OCO
OKLAHOMA CENTER FOR ORTHOPAEDICS & SPORTS MEDICINE

M. SEAN O'BRIEN, D.O.
BOARD CERTIFIED ORTHOPAEDIC SURGEON
3110 SW 89th Street, Suite 200C • OKC, OK 73159
Phone (405) 759-2663 • Fax (405) 759-7957

New Patient Information

(Please Print - Fill in All Blanks)

FIRST NAME	MIDDLE NAME	LAST NAME	DOB	SSN	SEX

ADDRESS:	CITY:	STATE:	ZIP CODE:

HOME PHONE: ( )	WORK PHONE: ( )	MOBILE PHONE: ( )

EMAIL ADDRESS	MARITAL STATUS:	MOTHER'S MAIDEN NAME (IF MINOR):	DO YOU NEED AN INTERPRETER? ☐ YES ☐ NO

PREFERRED LANGUAGE:	WRITTEN LANGUAGE:	RACE:	ETHNICITY:	RELIGION:

NEXT-OF-KIN INFORMATION

EMERGENCY CONTACT	RELATIONSHIP	PRIMARY PHONE: ( )	PREFERRED LANGUAGE	☐ LEGAL GUARDIAN?

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS ☐ Disabled ☐ Full-time ☐ Not Employed ☐ Active Military ☐ Part-Time ☐ Self-Employed ☐ Student ☐ Unknown

EMPLOYER:	ADDRESS	CITY / STATE	ZIP CODE:

APPOINTMENT INFORMATION

REFERRING PROVIDER:	IS THIS VISIT ACCIDENT RELATED? ☐ Yes ☐ No	DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ Yes ☐ No

GUARANTOR INFORMATION (PLEASE COMPLETE, IF GURANTOR IS NOT PATIENT/MINOR)

RELATIONSHIP TO PATIENT	NAME:	DOB:	SEX:	SSN:

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

PRIMARY COVERAGE:	SUBSCRIBER'S NAME:	SUBSCRIBER'S DOB

SUBSCRIBER'S ID:	PATIENT'S ID (IF DIFFERENT):	GROUP NUMBER:

SUBSCRIBER'S ADDRESS:	CITY	STATE	ZIP CODE

SUBSCRIBER'S EMPLOYMENT STATUS:	SUBSCRIBER'S EMPLOYER NAME:	EMPLOYER'S ADDRESS:

SECONDARY COVERAGE:	SUBSCRIBER'S NAME:

SUBSCRIBER'S ID:	PATIENT'S ID (IF DIFFERENT):	GROUP NUMBER:

SUBSCRIBER'S ADDRESS:	CITY	STATE	SUBSCRIBER'S ADDRESS:

SUBSCRIBER'S EMPLOYMENT STATUS:	SUBSCRIBER'S EMPLOYER NAME:	EMPLOYER'S ADDRESS:

Authorize the RELEASE of any MEDICAL INFORMATION if necessary to file Insurance Claim.
I Authorize PAYMENT OF MEDICAL BENEFITS to the undersigned physician or supplier for services rendered.
I accept responsibility for full payment on my account.
I acknowledge and agree that I have received a copy of the TPG Privacy Notice.

SIGNATURE _____ DATE _____

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Chief Complaint / Reason for Visit Summary

What body part / extremity are you being seen for today? _____ RT / LT / BOTH
Date of onset/injury (Insurance requires approx. date):MO. _____DAY_____YEAR_____

☐ **No Known Injury**

Is this injury a work-related injury? ☐ Yes ☐ NO

If yes, has a claim been filed for this injury? ☐ Yes ☐ NO
If yes, please complete Worker's Compensation Data Sheet

Is this injury due to a Motor Vehicle Accident? ☐ Yes ☐ NO If yes, has a claim been filed for this injury? ☐ Yes ☐ NO

If applicable, provide brief description of how injury occurred: _____

_____

_____

_____

Have you seen a doctor in the past for this problem? ☐ Yes ☐ NO

If yes, what doctor provided treatment? _____ APPROX Date of Treatment: _____
What treatment did you receive? ☐ Rest ☐ Medication ☐ Therapy ☐ Injections ☐ Other

Please explain your symptoms: _____

_____

_____

_____

Did your condition have a sudden onset of pain or has it been gradual?

