PATIENT PHONE NUMBERS

Primary Phone #: ____________________

Secondary Phone #: __________________

McBRIDE ORTHOPEDIC HOSPITAL CLINIC

ACCT# ____________________

Physician: ____________________

Date: ____________________

NAME: ____

DOB: ____________ **AGE:** ________ **SEX:** ☐ M ☐ F **HEIGHT:** ________ **WEIGHT:** ________ **HAND DOMINANCE:** ☐ Left ☐ Right ☐ Ambidextrous

DOCTOR USE ONLY:	**ENCOUNTER:** ☐ Initial ☐ Subsequent ☐ Sequelae
	BMI: ________ Blood Pressure: ________ / ________ Temp: ________ Pulse: ________

CHIEF COMPLAINT:

Main reason for today's visit: ____

☐ Left ☐ Right ☐ Both Date Symptoms Began/Date of Injury: ____________________

Date previously treated for this problem: ____________________ Treating Physician: ____________________

Previous Test Results? ☐ X-rays ☐ MRI ☐ CT Scan ☐ DEXA ☐ Other: ____________________

What is your pain level? » 0 1 2 3 4 5 6 7 8 9 10 «
(*No Pain*) (*Worst Pain*)

Describe your pain (i.e. aching, burning, shooting, throbbing) ____________________

What makes the pain worse? ____________________

What makes the pain better? ____________________

What treatments have you tried? (i.e. medications, injections, physical therapy, etc.) ____________________

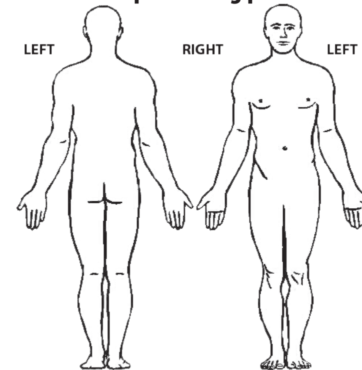
____

Please describe your illness/symptoms: ____________________

____

____

Please shade the areas where you are experiencing pain:



FOR NEW INJURIES:

What activity were you doing or what caused the injury? ____________________

____

Where were you at time of injury? ____________________

Did injury occur On the Job? ☐ Y ☐ N If yes, Employer at time of injury: ____________________

If yes, in what state did accident/injury occur: ____________________

Was this an auto accident? ☐ Y ☐ N If yes, in what state did accident occur: ____________________

MEDICAL HISTORY: Check if NONE ☐

☐ Y ☐ N Emphysema/COPD
☐ Y ☐ N Sleep Apnea
☐ Y ☐ N Abnormal Chest X-Ray
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Atrial Fibrillation
☐ Y ☐ N Heart Attack
☐ Y ☐ N Coronary Artery Disease
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N High Cholesterol
☐ Y ☐ N Anticoagulant Therapy

☐ Y ☐ N Blood Disease (Anemia, etc.)
☐ Y ☐ N Abnormal Bleeding Tendencies
☐ Y ☐ N Blood Vessel Disease (Phlebitis)
☐ Y ☐ N Positive HIV/AIDS Blood Test
☐ Y ☐ N Jaundice
☐ Y ☐ N Mononeucleosis
☐ Y ☐ N Glaucoma
☐ Y ☐ N Stroke
☐ Y ☐ N Epilepsy
☐ Y ☐ N Seizures
☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Bladder Infections

☐ Y ☐ N Enlarged Prostate
☐ Y ☐ N Kidney Disease/Dialysis
☐ Y ☐ N Stomach Ulcers
☐ Y ☐ N Irritable Bowel Syndrome
☐ Y ☐ N Heartburn/GERD
☐ Y ☐ N Hepatitis | Type: ____________
☐ Y ☐ N Diabetes | Type: ____________
☐ Y ☐ N Cancer | Where: ____________
☐ Y ☐ N Current or History of Pulmonary Embolism
☐ Y ☐ N Current or History of Deep Vein Thrombosis
☐ Y ☐ N Arthritis | Type: ____________
☐ Y ☐ N Mental Disorders | List: ____________
☐ Y ☐ N Have you ever had a pneumonia shot?
Year of last pneumonia shot: ____________

Other Medical Illness | List: ____

____

PT NAME______________________

ACCT#______________________

LIST OF PREVIOUS SURGERIES/HOSPITALIZATIONS: **Check if NONE** ☐

Surgery/Reason for Hospitalization/Date	**Surgery/Reason/Date**
1.	5.
2.	6.
3.	7.
4.	8.

