OKLAHOMA CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

OCO

PATIENT MEDICATION INFORMATION FORM.

DATE: ___/___/_____

NAME: _____ **DOB:** ___/___/_____

****What body part are you being seen for?** _____

_____ **RT | LT | BILATERAL**

Circle any known medication allergy:

NO KNOWN DRUG ALLERGIES Codeine Penicillin Sulfa Antibiotics

Iodine/Betadine Latex Tetracycline Radiographic Dyes

Morphine Adhesives NSAIDS OTHER ALLERGIES NOT LISTED (SPECIFY):

_____

_____.

****Please list any current medications.** ***(Include both Prescriptions and Over the Counter medications):***

Medication/Dose/# of times per day:	Medication/Dose/# of times per day:
Last day flu vaccine date: ___/___/_____.	Have you been fully vaccinated for COVID? YES: ☐ NO: ☐ Date of last dose: ___/___/_____.

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OCO

NAME:	DOB: ___/___/_____
HEIGHT: _____ WEIGHT: _____ PRIMARY LANGUAGE: _____	RACE/ETHNICITY: _____ _____.
FAMILY CARE PHYSICIAN: _____	WHO REFERRED PATIENT TO OUR OFFICE? _____
IS THIS INJURY WORK RELATED? Yes: ☐ No: ☐ Occupation:_____	Date of injury/Approx. date of injury? __/__/_____ *(**must have a date documented for insurance purposes**)*
Have you been treated for this problem previously? YES: ☐ NO: ☐ If yes- what doctor provided treatment? _____ _____. Approx. dates of treatment? ___/___/_____ What treatment did you have? (Please circle) Rest | Medication | Therapy | Injections | Other _____ _____ _____.	Please explain your symptoms… was this condition related to an injury, describe your symptoms? Was this a sudden onset or gradual? _____ _____ _____ _____ _____ _____ _____ _____ NO KNOWN INJURY: ☐ Have you had previous diagnostic tests? *(Circle all that apply):* MRI | X-Ray | CT Scan | Other

Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy on file. *Please note we CANNOT send medications to Sam's Club/Wal-Mart.*

PREFERRED PHARMACY & PHARMACY LOCATION:

Name of Pharmacy_____

RX Cross Street/City/Phone #: _____

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

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.

Pharmacy: _____

Address: _____

Phone: _____

All questions must be filled in. Please do not leave blank.

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

Signature _____

Dear Valued Patient,

On November 1, Oklahoma joined several states in a nationwide movement to restrict opioid and Schedule II medications prescribed for managing pain. **In order to be in compliance with this new law, we are required to change our clinic policies regarding the prescribing of pain medication.** You will need to continue attending your follow up appointments as suggested, but the frequency of those appointments could change. Oklahoma SB 1446 places patients into one of two categories, Acute Pain (temporary) or Chronic Pain (on-going). You will be required to sign a Patient / Provider Agreement prior to receiving a Schedule II medication.

- Acute Pain: SB 1446 places a 7 day supply limit on your initial prescription. If you need an additional 7 day supply, an assessment by your physician, physician assistant or nurse practitioner is required. If you need an additional supply of pain medication, you must be assessed for chronic pain and laws regarding prescribing pain medication for chronic pain will apply.

- Chronic Pain: SB 1446 requires patients to be assessed by the prescribing physician prior to an initial prescription and by either the prescribing physician, physician assistant or nurse practitioner prior to every prescription renewal and every 90 days as well. Your insurance company and your pharmacy may also impact prescription refill timing and limits as well.

Again, the change in our prescription refill policies is required for us to be in compliance with Oklahoma SB 1446.

We appreciate your understanding!

(Patient Signature) (Date)

DISCLOSURE OF PHYSICIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. M. Sean O'Brien has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian

Dated: _____