Southwest Orthopaedic & Reconstructive Specialists
southwestortho.com

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: _____

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:_____

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

*Updated 082019 - dh*

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*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)

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

SURGICAL HISTORY: (Check all that apply)

| | | |
|---|---|---|
| ☐Appendectomy | ☐Fracture Surgery | ☐Small Intestine Surgery |
| ☐Brain Surgery | ☐Gastrostomy | ☐Spine surgery |
| ☐Cosmetic Surgery | ☐Heart Surgery | ☐Tonsillectomy |
| ☐Ear tubes | ☐Hernia Repair | ☐Umbilical Hernia |
| ☐Eye Surgery | ☐Lymph Node Biopsy | ☐VP shunt |

Other: _____

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

| | | |
|---|---|---|
| ☐Alcohol abuse_____ | ☐Drug Abuse _____ | ☐Mental Illness _____ |
| ☐Arthritis_____ | ☐Early Death _____ | ☐Miscarriages _____ |
| ☐Birth Defect _____ | ☐Heart Disease _____ | ☐Suicide _____ |
| ☐Cancer_____ | ☐Hyperlipidemia _____ | ☐Suicide Attempt _____ |
| ☐COPD _____ | ☐Hypertension _____ | ☐Vision Loss _____ |
| ☐Depression _____ | ☐Kidney Disease _____ | ☐Other _____ |
| ☐Diabetes_____ | ☐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): _____

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**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:** _____