Gary B Anderson, MD
Joseph R Blythe, DO
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OKC ORTHOPEDICS SPORTS & PAIN MEDICINE

PATIENT INFORMATION

Patient's Last Name	First	Middle	Marital Status	Primary Care Physician
			❑ Single ❑ Married ❑ Widow	

Social Security Number	Mobile Phone	Other Phone	Birth Date	Age	Gender
	( )	( )	/ /		❑ Male ❑ Female

Street/Mailing Address	City	State / Zip

Email Address (required)	Spouse Name	Spouse Birth Date	Spouse Phone
		/ /	( )

Ethnicity	Race	Preferred Language
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White	❑ English ❑ Spanish ❑ Other:

Are you: (check one)	Employer	Employer Phone
❑ Employed ❑ Student ❑ Retired		( )

GUARANTOR (IF PATIENT IS A MINOR)

Person Responsible for Charges	Birth Date	Social Security Number	Phone
	/ /		( )

Address (if different)	Employer	Employer Phone
		( )

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD(S) TO THE RECEPTIONIST

Is the patient covered by health insurance? ❑ Yes ❑ No ❑ This injury is covered by Worker's Compensation

PRIMARY Insurance Company Name: _____ If SoonerCare: Aetna, Humana, or OK Complete Health

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

If the Patient is NOT the Subscriber:

⇨ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____

SECONDARY Insurance Company Name: _____ If SoonerCare: Aetna, Humana, or OK Complete Health

Who is the subscriber? ❑ Patient ❑ Spouse ❑ Parent/Guardian ❑ Other

If the Patient is NOT the Subscriber:

⇨ Subscriber's Name: _____ Subscriber's Birth Date: / / Subscriber's SSN: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone
		( )

HOW DID YOU HEAR ABOUT US?

❑ Doctor ❑ Attorney ❑ Family / Friend ❑ Hospital ❑ Internet Search ❑ Facebook ❑ Other _____

The above information is true to the best of my knowledge. I hereby authorize *Oklahoma City Orthopedics, Sports and Pain Medicine* to administer treatment to the above patient. I also authorize payment directly to *Oklahoma City Orthopedics, Sports and Pain Medicine* of the medical insurance benefits otherwise payable to me for medical services rendered. I understand I am financially responsible for any charges not covered by insurance.

X _____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

OKC ORTHOPEDICS
SPORTS & PAIN MEDICINE

Patient Privacy Notice
(Summary)
Effective August 2, 2017

In accordance with the Federal Privacy Law (HIPAA), *Oklahoma City Orthopedics, Sports and Pain Medicine* keeps medical information and records confidential and will only use them for patient treatment, health care operations, and billing purposes.

TREATMENT:	Our physicians, clinicians, and staff will use your medical information to give you the best possible care.
HEALTH CARE OPERATIONS:	*Oklahoma City Orthopedics, Sports and Pain Medicine* will use this information for appropriate follow-up care, patient notification, statistical and regulatory requirements, and internal quality assurance programs.
BILLING PURPOSES:	*Oklahoma City Orthopedics, Sports and Pain Medicine* will use your medical information to bill the appropriate third parties for your care.

DISCLOSURE OF INFORMATION WITH EXTENUATING CIRCUMSTANCES

1. Health information may be given to family members and/or friends in case of an emergency.
2. Health information may be given to other physicians or institutions, at the discretion of the physician, to facilitate diagnosis and treatment.
3. Information may be given to proper authorities when neglect or abuse is alleged or suspected.
4. Information may be provided to courts or other agencies when a subpoena is given to this office.

I understand that if I have any questions I can speak to the *Oklahoma City Orthopedics, Sports and Pain Medicine* Privacy Officer. I also understand that a detailed version of the *Patient Privacy Notice* is available upon request.

