



All questions contained in this questionnaire are strictly confidential and will become part of your medical record. It is very important that you clearly tell us your past medical background as this assists the physicians in understanding your problem and executing the best care and outcome for your current condition.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last First Middle Initial

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_ Male \_\_\_ Female Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_  
Name City State

Why are we seeing you today? \_\_\_\_\_

How long have you had this problem?  
1-2 3-5 6-8 9-12 days weeks months years  
         
choose one choose one

HISTORY OF THE PRESENT CONDITION

When did this occur? \_\_\_\_\_ Ever had this before?  Yes  No Date? \_\_\_\_\_

Was this an auto injury (accident)  Yes  No

Is your injury work / job related?  Yes  No Last date you worked? \_\_\_\_\_

Are you left or right handed?  Left  Right

What makes the condition worse? \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

State in your own words how the present problem happened and what you felt at the time:

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

Have you had any of the following tests (past 12 months):

- Bone Scan  Blood Tests  MRI  CT Scan  EMG/Nerve Test
- Myelogram  X-Rays  Other \_\_\_\_\_

Mark the following you have done recently:

- Steroid Shots  Daily Exercise  Pain Clinic  Brace/Corset  Taken Medications
- Quit Smoking  Phys. Therapy  Swimming  Biking  Walking  Lost Weight



### Past Medical History

Fill in the circles if you have had any of the following problems.

- |   |  |   |
|---|--|---|
| <input type="radio"/> Coronary Artery Disease | <input type="radio"/> Kidney disease/Stones    | <input type="radio"/> Cancer - What Kind?: _____    |
| <input type="radio"/> Heart Failure           | <input type="radio"/> Prostate problems        | <input type="radio"/> Allergy to anesthesia         |
| <input type="radio"/> High Blood Pressure     | <input type="radio"/> Thyroid Disease          | <input type="radio"/> Drug/Alcohol Addiction        |
| <input type="radio"/> Blood Vessel Disorder   | <input type="radio"/> Stomach Ulcers           | <input type="radio"/> Ear, Nose, Throat problems    |
| <input type="radio"/> COPD / Asthma           | <input type="radio"/> Gastro-intestinal Reflux | <input type="radio"/> Sleep Apnea/CPAP              |
| <input type="radio"/> Stroke / Blood Clots    | <input type="radio"/> Liver problems/Hepatitis | <input type="radio"/> Osteoporosis                  |
| <input type="radio"/> Neurological problems   | <input type="radio"/> Tuberculosis             | <input type="radio"/> Arthritis - What Kind?: _____ |
| <input type="radio"/> Depression              | <input type="radio"/> Diabetes                 | <input type="radio"/> HIV/AIDS                      |
| <input type="radio"/> Incontinence            | <input type="radio"/> Lung/breathing problems  | <input type="radio"/> Anemia/Blood Disorder         |
| <input type="radio"/> Abnormal EKG            | <input type="radio"/> Abnormal Chest X-Ray     | <input type="radio"/> Other: _____                  |

Over the past year have you fallen and broken a bone, or fallen more than once?  Yes  No

Mark if allergic to:  Metals  Latex  Iodine  IVP Dye  Steroids  Aspirin

Do you have any of the following?  Metal implants  Infusion catheters  Surgical clips  Pacemaker

### Past Surgical History

Please indicate all previous surgeries you have had.

Year	Procedure Done	Surgeon's name.../and where?

### Current Medications

Please list all prescription and over-the-counter medicines

Name	Name	Name

### Allergies to Medications, foods or other substances

Name the medication/item	Indicate the reaction you had



Do you have a living will indicating your advanced directive?  Yes  No

### Family Medical History

Fill in circles if any of the following exist in your family or relatives.

- Arthritis
- Osteoporosis
- Diabetes
- Peripheral Vascular Disease
- Psychiatric Problems
- Neurological problems
- Stroke
- Kidney Failure
- Heart Failure
- Cancer
- Seizures
- Bleeding Problems

### Social History

- Marital Status:**  Single  Married  Divorced  Widowed
- Education:**  Some High school  High School Grad  College  Post Grad
- Employment:**  Currently working  Seeking work  Disabled  Retired  Other
- Exercise:**  Sedentary  Mild  Moderate  Vigorous
- Tobacco:**  Never used  Former smoker  I smoke Amount: \_\_\_\_\_  I chew Amount: \_\_\_\_\_
- Alcohol:**  Never  Occasional  Frequently
- Pregnant:**  Yes  No  Planning
- My health is:**  Excellent  Very Good  Good  Fair  Poor

### Review of Systems

fill in circle if you have had any of the following in the last 2 weeks

- Headaches
- Leg numbness
- Heart or chest pain
- Depression
- Seizures
- Leg cramps
- Shortness of breath
- Anxiety
- Visual changes
- Loss of bladder control
- Difficulty swallowing
- Recent Falls
- Arm weakness
- Loss of bowel control
- Joint swelling
- Dizziness
- Arm numbness
- Gastric Ulcers
- Chills/Fever
- Dry Skin/Sores
- Leg weakness
- Heartburn/Reflux
- Insomnia (trouble sleeping)
- Night Sweats



### Insurance Verification

All fields must be completed in order to be seen by a physician.

