OKLAHOMA CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

PLEASE PRINT

M. Sean O'Brien, D.O. | Kevin Mason, PA-C

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone

Last	First	Middle	Sex
			❑ M ❑ F

Address	City	State	Zip

Home Telephone	Age	Birthdate	Marital Status	SS#
( )		/ /	S M W D DEP	— —

Employer/School	Address	City	State	Zip

Work Phone & Ext.	Cell Phone	Pager	E-Mail
( )			

Patient's Nearest Relative (Other than Spouse)	Relation	Home Phone	Work Phone & Ext.
		( )	( )

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient	Home Telephone
		( )

Address	City	State	Zip

Employer	SS#	Birthdate	Age	Work Phone & Ext.
	— —	/ /		( )

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance	Insurance Type		
	❑ Group	❑ Individual	❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate	Patient Relation to Insured				Insured's Sex		Insured's SS#
/ /	❑ Self	❑ Spouse	❑ Child	❑ Other	❑ M	❑ F	— —

Insured's Employer	Telephone & Ext.
	( )

Secondary Insurance	Insurance Type		
	❑ Group	❑ Individual	❑ Cobra

Address	City	State	Zip

Insured's Name on Card	I.D. #	Group #

Insured's Birthdate	Patient Relation to Insured				Insured's Sex		Insured's SS#
/ /	❑ Self	❑ Spouse	❑ Child	❑ Other	❑ M	❑ F	— —

Insured's Employer	Telephone & Ext.
	( )

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Oklahoma Center for Orthopaedic & Sports Medicine. I understand I am financially responsible for any charge not covered by my insurance.

PATIENT OR AUTHORIZED PERSON

DATE

Reorder From B.M.S.I. (405) 685-0177 • OKC266- Form # R-0003 (Rev. 07/12)

Oklahoma Center for Orthopaedics & Sports Medicine
3110 S.W. 89th, Suite 200C
Oklahoma City, OK 73159
Fax (405) 759-3827

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Telephone (405) 759-2663

NEW PATIENT QUESTIONNAIRE

DATE:

NAME:		PHONE:	
AGE:	SEX:	HEIGHT:	WEIGHT:
RACE/ETHNICITY:		LANGUAGE:	
FAMILY PHYSICIAN:		REFERRED BY:	
REASON FOR VISIT:		**IS THIS INJURY WORK RELATED?** ☐**YES** ☐**NO**	
R/L/BIL		OCCUPATION:	

DATE OF ONSET/INJURY(INSURANCE REQUIRES APPROX. DATE) **MO.**_____ **DAY**_____ **YEAR**_____

HAND DOMINANCE	**CURRENT LEVEL OF FUNCTION**	**CURRENT LEVEL OF PAIN**
RIGHT / LEFT	0-100 (0 BEING WORST) _____	0-10 (10 WORST) _____

HAVE YOU SEEN A DOCTOR IN THE PAST FOR THIS PROBLEM? YES/NO WHO, WHEN, WHERE?

EXPLAIN YOUR CONDITION OR HOW YOUR INJURY OCCURRED:

WHAT TREATMENT HAVE YOU HAD? (PLEASE CIRCLE)
REST / MEDICATION / THERAPY / INJECTIONS / OTHER: _____

HAVE YOU HAD ANY PREVIOUS DIAGNOSTIC TESTS? (PLEASE CIRCLE)
MRI / X-RAY / CT SCAN / OTHER: _____

CIRCLE ANY MEDICAL PROBLEMS LISTED THAT YOU HAVE OR HAVE HAD IN THE PAST:

NO KNOWN MEDICAL PROBLEMS	HIGH BLOOD PRESSURE	HEART DISEASE/HEART ATTACK
LIVER DISEASE/HEPATITIS	DIABETES	COPD/EMPYSEMA
ULCERS	CANCER	TUBERCULOSIS
THYROID DISEASE	IMMUNE DISORDER	BONE INFECTION
PERIPHERAL VASCULAR DISEASE	ASTHMA	SEIZURE DISORDER
STROKE	SLEEP APNEA	OVERWEIGHT / OBESITY

OTHER: _____

TOBACCO USAGE? YES / NO
PACKS PER DAY _____ HOW MANY YEARS_____

ALCOHOL USAGE?
NONE / OCCASIONAL / DAILY / >4 DRINKS/DAY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?

NONE KNOWN	CANCER	LEUKEMIA	CORONARY ARTERY DISEASE
RHEUMATIC FEVER	DIABETES	HYPOTHYROIDISM	HIGH BLOOD PRESSURE
TUBERCULOSIS	COLITIS	STROKE	BLEEDING TENDENCY
ASTHMA	SEIZURES	OTHER: _____	

WHAT SURGERIES HAVE YOU HAD IN THE PAST?