LIST OF CURRENT MEDICATIONS: **Check if NONE** ☐

(Please include prescription, drugs and/or non-prescription medications, including over-the-counter and vitamins/supplements)

Medication Name/Dose/Frequency	**Medication/Dose/Frequency**
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

ALLERGIES: **Check if NONE** ☐ (Please include medication and/or food allergies)

List Medication/Allergies/Reaction	**Medication/Allergies/Reaction**
1.	4.
2.	5.
3.	6.

Have you ever had a blood transfusion? ☐ Y ☐ N

Have you ever had general anesthesia? ☐ Y ☐ N

Have you ever had problems with anesthesia? ☐ Y ☐ N If yes, please explain:______________________

____

Are you allergic to any metals? ☐ Y ☐ N If yes, please list:______________________

FAMILY HISTORY: **Check if UNKNOWN** ☐

(parents, grandparents, siblings)

☐ Y ☐ N Heart Disease
☐ Y ☐ N Cancer
☐ Y ☐ N Diabetes
☐ Y ☐ N Dementia
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Stroke
☐ Y ☐ N Blood Clots
☐ Y ☐ N Lung Disease
☐ Y ☐ N Kidney Disease

Other:______________________

SOCIAL HISTORY:

☐ Married ☐ Divorced ☐ Single ☐ Widowed

☐ Y ☐ N Do you live alone?

If not, with whom:______________________

Residence:______________________

☐ Working ☐ Disabled ☐ Retired ☐ Student

Occupation:______________________

☐ Y ☐ N Pregnant or Nursing?

\# of months:____________

☐ Never Smoked or Chewed Tobacco

☐ Current User: Type______________

How often: __________ per day

☐ Quit Date (smoking or chewing):

____

Are you regularly exposed to tobacco smoke? ☐ Y ☐ N

If Yes, How? ☐ At Home ☐ At Work

Have you been diagnosed with a tobacco-related illness? ☐ Y ☐ N

If Yes, illness: ______________________

Do you drink alcohol? ☐ Yes ☐ No

How much?______________________

How often?______________________

☐ Y ☐ N Do you currently use or have a history of illicit substance use?

PT NAME________________________

ACCT#__________________________

REVIEW OF SYSTEMS:

MUSCULOSKELETAL
(Other than the reason you are here today)
Check if NONE ☐
☐ Y ☐ N Joint Pain/Stiffness
☐ Y ☐ N Joint Swelling
☐ Y ☐ N Back Pain
☐ Y ☐ N Difficulty Walking

CARDIOVASCULAR
Check if NONE ☐
☐ Y ☐ N Chest Pain/Tightness
☐ Y ☐ N Irregular Heartbeat
☐ Y ☐ N Swelling of Feet or Legs

RESPIRATORY
Check if NONE ☐
☐ Y ☐ N Oxygen at Home
☐ Y ☐ N Cough
☐ Y ☐ N Wheezing
☐ Y ☐ N Snoring
☐ Y ☐ N Shortness of Breath

ENDOCRINE
Check if NONE ☐
☐ Y ☐ N Excessive Thirst
☐ Y ☐ N Excessive Urination
☐ Y ☐ N Heat/Cold Intolerance

HEME/LYMPH
Check if NONE ☐
☐ Y ☐ N Easily Bruised
☐ Y ☐ N Bleeds Easily
☐ Y ☐ N Swollen Lymph Nodes

CONSTITUTIONAL
Check if NONE ☐
☐ Y ☐ N Fever/Chills
☐ Y ☐ N Fatigue/Weakness
☐ Y ☐ N Weight Loss/Gain

GASTROINTESTINAL
Check if NONE ☐
☐ Y ☐ N Nausea/Vomiting
☐ Y ☐ N Constipation
☐ Y ☐ N Diarrhea

GENITOURINARY
Check if NONE ☐
☐ Y ☐ N Incontinence
☐ Y ☐ N Frequent Urination
☐ Y ☐ N Painful Urination