Patient Name: \_\_\_\_\_ Sex:  Male  Female

Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Guarantor Name: \_\_\_\_\_ Sex:  Male  Female

Guarantor Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Guarantor SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Patient Address: \_\_\_\_\_  
Street Apt

City State Zip Code

Patient Phone: Home: ( ) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

Work: ( ) \_\_\_\_ - \_\_\_\_ Occupation: \_\_\_\_\_

Cell: ( ) \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ ( ) \_\_\_\_ - \_\_\_\_  
Name Relationship to Patient Phone

Primary Insurance Company Name and Address: \_\_\_\_\_  
Company Name

Street Suite

City State Zip Code ( ) \_\_\_\_ - \_\_\_\_  
Phone Number

Personal ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Subscriber Name (Insured): \_\_\_\_\_

Subscriber SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance Company Name and Address: \_\_\_\_\_  
Company Name

Street/PO Box Suite

City State Zip Code ( ) \_\_\_\_ - \_\_\_\_  
Phone Number

Personal ID#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

Subscriber Name (Insured): \_\_\_\_\_

Subscriber SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Subscriber Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Referral Source Information

How did you hear about us? Who were you referred by?

Physician Name: \_\_\_\_\_ Physician Address: \_\_\_\_\_

Physician Phone: ( ) \_\_\_\_ - \_\_\_\_ Physician City/State: \_\_\_\_/\_\_\_\_

Phone Book: White or Yellow (Circle One)  Athletic Trainer: \_\_\_\_\_  www.OSOI.com  
Name of School

Friend: \_\_\_\_\_  Advertisement: \_\_\_\_\_  Website: \_\_\_\_\_  
Name Where did you see our ad? Address

Other: \_\_\_\_\_

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### AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Sports and Orthopedics Institute to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports and Orthopedics Institute 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 and Orthopedics Institute 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 VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Sports and Orthopedics Institute, its agent and its employees from liability in connection with the release of the information contained therein.

**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.

### 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 and Orthopedics Institute. **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 and Orthopedics Institute from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand a photocopy of this document is as valid as the original.

**SIGNED** \_\_\_\_\_  
(PATIENT)

**DATE** \_\_\_\_\_

**OR** \_\_\_\_\_  
(NEAREST RELATIVE OR  
RESPONSIBLE PARTY)

**POLICYHOLDER'S  
SIGNATURE** \_\_\_\_\_

\_\_\_\_\_  
(RELATIONSHIP TO PATIENT)



**Oklahoma Sports and Orthopedics Institute**

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION  
AND NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT**

Patient Name: (Last) \_\_\_\_\_, (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_ Med Rec #: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**I hereby authorize Oklahoma Sports and Orthopedics Institute to release all information contained in my medical record to the following. I understand this may include information relating to SUBSTANCE ABUSE AND HIV RELATED TESTING.**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

The purpose of this disclosure: \_\_\_\_\_

I understand that this authorization will expire 90 days from the date I am released from care by Oklahoma Sports and Orthopedics Institute.

I understand that I may revoke this authorization at any time by notifying Oklahoma Sports and Orthopedics Institute in writing. The cancellation will be effective on the date notification is received by Oklahoma Sports and Orthopedics Institute.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by Federal privacy regulations.

I understand that if I do not sign this form authorizing release of information that my health care and payment for my health care will not be affected.

**By signing this form I am acknowledging that I have received a copy of Oklahoma Sports and Orthopedics Institute's Notice of Privacy Practices as required by HIPAA.**

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian/Authorized Person

\_\_\_\_\_  
Date

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 providers' 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, prior-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 current 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 claim.

If your injury was due to a Motor Vehicle Accident or any other "Third Party Liability" accident, you will be set up on a self-pay account requiring a down-payment of \$300.00. If charges exceed \$1,500.00, a claim will be filed 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 OSOI Physicians will accept third party/MVA patients.

### Additional Charges

There is a \$20.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion. There is a \$20.00 charge for any returned check. This charge is applicable per returned check. Returned checks may be submitted to the District Attorney's office. There will be a \$20.00 charge assessed to your account for No-Showing an appointment or for cancellations within 24 hours of your scheduled appointment.

### Gemini Financial Solutions

In the interest of good business practice, the desire to continue to provide quality health services and maintain fiscal responsibility, Oklahoma Sports & Orthopedics Institute has developed a policy regarding partial payments for outstanding accounts. You are responsible for payment of all medical treatment and related services provided by Oklahoma Sports & Orthopedics Institute. As a service and out of consideration to you, this office will file insurance claims for all covered services. As appropriate, based on our contractual provisions with your insurer, this office will accept your insurance company's maximum allowable reimbursement. You will be responsible for any deductible or co-payment amounts and any non-covered services incurred at the time of service. **All accounts are considered due, after payment from insurance company is received.** Payments can be made by cash, check, money order, Visa, MasterCard, American Express, or Discover card. 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.