I understand and agree to the above Privacy Policy:

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

OKC ORTHOPEDICS
SPORTS & PAIN MEDICINE

Release of Medical Information
To Others Involved in Your Healthcare

As stated in our *Patient Privacy Notice*, we cannot disclose to members of your family, your friends, or other acquaintances any protected health information that directly relates to your health care unless we have written permission from you. We request that you designate the individuals with whom we may discuss your protected health information. **Other persons calling about your appointment, billing, or direct health care issues will be refused access to this information.**

I give *Oklahoma City Orthopedics, Sports and Pain Medicine* permission to discuss my protected health information with the following persons:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand that I may rescind or modify this permission at any time. Such changes must be in writing to *Oklahoma City Orthopedics, Sports and Pain Medicine*.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date

I do not want my medical records, including appointment times, released to anyone including my work/school, spouse, family members, or attorney. _____initial

OKC ORTHOPEDICS
SPORTS & PAIN MEDICINE

FINANCIAL AGREEMENT

1. We 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.**

2. You are responsible for payment of all medical treatment and related services and supplies provided. If payment is not made as agreed, you shall be responsible for any and all interest (at 1.5% per month or 18% per annum), reasonable attorney fees, costs of collection and court costs incurred in efforts to enforce this agreement.

3. **If you have insurance but did not bring your insurance ID card(s)** you will be set up on a self-pay account and you must pay for your visit at the time of service or your appointment will be rescheduled. Any overpayment on your account will be refunded after your insurance pays.

4. **There is a $25.00 charge for the completion of any patient-requested form such as *Family Medical Leave Act* (FMLA) forms, disability forms, etc.** This charge is applicable per form and is payable prior to completion. Please allow 7-14 days for form completion.

5. If you need to re-schedule or cancel your appointment, please contact us 48 hours prior to your scheduled office visit or 72 hours prior to a scheduled procedure or surgery. If we are not notified **a no-show charge of $50.00 for office visits or $100.00 for procedures/surgeries will apply.**

6. We may occasionally communicate with you via text message (SMS or iMessage). You may opt out by responding with your request via text message.

In keeping with our commitment to serve our patients in need of financial assistance, we have secured arrangements for patient financing through Care Credit® for your convenience. Ask a staff member or visit www.carecredit.com for details.

I, the undersigned, in consideration of goods and/or services rendered pursuant to this agreement, do hereby personally, individually, and severally guarantee the full payment of all sums of money due and owing to **Oklahoma City Orthopedics, Sports & Pain Medicine.** In addition, any sums of money that may become due and owing or past due according to the terms of this agreement shall be my responsibility.

Name: (Print) _____ Name: (Signature) _____

Date: _____

OKC ORTHOPEDICS
SPORTS & PAIN MEDICINE

NARCOTICS POLICY

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be refilled if you are unable to keep these appointments.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you. It is your responsibility to notify us of any other physician who is prescribing narcotic pain medication to you. It is also your responsibility to inform other physicians that we are prescribing and managing your narcotic pain medications.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are handled Monday through Thursday from 8:30 AM to 3:30 PM ONLY. **PRESCRIPTION REFILL REQUESTS ARE NOT PROCESSED ON FRIDAY, SATURDAY, SUNDAY, HOLIDAYS OR AFTER HOURS FOR ANY REASON**. Prescription refills will be processed within 5 business days of the request.
- Lost, stolen, or misplaced narcotic prescriptions or medications ARE NEVER REPLACED – NO EXCEPTIONS. Your medications and prescriptions are your responsibility.

Name: (Print) _____ **Name: (Signature)** _____

Date: _____

Thank you for allowing *Oklahoma City Orthopedics, Sports and Pain Medicine* to participate in your care.