EARS, NOSE, THROAT, MOUTH
Check if NONE ☐
☐ Y ☐ N Difficulty Hearing
☐ Y ☐ N Difficulty Swallowing
☐ Y ☐ N Dentures

SKIN
Check if NONE ☐
☐ Y ☐ N Rashes
☐ Y ☐ N Dryness
☐ Y ☐ N Open Sores

NEUROLOGICAL
Check if NONE ☐
☐ Y ☐ N Headaches
☐ Y ☐ N Numbness/Tingling
☐ Y ☐ N Tremors

PSYCHIATRIC
Check if NONE ☐
☐ Y ☐ N Feelings of Depression
☐ Y ☐ N Anxiety
☐ Y ☐ N Nervousness

Family Physician: ________________________ Phone:________________

Cardiologist:________________________ Phone:________________

Referring Physician: ________________________ Phone:________________

Other Physician(s): ________________________ Phone:________________

Preferred Pharmacy:________________________ Phone:________________
(*include address/city*)

COMPLETED BY: ________________________ **DATE:** ____________

PATIENT SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

PHYSICIAN SIGNATURE:________________________ **DATE:** ____________

OFFICE USE ONLY:

1. ENCOUNTER:
   ☐ Initial ☐ Subsequent ☐ Sequelae
2. UDPATE ROS
3. BMI
4. LATERALITY & SPECIFICITY
5. ☐ ACUTE CONDITION
   ☐ CHRONIC CONDITION
6. FOR NEW INJURIES
   - Activity
   - External Cause
   - Place of Occurence
7. IF SEQUELAE, LIST LATE EFFECTS
8. FOR FRACTURES:
   - Type
   - Localization
   - Classification
   - Laterality
   - Displacement
   - Healing
9. RESPONSE TO CONSERVATIVE TREATMENTS

I am seeing Dr./PA/APRN ______________________

ACCT# ______________________

Date ______________________

PATIENT INFORMATION: (Please Print)

Last Name: ______________ First Name: ______________ Middle Initial: ________ Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

DOB: ____________ Age: ________ Soc. Sec. #: ______________________ Ethnicity: ☐ Latino/Hispanic ☐ Other

Address: ______________________________ City: ____________ State: ______ Zip: ________

Home Phone: ________________ Cell #: ________________ Preferred #: ☐ Home ☐ Cell ☐ Work

E-mail: ______________________________

What is your race? ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Black ☐ White ☐ Other ☐ Unknown

Preferred Language? ☐ English ☐ Spanish ☐ Other, Please Specify: ______________________

Employer: ______________________________ Work Phone: ________________

Employer Address: ______________________________

SPOUSE OR PERSON RESPONSIBLE FOR BILL: (If Minor, Parent or Guardian Information)

Name: ______________________ SS# ______________ Phone: ______________

DOB: ______________ Relationship to Patient: ______________________

Address: ______________________________ City: ____________ State: ______ Zip: ________

Employer: ______________________________ Work Phone: ____________ Ext: ________

INSURANCE:

	PRIMARY	SECONDARY
Ins. Co. Name:		
Policy Holder:		
Employer the policy is through:		
Group No: ________ Policy No:		
SS#: ________ DOB:		

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY: (Not living with patient)

Name: ______________________ Relationship to Patient: ______________

Address: ______________________________ Phone: ______________

THE FOLLOWING INFORMATION IS REQUIRED FOR PROPER FILING OF YOUR INSURANCE CLAIM:

What body part are we seeing you for today? ______________________ ☐ Right ☐ Left ☐ Both

Is this visit due to an accident/injury? ☐ Yes ☐ No If yes, when did the accident/injury occur? ______________

In what state did the accident/injury occur? ______________________

Is this work related? ☐ Yes ☐ No Employer at time of injury: ______________________

How did the accident/injury happen? ______________________

Do you have X-rays? ☐ Yes ☐ No Referring Physician: ______________________

I hereby authorize release of information for insurance claim purposes.

I fully agree and understand that payment is due at the time of service. I fully agree that I am responsible for all services and co-payments not covered by my insurance company. Financial arrangements, if needed, should be made prior to treatment.