**In keeping with our commitment to serve our patients, Oklahoma Sports & Orthopedics Institute has secured arrangements for partial payments for your convenience. The following is the billing procedure for Oklahoma Sports and Orthopedics Institute**

- A) Initial balance due will be sent to the patient for an attempt to collect the balance in full.**  
**B) In the event payment in full is not received by Oklahoma Sports & Orthopedics Institute within 30 days of said statement, the following will automatically occur:**
- 1) This amount and any future balances due will be handled by our billing agent, Gemini Financial Services, LLC (GFS)**
  - 2) The patient shall be billed a \$15.00 annual administrative fee by GFS to cover administrative and set up costs.**
  - 3) The patient shall be billed 1.375% monthly service fee on the outstanding balance.**
  - 4) The patient will be required to pay the GREATER of \$30.00 or 3% of the outstanding balance each month until the balance is paid in full.**

Again, thank you for allowing Oklahoma Sports and Orthopedics Institute to participate in your care.

Sincerely,  
OSOI Physicians and Staff

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My signature below acknowledges receipt of this Financial Policy:

Signed: \_\_\_\_\_ Date \_\_\_\_\_  
(Signature of person financially responsible for payment)

Relationship if other than patient: \_\_\_\_\_

# Oklahoma Sports and Orthopedics Institute

Dr. James Bond, MD Dr. Scott de la Garza, MD Dr. Richard Kirkpatrick, MD Dr. Ted Boehm MD  
Dr. Corey Ponder, MD Dr. Timothy Geib, MD Dr. Scott Waugh, MD Dr. Seethal Madhavarapu, MD

## Contract for Narcotic Prescriptions

Controlled substance medications (Narcotics, Opiates, Tranquilizers, Barbiturates) can be useful to treat some painful conditions, but have a high potential for misuse and abuse and are therefore closely controlled by the government. If used excessively, they can cause adverse affects such as impaired judgment, vomiting, constipation, lethargy and even death. To insure that these medications are used properly to treat my pain, **I agree** to follow the instructions listed below. **I understand** that if I do not abide by these instructions and conditions, the prescribing of **my narcotic pain medication and my entire treatment at Oklahoma Sports and Orthopedics Institute will be discontinued.**

1. **I am responsible for my narcotic medication.** They are like money, in the sense that, if the prescription or the medication itself is lost, misplaced or stolen, or if I run out too soon, **the medication is gone and will not be replaced.** I will not increase the dose (take more than prescribed) of my medicine without first discussing it with the physician. Requests for early refills will be denied and if the requests continue, my treatment with Oklahoma Sports and Orthopedics will be terminated.
2. **Refills of narcotic medication will be made only during business hours.** Narcotic refills are filled Monday-Thursday 8:30-4:00. Refill requests will not be taken on Fridays. When requesting refills please provide the nursing staff with your pharmacy name and phone number. Refills of narcotic medications will not be made after hours, on the weekends or on holidays. The answering service will not contact the doctor for refills. It is my responsibility to contact the office 24-48 hours prior to using the last of my medicine to ensure that I do not run out. Narcotic medications will only be given up to 3 months after surgery. After that time, it is my responsibility to find a physician to take over that care if necessary. I understand that stopping my medicine supply may be dangerous to my health and cause serious withdrawal symptoms. I understand that narcotic prescriptions may be required to be picked up and a photo ID will be required before the prescription will be released. If a person other than me will pick up the prescription, that person will be required to bring his/her photo ID and a note from myself authorizing my medication to be released.
3. **I will not request nor accept narcotic medication from any other physician and/or other individual while I am receiving such medication from this office.** If I must go to the emergency room and/or hospital for any actual emergency and if at that time I am given a narcotic prescription, I will notify this office within 24 business hours. **I understand that it is ILLEGAL to obtain narcotic medication from multiple physicians. It is also illegal to accept medications from other individuals or to share my medicine.**
4. **I have been informed by my physician about narcotic effects,** including normal physiological effects of tolerance (need for more medicine to achieve the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking the medicine abruptly) and the abnormal effect of addiction (psychological dependency leading to abnormal behavior), which is very rare in patients with genuine pain. Narcotics can adversely affect my judgment in making business decisions and in operating equipment, such as an automobile
5. **I understand that if I violate ANY of the above instructions or conditions, or if I decline at any time when requested by my physician to take a blood or urine test for controlled drug screening (at my own expense) MY NARCOTIC PRESCRIPTIONS AND MY ENTIRE TREATMENT AT OKLAHOMA SPORTS AND ORTHOPEDICS WILL BE TERMINATED IMMEDIATELY. Any violation of this contract will be reported to any other physician and to local medical facilities involved in my care. Any violations of State or Federal Law will be reported to the authority.**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date