Sincerely,

Oklahoma City Orthopedics, Sports and Pain Medicine Physicians and Staff

TODAY'S PROBLEM

Patient Name: _____

What is your current problem(s)? _____
Location: _____

Date of injury: _____ OR Date symptoms began: _____

How did the injury occur? _____

Current severity of a scale of 1-10: _____ Type of pain: _____

Associated Symptoms (circle): numbness radiating pain burning change in temperature change in color

Were you injured **on the job**? ❑ Yes ❑ No
Has a Worker's Compensation Claim been filed? ❑ Yes ❑ No
Were you injured in an accident?
Motor vehicle ❑ Yes ❑ No
Third party liability ❑ Yes ❑ No

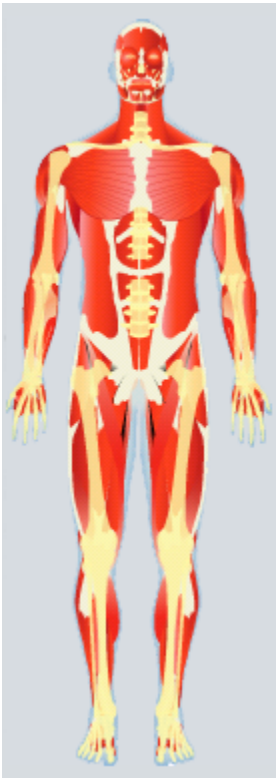
Are you represented by an attorney? ❑ Yes ❑ No
Attorney name: _____
Attorney phone #: _____

Have you been treated before for this injury? ❑ Yes ❑ No
If Yes, describe the treatment: _____

Were x-rays, MRI scans, or other tests done? ❑ Yes ❑ No
Did you bring films or a report with you? ❑ Yes ❑ No
Are you here for a second opinion about surgery? ❑ Yes ❑ No
ARE YOU IN PAIN MANAGEMENT? **❑ Yes ❑ No**

Please circle the location of pain we are seeing you for today.

Right



Left

Are you able to continue activity or work? ❑ Yes ❑ No

MEDICAL HISTORY

Height: ____ feet _____ inches Weight: _____ pounds Occupation: _____

ALLERGIES (check all that apply)

No allergies **_____***initial*

- ❑ Accupril (quinapril)
- ❑ Acetaminophen/Tylenol
- ❑ Acyclovir
- ❑ Advil (ibuprofen)
- ❑ Altace (ramipril)
- ❑ Ampicillin
- ❑ Amaryl (glimepiride)
- ❑ Augmentin (amoxicillin)
- ❑ Aspirin
- ❑ Bactrim (sulfamethoxazole)
- ❑ Biaxin
- ❑ Carafate (sucralfate)
- ❑ Ceclor (cefaclor)
- ❑ Celebrex
- ❑ Cephalosporins
- ❑ Cipro (ciprofloxacin)
- ❑ Clinoril (sulindac)
- ❑ Contrast media (ioversol)
- ❑ Codeine
- ❑ Coumadin
- ❑ Darvon
- ❑ Demerol
- ❑ Depakote
- ❑ DiaBeta (glyburide)
- ❑ Diamox
- ❑ Dicloxacillin
- ❑ Doxycycline
- ❑ Egg
- ❑ Erythromycin
- ❑ Famotidine
- ❑ Flagyl
- ❑ Floxin
- ❑ Glucotrol (glipizide)
- ❑ heparin
- ❑ Ibuprofen
- ❑ Inderal (propranolol)
- ❑ Indocin (indomethacin)
- ❑ Insulin (animal)
- ❑ Iodine or Shellfish
- ❑ Keflex (cephalexin)
- ❑ Klonopin
- ❑ Lasix (furosemide)
- ❑ Latex
- ❑ Levofloxacin
- ❑ Lidocaine
- ❑ Lipitor
- ❑ Lodine
- ❑ Lopressor (metoprolol)
- ❑ Lortab/Hydrocodone
- ❑ Micronase (glyburide)
- ❑ Minocin (minocycline)
- ❑ Morphine
- ❑ Motrin (ibuprofen)
- ❑ Naprosyn (naproxen)
- ❑ Neptazane
- ❑ Niacin
- ❑ Peanut
- ❑ Penicillin
- ❑ Percocet (oxycodone)
- ❑ Persantine
- ❑ Plavix
- ❑ Phenytoin
- ❑ Pravachol
- ❑ Prevacid
- ❑ Prilosec
- ❑ Prinivil
- ❑ Quinolones
- ❑ Ranitidine
- ❑ Septra (sulfamethoxazole)
- ❑ Sulfa
- ❑ Tagamet (cimetidine)
- ❑ Tegretol (carbamazepine)
- ❑ Tenormin (atenolol)
- ❑ Tetanus toxoid
- ❑ Tetracycline
- ❑ Ticlid
- ❑ Valium (diazepam)
- ❑ Vancomycin
- ❑ Vasotec
- ❑ Zestril
- ❑ Zithromax
- ❑ Zocor (simvastatin)
- ❑ Zyloprim (allopurinol)
- ❑ Other: _____