______________________ ______________________________

Date **Patient, Parent or Legal Guardian's Signature**

Photostat of the above is as valid as the original.

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

Patient Name: ____

Last First MI Maiden or Other Name

Date of Birth:____/____/_____ SS#: _____/____/_______ Medical Record #:________________________

MO DAY YR

Address:_________________________________ City:____________________State______Zip__________

Day Phone: ______________________________________Evening Phone: ______________________________

With your permission, McBride Orthopedic Hospital Clinic may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, McBride Orthopedic Hospital Clinic may tell a family member when your next medical appointment is scheduled, the results of a laboratory test or a procedure or provide the person with a copy of a prescription. By completing the top portion of this form, you are authorizing release of this information to these individuals. However, you are not authorizing McBride Orthopedic Hospital Clinic to provide extensive information about your medical history or copies of information from your medical record. If you wish to have this information disclosed, you must complete a separate authorization form. Please be aware that McBride Orthopedic Hospital Clinic may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name:________________________________ Phone #:___________________ Relationship:_________________ Date of Birth:_______________

Name:________________________________ Phone #:___________________ Relationship:_________________ Date of Birth:_______________

Name:________________________________ Phone #:___________________ Relationship:_________________ Date of Birth:_______________

Name:________________________________ Phone #:___________________ Relationship:_________________ Date of Birth:_______________

- **By signing, I acknowledge that I have received a copy of McBride Orthopedic Hospital Clinic's Notice of Privacy Practices/Patient Rights & Responsibilities, as required by HIPAA.**
- **I understand that if I want to make any changes to the information listed above, I must contact McBride Orthopedic Hospital Clinic to revoke this form in its entirety or complete a new form.**

____

Patient Name (Please Print)

____ ____

Signature of Patient Date

____ ____

Parent/Legal Guardian/Authorized Person Date

McBride Orthopedic Hospital

Patient # ____________________

FINANCIAL POLICY

We are committed to providing you with the best possible medical care. If you have special needs, we can assist you. The following information is provided to avoid any misunderstanding concerning payment for professional services.

- McBride Orthopedic Hospital Clinic participates in numerous insurance plans. **It is your responsibility to:**
    - Bring your insurance card to every visit.
    - Be prepared to pay your co-pay at each visit. Payment can be made by cash, check, Visa, Discover or MasterCard.
    - Be prepared to make **payment in full at the time of visit** for medical care not covered under your insurance. This includes deductibles, co-pays and any non-covered expenses.
- If you have insurance in which we do not participate, we are happy to file the claim; however, payment of deductibles and any other non-covered expenses is necessary at the time of service.
- All surgical procedures, hospital services, or therapeutic services which require ongoing visits will have insurance benefits verified in advance and benefits estimated.
- It is your responsibility to bring any required **referrals or authorizations for treatment** with you on or prior to your visit. If you have not provided us with an authorization, or if we are unable to obtain authorization, you will be given the option to reschedule your visit or pay at the time of service.
- If you do not have insurance, you were provided with an amount to bring with you as a deposit for your visit today. After your visit, we will send you a statement for any balance which remains after application of this deposit to your account.
- If the patient is a minor (younger than 18 years old), the parent or guardian must sign below.
- There is a $25 charge for completion of paper or electronic insurance or disability forms. This is due at time of service.
- McBride Orthopedic Hospital Clinic is a Hospital-Based Outpatient Department. Receiving ancillary services (e.g., x-rays, infusions, injections, casts, etc.) at this Clinic may result in a facility charge for that ancillary service as well as a professional charge for the physician/ physician assistant/nurse practitioner interpretation or administration of that service.
- If you have questions about your insurance or any other financial arrangements, please contact the McBride Orthopedic Hospital Clinic Business Office at 405-230-9226.
- I fully agree and understand that payment is due at the time of service. I fully agree that I am responsible for all services and copayments not covered by my insurance company. Financial arrangements, if needed, will be made prior to treatment.
- I hereby authorize release of information for insurance claim purposes.
- McBride Orthopedic Hospital Clinic firmly believes that a good clinic/patient relationship is based upon understanding and good communications. **Please sign that you have read and agree to this Financial Policy.**

____ ____________________

Signature of Patient or Responsible Party Date

____

(Print Name)