OKLAHOMA CENTER FOR ORTHOPAEDIC & SPORTS MEDICINE

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

PLEASE PRINT

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 CAPP (405) 685-0177 • OKC266- Form # R-0003 (Rev. 6/22)

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

M. Sean O'Brien, D.O.
Kevin Mason, PA-C
Telephone (405) 759-2663

NEW PATIENT QUESTIONNAIRE

DATE:

NAME:			DOB / /
PHONE:		EMAIL:	
AGE:	SEX:	HEIGHT:	WEIGHT:
RACE/ETHNICITY:		PRIMARY LANGUAGE:	
FAMILY PHYSICIAN:		REFERRED BY:	

WHAT BODY PART ARE YOU BEING SEEN FOR?

☐RIGHT ☐LEFT ☐BILATERAL **IS THIS INJURY WORK RELATED? ☐YES ☐NO**

OCCUPATION:

DATE OF ONSET/INJURY(INSURANCE REQUIRES APPROX. DATE) **MO._____ DAY_____ YEAR_____**
PLEASE EXPLAIN YOUR SYMPTOMS AND ANSWER THE FOLLOWING QUESTIONS. WAS THIS CONDITION RELATED TO AN INJUY? DID YOUR CONDITION HAVE A SUDDEN ONSET OF PAIN OR HAS IT BEEN GRADUAL?

☐NO KNOWN INJURY

WHEN WAS YOUR LAST FLU IMMUNIZATION? _____(MM/DD/YYYY) **CURRENT LEVEL OF PAIN**
WHEN WAS YOUR LAST PNEUMONIA VACCINE? _____(MM/DD/YYYY) 0-10 (10 WORST) _____
FULLY VACCINATED FOR COVID? ☐YES ☐NO **DATE OF LAST DOSE?** _____(MM/DD/YYYY)
HAVE YOU SEEN A DOCTOR IN THE PAST FOR THIS PROBLEM? ☐YES ☐NO
IF YES, WHAT DOCTOR PROVIDED TREATMENT? _____
APPROX. DATE OF TREATMENT _____(MM/DD/YYYY)
WHAT TREATMENT DID YOU RECEIVE? ☐REST ☐MEDICATION ☐THERAPY ☐INJECTIONS
☐OTHER _____
HAVE YOU HAD ANY PREVIOUS DIAGNOSTIC TESTS? ☐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.
NAME OF PHARMACY _____ PHARMACY PHONE NUMBER _____
RX CROSS STREETS/ADDRESS/CITY _____

PLEASE CHECK 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 & OVER THE COUNTER)

Medication / Dose / # of times per day	Medication / Dose / # of times per day

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of Oklahoma Center for Orthopedic Excellence & Sports Medicine's Notice of Privacy Practices. This Notice describes how Oklahoma Center for Orthopedic 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	Relation to Patient	Date

ACCESS TO MEDICAL RECORDS

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

_____	_____	_____
Name	Relation to Patient	Phone Number
_____	_____	_____
Name	Relation to Patient	Phone Number

CONSENT TO DISCUSS DIAGNOSIS & 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 (if patient is under 18 years of age)	Date

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)

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WORKER'S COMPENSATION

Date:_____

Patient: _____ DOB_____ SS#_____

Patient Address:_____
Street City State Zip

Home Phone: _____ Mobile/Cell_____

Patient Email:_____

Employer: _____ Employer Phone: _____

Employer Address:_____
Street City State Zip

Are you claiming this as an on the job injury? ___Yes ___No **Date of Injury:** _____

What type of injury? _____ How did it occur? _____

Has your employer been informed of the injury? ___Yes ___No Supervisor:_____

Work Comp Company_____

Work Comp Address_____
Street City State Zip

Contact Person: _____ Phone #: _____ Fax #:_____

Nurse Case Manager:_____ Phone #:_____ Fax #:_____

Claim Number_____ Verified By_____

If yes, are you receiving compensation? ___Yes ___No

Do you have an attorney? ___Yes ___No if yes, who _____

Were you referred to our office? ___Yes ___No if yes, who _____

Have you been treated by any other Doctor for this injury? ___Yes ___No

If yes, who_____ Phone Number _____