

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) _____

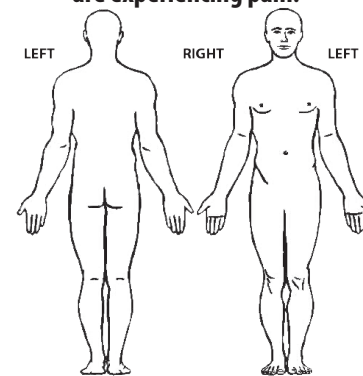
What makes the pain worse? _____

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: _____

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 Stroke
- Y N Cancer Y N Blood Clots
- Y N Diabetes Y N Lung Disease
- Y N Dementia Y N Kidney Disease
- Y N High Blood Pressure
- 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?

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:
<input type="checkbox"/> Initial <input type="checkbox"/> Subsequent <input type="checkbox"/> Sequelae | 6. FOR NEW INJURIES
- Activity
- External Cause
- Place of Occurrence | 8. FOR FRACTURES:
- Type
- Localization
- Classification
- Laterality
- Displacement
- Healing |
| 2. UPDATE ROS | 7. IF SEQUELAE, LIST LATE EFFECTS | 9. RESPONSE TO CONSERVATIVE TREATMENTS |
| 3. BMI | | |
| 4. LATERALITY & SPECIFICITY | | |
| 5. <input type="checkbox"/> ACUTE CONDITION
<input type="checkbox"/> CHRONIC CONDITION | | |

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

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

Home Phone: _____ DOB: _____ Age: _____ Soc. Sec. #: _____

Cell #: _____ E-mail: _____

Ethnicity: Latino/Hispanic Other

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

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

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)