REVIEW OF SYSTEMS (check all that apply)

All are normal **_____***initial*

Constitutional
- ❑ Chills
- ❑ Fatigue
- ❑ Fever
- ❑ Night sweats
- ❑ Weakness
- ❑ Weight gain
- ❑ Weight loss
- ❑ Other: _____

Cardiovascular
- ❑ Chest pain
- ❑ Heart murmur
- ❑ Water retention/swelling
- ❑ Syncope (fainting)
- ❑ Other: _____

Skin
- ❑ Contact allergy
- ❑ Itchy skin
- ❑ Rash
- ❑ Skin infections
- ❑ Skin lesions
- ❑ Other: _____

Metabolic / Endocrine
- ❑ Cold intolerant
- ❑ Hair loss
- ❑ Heat intolerant
- ❑ Other: _____

Head/Eyes/Ears/Nose/ Throat
- ❑ Blurred vision
- ❑ Double vision
- ❑ Trouble Speaking
- ❑ Headache
- ❑ Hearing loss
- ❑ Ringing in ears
- ❑ Vision loss
- ❑ Other _____

Gastrointestinal
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Black tarry stools
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Jaundice/Yellow eyes, skin
- ❑ Loss of appetite
- ❑ Nausea/vomiting
- ❑ Other _____

Neurological
- ❑ Seizures
- ❑ Dizziness/ Vertigo
- ❑ Poor coordination
- ❑ Memory loss
- ❑ Paresthesia/Numbness
- ❑ Tremors
- ❑ Other _____

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia
- ❑ Mental Illness _____
- ❑ PTSD
- ❑ Other _____

Respiratory
- ❑ Chest pain (respiratory)
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Recent infections
- ❑ Known TB exposure
- ❑ Wheezing
- ❑ Other _____

Genitourinary
- ❑ Pain with urination
- ❑ Frequent urination
- ❑ Hematuria/Blood in Urine
- ❑ Other _____

Immunological
- ❑ Asthma
- ❑ Bee sting allergies
- ❑ Contact dermatitis
- ❑ Environmental allergies
- ❑ Food allergies
- ❑ Seasonal allergies
- ❑ Other _____

PAST MEDICAL HISTORY (check all that apply) *No major illness_____initial*

- ❑ Aids/HIV
- ❑ Alcoholism
- ❑ Alzheimer's
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ Benign prostatic hypertrophy
- ❑ Cancer _____
- ❑ CVA/Stroke
- ❑ Congestive heart failure
- ❑ COPD
- ❑ Coronary artery disease
- ❑ Crohn's disease
- ❑ Degenerative joint disease
- ❑ Depression
- ❑ Diabetes _____
- ❑ Drug abuse
- ❑ DVT / Blood Clot
- ❑ Fibromyalgia
- ❑ Gall bladder disease
- ❑ GERD/Heartburn
- ❑ Gout
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Inflammatory bowel disease
- ❑ Juvenile rheumatoid arthritis
- ❑ Kidney disease
- ❑ Liver disease
- ❑ **METAL IN YOUR BODY**
- ❑ Migraine headaches
- ❑ Multiple sclerosis
- ❑ MI / Heart Attack
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parkinson disease
- ❑ Peptic ulcer disease
- ❑ Psoriasis
- ❑ PVD/Circulation Problems
- ❑ Renal disease
- ❑ Rheumatoid arthritis
- ❑ Scoliosis
- ❑ Seizure disorder
- ❑ Sleep apnea
- ❑ SLE / Lupus
- ❑ Spinal stenosis
- ❑ Spondyloarthropathy
- ❑ Thyroid disease
- ❑ Valvular disease
- ❑ Other _____

