SOS Southwest Orthopaedic & Reconstructive Specialists
southwestortho.com

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: _____

Insured Name: _____

Relationship to patient: _____

SSN: _____ DOB: _____

Policy or ID number: _____

Group number: _____

Employer: _____

Secondary:
Insurance: Company_____

Insured Name: _____

Relationship to patient_____

SSN: _____ DOB: _____

Policy or ID number: _____

Group number: _____

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

_____

_____

_____

_____

_____

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

☐ 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 <u>appointment reminders</u>:

☐Text Message ☐ Voicemail at (_____) _____ - _____ This is my: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

Please indicate which phone number we may leave a voicemail with <u>clinical information</u>:

(_____) _____ - _____ 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

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Patient Intake

[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)

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

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 Quit in _____
Drink: ☐Yes ☐No If YES: beer, alcoholic drinks, wine (Circle one) 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…)
☐Bleeding Tendency		☐Diabetes	
☐Blood Clot		☐Heart Attack	
☐Cancer		☐Heart disease	
☐High Blood Pressure		☐Osteoarthritis	
☐Rheumatoid arthritis		☐Stroke	
☐Tuberculosis		☐Depression	

CURRENT REVIEW OF SYSTEMS:(Check all that apply)

☐Fever	☐Rapid weight loss or gain	☐Jaundice
☐Swollen ankles	☐Night sweats	☐Palpitations
☐Chest pain/angina	☐Numbness or tingling	☐Weakness of arm or leg
☐Taking blood thinners	☐Excessive bleeding	☐Shortness of breath
☐Hearing loss	☐Vision changes	☐Rash
☐Active infection of _____	☐Other_____	☐Other_____

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