cardiologist? Yes No If Yes, Dr. \_\_\_\_\_ Phone \_\_\_\_\_

Last Influenza Vaccination (date): \_\_\_\_\_ Last Pneumonia Vaccination (date): \_\_\_\_\_

**REGARDING CURRENT INJURY:**

Were you treated at a hospital or by another physician?  YES  NO

If YES, by Whom and When? \_\_\_\_\_

Have you had X-ray MRI CT Scan Ultrasound

Other(\_\_\_\_\_)?

If Yes, list Where and When: \_\_\_\_\_

Have you had surgery before for this?  YES  NO

If Yes, list Date and Type: \_\_\_\_\_

Who performed the surgery? \_\_\_\_\_

**MEDICAL HISTORY:** (Check all that apply)

- |   |   |                                     |   |                                       |
|---|---|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Osteomyelitis  | <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Blood Clots    | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Failure          | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Murmur   | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Chest Pain/Angina  | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> Recurrent Bronchitis   | <input type="checkbox"/> Anemia     | <input type="checkbox"/> Sickle Cell    | <input type="checkbox"/> HIV          |
| <input type="checkbox"/> AIDS                   | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Fractures  | <input type="checkbox"/> Paralysis      | <input type="checkbox"/> Head injury  |
| <input type="checkbox"/> Cancer of<br>the _____ | <input type="checkbox"/> Tuberculosis (Circle one:<br>Currently Active TB or Inactive TB) | <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Other<br>_____ |                                       |

**SOCIAL HISTORY:**

Have you ever been addicted or dependent on drugs or pain medicine? Yes No

Smoke: Every Day Some Days Never Smoker Former Smoker

Drink: Yes No If YES: beer, alcoholic drinks, wine (Circle one)

Yes No

Quit in \_\_\_\_\_

How much per month? \_\_\_\_\_

**SURGICAL HISTORY:**

Date: \_\_\_\_\_

\_\_\_\_\_

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

**FAMILY HISTORY:** (List relatives with conditions)

Medical Condition	Relative (mother, brother...)	Medical Condition	Relative (mother, brother...)
<input type="checkbox"/> Bleeding Tendency	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Blood Clot	_____	<input type="checkbox"/> Heart Attack	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Heart disease	_____
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Osteoarthritis	_____
<input type="checkbox"/> Rheumatoid arthritis	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Depression	_____

**CURRENT REVIEW OF SYSTEMS:**(Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Fever                     | <input type="checkbox"/> Rapid weight loss or gain | <input type="checkbox"/> Jaundice               |
| <input type="checkbox"/> Swollen ankles            | <input type="checkbox"/> Night sweats              | <input type="checkbox"/> Palpitations           |
| <input type="checkbox"/> Chest pain/angina         | <input type="checkbox"/> Numbness or tingling      | <input type="checkbox"/> Weakness of arm or leg |
| <input type="checkbox"/> Taking blood thinners     | <input type="checkbox"/> Excessive bleeding        | <input type="checkbox"/> Shortness of breath    |
| <input type="checkbox"/> Hearing loss              | <input type="checkbox"/> Vision changes            | <input type="checkbox"/> Rash                   |
| <input type="checkbox"/> Active infection of _____ | <input type="checkbox"/> Other _____               | <input type="checkbox"/> Other _____            |

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X \_\_\_\_\_

Signature of patient, parent or legal guardian/ relationship is required