PAST SURGICAL HISTORY (check all that apply) *No past surgeries_____initial*

- ❑ ACL surgery
- ❑ Angioplasty
- ❑ Angio w/stent
- ❑ Appendectomy
- ❑ Arthroscopy ankle
- ❑ Arthroscopy elbow
- ❑ Arthroscopy hip
- ❑ Arthroscopy knee
- ❑ Arthroscopy wrist
- ❑ Arthroscopy shoulder
- ❑ Back surgery
- ❑ CABG/Heart Bypass
- ❑ Cardiac valve replacement
- ❑ Carpal tunnel release
- ❑ Cataract extraction
- ❑ Gallbladder Removal
- ❑ Colonoscopy
- ❑ Discectomy
- ❑ Gastric bypass
- ❑ Hernia repair
- ❑ Hip arthroplasty
- ❑ Hip replacement
- ❑ Knee replacement
- ❑ Laminectomy
- ❑ LASIK
- ❑ Meniscus surgery
- ❑ Muscle biopsy
- ❑ ORIF/Fracture Repair
- ❑ **PACEMAKER**
- ❑ Small bowel resection
- ❑ Thyroidectomy
- ❑ Tonsillectomy
- ❑ Cesarean section
- ❑ Hysterectomy
- ❑ Tubal Ligation
- ❑ Mastectomy
- ❑ Other _____

FAMILY HISTORY (check all that apply)

- ❑ ADD/ADHD
- ❑ Alcoholism
- ❑ Allergies
- ❑ Alzheimer's Disease
- ❑ Anemia
- ❑ Asthma
- ❑ Blood disease
- ❑ Cancer Bone
- ❑ CAD/Coronary Artery Disease
- ❑ Cancer _____
- ❑ Colitis
- ❑ Congenital heart disease
- ❑ Congestive heart failure
- ❑ COPD
- ❑ CVA (stroke)
- ❑ Depression
- ❑ Developmental delay
- ❑ Diabetes _____
- ❑ Drug abuse
- ❑ Gout
- ❑ Hearing impairment
- ❑ Heart disease
- ❑ Hodgkin's disease
- ❑ Hypertension
- ❑ Kidney disease
- ❑ Learning disability
- ❑ Liver disease
- ❑ Mental illness
- ❑ Migraines
- ❑ Muscle disease
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Parkinson's
- ❑ PVD/Circulation Problems
- ❑ Renal disease
- ❑ Seizure disorder
- ❑ Thyroid disorder
- ❑ Other: _____

SOCIAL HISTORY

Hand dominance? ❑ Left ❑ Right

Are you pregnant? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No ❑ Formerly

Drink Alcohol? ❑ Yes ❑ No ❑ Formerly

Medications

To improve the accuracy of your medical record, we will attempt to securely obtain a list of your medications from your pharmacy network(s). Our health record system will electronically request the information. If you prefer that we NOT request this information, check the box below:

❑ **DO NOT** request my list of medications

Please list **ALL** of your medications including medications not related to your orthopedic problem. (If you have a list of your medications, please allow the receptionist to make a copy.)

Medication	**Dose**	**Prescribed by**

I am taking no medications of any kind. _____*initial*

My Preferred Pharmacy

Pharmacy name: _____ Phone #: _____

Address (if known): _____ City: _____