NO PREVIOUS SURGERY	HYSTERECTOMY	MASTECTOMY	APPENDECTOMY
HERNIA REPAIR	CABG/OPEN HEART	GALL BLADDER	CATARACT EXTRACTION
PROSTATE SURGERY	LUMBAR SPINE SURGERY	TONSILLECTOMY	OTHER: _____

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REVIEW OF SYSTEMS

NAME: _____ D.O.B. _____

PLEASE CIRCLE ALL THAT CURRENTLY APPLY

GENERAL, CONSTITUTIONAL:

GOOD GENERAL HEALTH
RECENT WEIGHT CHANGE
FATIGUE
FEVER

EYES AND VISION:

WEAR GLASSES/CONTACTS
BLURRED/DOUBLE VISION
EYE DISEASE OR INJURY
GLAUCOMA/CATARACT

EARS, NOSE, THROAT:

SWOLLEN GLANDS IN NECK
EARACHES OR DRAINAGE
SINUS PROBLEMS
RINGING IN EARS
HEARING LOSS
NOSE BLEEDS

RESPIRATORY:

SHORTNESS OF BREATH
ASTHMA OR WHEEZING
FREQUENT COUGHING
SPITTING UP BLOOD

CARDIOVASCULAR:

SWELLING OF EXTREMITIES
IRREGULAR HEARTBEAT
HEART TROUBLE
CHEST PAINS

GASTROINTESTINAL:

CHANGE IN BOWEL MOVEMENTS
NAUSEA/VOMITING/DIARRHEA
LOSS OF APPETITE
CONSTIPATION
BLOOD IN STOOL
ULCERS

GENITOURINARY:

BURNING/PAINFUL URINATION
STRAIN WITH URINATION
FREQUENT URINATION
BLOOD IN URINE
KIDNEY STONES
INCONTINENCE
FREQUENT UTI

MUSCULOSKELETAL:

JOINT PAIN/STIFFNESS/SWELLING
WEAKNESS OF MUSCLES/JOINTS
CHANGE IN HAT OR GLOVE SIZE
MUSCLE PAIN OR CRAMPS
DIFICULTY WALKING
COLD EXTREMITIES
BACK PAIN

NEUROLOGICAL:

LOSS OF CONSCIOUSNESS
LIGHT HEADED OR DIZZY
NUMBNESS OR TINGLING
SEIZURE OR STROKE
SEVERE HEADACHES
HEAD INJURY
PARALYSIS
TREMORS

PSYCHIATRIC:

MEMORY LOSS/CONFUSION
SLEEP PROBLEMS
NERVOUSNESS
DEPRESSION

ENDOCRINE:

EXCESSIVE THIRST/URINATION
GLAND/HORMONE PROBLEM
HEAT/COLD INTOLERANCE
CHANGE IN SKIN COLOR
THYROID DISEASE
RASH OR ITCHING
DIABETES
DRY SKIN

LYMPHATIC/ HEMATOLOGICAL:

EASILY BRUISE OR BLEED
SLOW TO HEAL AFTER CUT
TRANSFUSION REACTIONS
PHLEBITIS/BLOOD CLOTS
SWOLLEN GLANDS
ANEMIA

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MEDICATION / ALLERGY SHEET

NAME: _____ D.O.B. _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?
PLEASE INCLUDE BOTH PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS:

MEDICATION	**DOSE**	**# TIMES A DAY**

CIRCLE ANYTHING LISTED BELOW TO WHICH YOU ARE ALLERGIC:

NO KNOWN DRUG ALLERGIES
PENICILLIN
TETRACYCLINE
SULFA
MORPHINE
CODEINE
IODINE / BETADINE
RADIOGRAPHIC DYES
ADHESIVE TAPE
ERYTHROMYCIN
OTHER (SPECIFY):

_____

_____

_____

_____

_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of
(Patient Name)
Oklahoma Center for Orthopaedic Excellence & Sports Medicine's Notice of Privacy Practices. This Notice describes how Oklahoma Center for Orthopaedic Excellence & Sports Medicine may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of Patient, or Personal Representative Date

_____
Relation to Patient

ACCESS TO MEDICAL RECORDS

The person or persons listed below may have access to my medical records.

_____ _____
Name Relation to Patient

_____ _____
Name Relation to Patient

CONSENT TO DISCUSS DIAGNOSIS AND TREATMENT WITH ATHLETIC TRAINER

☐ I authorize OCO to discuss my diagnosis and treatment with my school's athletic training staff.

I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreement by signing below.

_____ _____
Patient Date

_____ _____
Parent or Guardian Date
(if patient is under 18 years of age)

PHARMACY INFORMATION

Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy we have on file for you.

Attn Tricare pts: Please note that we are not able to call-in, fax, or E-prescribe prescriptions to military post/base pharmacies. You we need to provide us with a civilian pharmacy that accepts your insurance.

Pharmacy: _____

Address: _____

Phone: _____

<u>All questions must be filled in. Please do not leave blank.</u>

I _____ **understand that I can only use one pharmacy for prescriptions to be called in from this office.**

Signature _____