



DATE: _____

Name: (Last) _____ (First) _____ (MI) _____ (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 primary policy 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: _____

Demographic Information:

Preferred Language: _____

- Race: White Black Asian Native American Hispanic Native Hawaiian Unknown
- Ethnicity: Hispanic Non-Hispanic Unknown Decline to answer the above

Patient name _____ DOB _____

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 lien filing process on accounts with charges over \$200. MVA Liens will not be filed for medical charges if you are a Medicare/Medicaid recipient.

Are you represented by an attorney? YES NO

If Yes, list attorney's name and phone:

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?

_____ By initialing, 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
_____	_____	_____
_____	_____	_____

_____ 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, Matthew Diesselhorst, MD, Mehdi Adham, MD, Daniel Jones, MD.

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 DATE

WELCOME TO SOUTHWEST ORTHOPAEDIC & RECONSTRUCTIVE SPECIALISTS

PATIENT NAME: _____ **DATE:** _____

Are you in pain management? Yes No Dr. _____ Phone: _____

Do you have a cardiologist? Yes No If Yes, Dr. _____ Phone: _____

Do you have a pacemaker? Yes No If Yes, when? _____

What do you expect to be seen for today? _____

- ❖ Which side? Right Left Both
- ❖ Which body part? Head Neck Shoulder Elbow Wrist Hand Finger Back Hip Knee Ankle
 Foot Toes Ribs Face Abdomen Breast Other _____
- ❖ Was this injury/illness due to an accident? Yes No
If Yes, what type? Work - Related Injury? Motor Vehicle - Related?

Date of Injury/Illness Began: _____

REGARDING CURRENT INJURY/ILLNESS:

Have you been treated at a hospital or by another physician for this injury/illness? Yes No
If YES, by Whom and When? _____

Have you had a/an: X-ray MRI CT Scan Ultrasound EMG
If yes, list where and when: _____

Have you had surgery for current injury? Yes No
If yes, list list date and Doctor: _____

What is your current: Height _____ Weight _____

OB/GYN (Females Only):
 Currently Pregnant? Yes No
 Menstrual Status: Having Periods Hysterectomy Perimenopausal Postmenopausal

ALLERGIES:

Do you have any drug allergies? Yes, Name: _____ No known Drug Allergies
 Do you have any allergies to these? Latex Adhesive Tape Iodine Metal Other _____

PHARMACY INFORMATION:

What is your preferred pharmacy?
 Name: _____ Location: _____

CURRENT MEDICATIONS: (attach list as needed)

_____ mg _____
 _____ mg _____
 _____ mg _____
 _____ mg _____
 _____ mg _____

(over)

PATIENT NAME: _____ DATE: _____

MEDICAL HISTORY: (Check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Failure to thrive | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> GERD | <input type="checkbox"/> Lead Poisoning | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headache | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis (ACTIVE TB) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Obesity | <input type="checkbox"/> Varicella |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Otitis Media | <input type="checkbox"/> Vision impairments |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> IBS/IBD | <input type="checkbox"/> Seizure | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sickle Cell Anemia | |

SURGICAL HISTORY: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Small Intestine Surgery |
| <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Gastrostomy | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Umbilical Hernia |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Lymph Node Biopsy | <input type="checkbox"/> VP shunt |

Other: _____

FAMILY HISTORY : (List relatives with conditions. For example mother, father, brother, sister, paternal grandmother, paternal grandfather, maternal grandmother, or maternal grandfather)

- | | | |
|--|--|--|
| <input type="checkbox"/> Alcohol abuse _____ | <input type="checkbox"/> Drug Abuse _____ | <input type="checkbox"/> Mental Illness _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Early Death _____ | <input type="checkbox"/> Miscarriages _____ |
| <input type="checkbox"/> Birth Defect _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Hyperlipidemia _____ | <input type="checkbox"/> Suicide Attempt _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Vision Loss _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Learning Disabilities _____ | |

SOCIAL HISTORY:

Do you drink alcohol? Yes How often: _____ No

Smoke: Every day Some Days Never Smoker Former Smoker Quit in _____

Smokeless Tobacco: Yes No Never Former Smokeless Tobacco - Quit all tobacco in (year): _____

By signing this medical history form, I attest that the information stated within is true and current medical history to the best of my knowledge, and I agree to contact/inform Southwest Orthopaedic Specialists medical staff or my provider of any medical changes to the information stated herein.

X _____
Signature of patient - Parent or Legal Guardian

Date

Print Name of Parent or Legal Guardian, if patient is a minor: _____