ORTHOKANSAS, LLC

Patient Registration

Please PRINT and complete ALL sections below

Personal Information & Social History

Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Best Phone #:_____

Alternate Contact #:_____

SS#:_____

Date of Birth:_____/_____/_____ Age:_____

Email:_____

Occupation:_____

Employer:_____

Phone #:_____

Referred By: ☐ Physician ☐ Coach/Trainer ☐ Other

Name of Person Referred By:_____

Spouse/Significant Other Name:_____

Sex: ☐ Male ☐ Female Other:_____

Race: ☐ American Indian/Alaska Native ☐ Asian
☐ Black ☐ Native Hawaiian ☐ White
☐ More Than One Race ☐ Unknown/Other

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Unknown

Preferred Language:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children:_____ ☐ Rt or ☐ Lt Handed

Height:_____ Weight:_____

Smoke? Yes No Packs per day?_____ # of years _____

Former Smoker? Start:_____ Stop:_____

Alcohol? Yes No Frequency?_____

Recreational Drugs? Yes No Type:_____

Hobbies/Activities:_____

_____

Insurance/Billing Information

Primary Insurance:_____

Subscriber's Name :_____

Subscriber Date of Birth:____/____/_____

Insurance ID #:_____

Group #:_____

Subscriber SS#:_____-_____-_____

Relationship to Patient:_____

Secondary Insurance:_____

Subscriber's Name :_____

Subscriber Date of Birth:____/____/_____

Insurance ID #:_____

Group #:_____

Subscriber SS#:_____-_____-_____

Relationship to Patient:_____

If someone other than the patient is responsible for billing please complete the following:

Responsible Billing Party:_____ Relationship to Patient:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ Email:_____

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

Assignment of Benefits & Financial Agreement

I herey give lifetime authorization for payment of insurance benefits to be made directly to the physicians of OrthoKansas, LLC for services rendered by them. I realize that my insurance policy is a contract between me and my insurance company and that I am financially responsible for all charges 60 days after treatment whether or not they are covered by my insurance. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits and agree that a photocopy of this agreement shall be valid as the original.

Date:_____ Signature:_____

ORTHOKANSAS, LLC

Current Symptoms related to Orthopedic Consult

Patient Name:_____ DOB:_____ _

Reason for seeing Doctor today? Please include exact location of your problem(s):

_____

_____

_____

Date of Injury:_____ Work Related Injury: YES NO Auto Related Injury: YES NO

How and Where did injury occur?_____

_____

Intensity of Pain: 0 1 2 3 4 5 6 7 8 9 10

Have you had any of the following <u>related to current problem</u>?

*If yes please list date and location

☐ Y ☐ N XRAYs

_____

☐ Y ☐ N MRI

_____

☐ Y ☐ N CT Scan

_____

☐ Y ☐ N EMG

_____

☐ Y ☐ N Injections

_____

☐ Y ☐ N Chiropractic Care

_____

☐ Y ☐ N Physical Therapy

_____

☐ Y ☐ N Surgeries, please list all

_____

_____

_____

☐ Y ☐ N Hospitalizations, please list all

_____

_____

ORTHOKANSAS, LLC

Medication History

Patient Name:_____ DOB:_____

Pharmacy of Choice:_____ Address/Intersection:_____

Latex Allergy: YES NO

Medication Allergies and Reactions:_____

_____

_____

Other Allergies:_____

_____

Current Medication list Including Over the Counter Meds & Supplements	Taken How Often? Dosage?	Reason Taken?	Prescribing Physician?

**Please attach full list of medications if needing additional space .*

OrthoKansas Narcotic Policy

At OrthoKansas,LLC, we are aware that many of the conditions that we see and treat are painful due to their musculoskeletal nature. However, we are not a pain clinic, and we do not treat chronic pain.

Narcotic pain medicines can cause dependence, have serious side effects including death, and prescriptions for these medicines are monitored and controlled by the federal government.

Examples of these medicines may include:

> Percocet (oxycodone), OxyContin (oxycodone), Lortab/Vicodin/Norco (hydrocodone), codeine, morphine, Duragesic (fentanyl), Dilaudid (hydromorphone), and Ultram (tramadol)

Our physicians, at their discretion, may prescribe these medicines to you on a short-term basis. The duration of treatment will be determined by the physicians based on your underlying condition.

Our on call physicians and physician assistants will not refill any medication, including narcotics, on nights, weekends or holidays. It is your responsibility to obtain a refill of medicine, if needed, during regular office hours.

We also will not provide long-term pain control. If you require long-term narcotics for chronic pain, we will refer you back to your primary care physician or to pain management to provide service for you.

I agree that OrthoKansas may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature:_____ Date_____

ORTHOKANSAS, LLC

Health History Questionnaire

Patient Name:_____ DOB:_____

Primary Care Doctor:_____

Other Doctors you see for your health care:_____

_____

Do/Did you have?	Health Problems Circle or Write In Specifics	Does/Did immediate family have?	Who? List specifics if available
yes ☐ no ☐	Diabetes	yes ☐ no ☐	
yes ☐ no ☐	Ulcers/GERD	yes ☐ no ☐	
yes ☐ no ☐	High/Low Blood Pressure	yes ☐ no ☐	
yes ☐ no ☐	Heart Disease/Issues (Heart Attack, Bypass, Stents, Irregular Heartbeat, Pacemaker, Angina)	yes ☐ no ☐	
yes ☐ no ☐	Seizure	yes ☐ no ☐	
yes ☐ no ☐	Blood Diseases/Bleeding Problems/ Blood Clots	yes ☐ no ☐	
yes ☐ no ☐	AIDS/HIV	yes ☐ no ☐	
yes ☐ no ☐	Kidney Problems	yes ☐ no ☐	
yes ☐ no ☐	Liver Problems (Hepatitis, Cirrhosis)	yes ☐ no ☐	
yes ☐ no ☐	Stroke	yes ☐ no ☐	
yes ☐ no ☐	Cancer (What kind?)	yes ☐ no ☐	
yes ☐ no ☐	Rheumatoid Arthritis	yes ☐ no ☐	
yes ☐ no ☐	Osteoarthritis	yes ☐ no ☐	
yes ☐ no ☐	Multiple Sclerosis	yes ☐ no ☐	
yes ☐ no ☐	Sleep Apnea	yes ☐ no ☐	
yes ☐ no ☐	Staph Infection	yes ☐ no ☐	
yes ☐ no ☐	Lung Issues (COPD, Asthma, Emphysema, Pneumonia Chronic Bronchitis, Pulmonary Embolism)	yes ☐ no ☐	
yes ☐ no ☐	Tuberculosis	yes ☐ no ☐	

Other health problems/chronic illness? Explain:_____

_____

_____

Do you have any handicaps or disabilities? If so, what are they:_____

_____

_____

Emergency Contact Name:_____ Phone#:_____

Relationship:_____

Receipt of Notice of Privacy Practices

Written Acknowledgement Form

I, _____have received a copy of OrthoKansas, LLC's Notice of Privacy Practices.

I authorize disclosure of my Protected Health Information to the following individuals:

(Protected Health Information includes, but not limited to, billing, scheduling, picking up prescriptions.)

ATHLETES-MAKE SURE YOU LIST COACHES AND TRAINERS

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Patient Representative Signature (if applicable)_____ Date:_____

Relationship:_____