_____

Previous treatment includes:

☐ Splint/Brace ☐ Ice/Heat ☐ Walker/Boot ☐Ice/Heat ☐Sling ☐Crutches

☐ Surgical Repair: _____ ☐Medications: _____

Have you had any radiology procedures (ex: X-Ray, MRI, CT scan) specific to the reason you are here today?
☐ No ☐ Yes *(Please list)*

Radiology Procedure	Year

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Review of Systems

Are you experiencing any of the following symptoms?

Constitutional:
- ☐ appetite loss
- ☐ chills
- ☐ diaphoresis
- ☐ fever
- ☐ malaise/fatigue
- ☐ night sweats
- ☐ weight gain
- ☐ weight loss

HENT:
- ☐ congestion
- ☐ ear discharge
- ☐ ear pain
- ☐ hearing loss
- ☐ hoarseness
- ☐ odynophagia
- ☐ sore throat
- ☐ stridor
- ☐ tinnitus

GI:
- ☐ abdominal bloating
- ☐ abdominal pain
- ☐ anorexia
- ☐ bowel habits change
- ☐ bowel incontinence
- ☐ constipation
- ☐ diarrhea
- ☐ dysphagia
- ☐ excessive appetite
- ☐ flatus
- ☐ heartburn
- ☐ hematemesis
- ☐ hematochezia
- ☐ jaundice
- ☐ melena
- ☐ nausea
- ☐ vomiting

Eyes:
- ☐ blurred vision
- ☐ discharge
- ☐ double vision
- ☐ pain
- ☐ photophobia
- ☐ redness
- ☐ vision loss – left
- ☐ vision loss – right
- ☐ visual disturbance
- ☐ visual halos

Cardiology:
- ☐ chest pain
- ☐ claudication
- ☐ cyanosis
- ☐ dyspnea on exertion
- ☐ irregular heartbeats
- ☐ leg swelling
- ☐ near-syncope
- ☐ orthopnea
- ☐ palpitations
- ☐ PND
- ☐ syncope

GU:
- ☐ bladder incontinence
- ☐ decreased libido
- ☐ dysuria
- ☐ flank pain
- ☐ frequency
- ☐ genital sore
- ☐ hematuria
- ☐ hesitancy
- ☐ incomplete emptying
- ☐ menorrhagia
- ☐ missed menses
- ☐ nocturia
- ☐ non-menstrual bleeding
- ☐ pelvic pain
- ☐ urgency

Respiratory:
- ☐ cough
- ☐ hemoptysis
- ☐ shortness of breath
- ☐ sleep disturbances due to breathing
- ☐ snoring
- ☐ sputum production
- ☐ wheezing

Endocrine:
- ☐ intolerance of cold
- ☐ intolerance of heath
- ☐ polydipsia
- ☐ polyuria

Heme/Lymph:
- ☐ adenopathy
- ☐ bleeding
- ☐ easy bruising/bleeding

Neurological:
- ☐ aphonia
- ☐ brief paralysis
- ☐ concentration difficulty
- ☐ coordination disturbances
- ☐ daytime sleepiness
- ☐ dizziness
- ☐ focal weakness
- ☐ generalized weakness
- ☐ headaches
- ☐ light-headedness
- ☐ loss of balance
- ☐ numbness
- ☐ paresthesia
- ☐ seizures
- ☐ sensory change
- ☐ tremors
- ☐ vertigo

Skin:
- ☐ changes in nail beds
- ☐ discoloration
- ☐ dryness
- ☐ flushing
- ☐ itching
- ☐ poor wound healing
- ☐ rash
- ☐ skin cancer
- ☐ suspicious lesions
- ☐ unusual hair distribution

Musculoskeletal:
- ☐ arthritis
- ☐ back pain
- ☐ falls
- ☐ gout
- ☐ joint pain
- ☐ joint swelling
- ☐ muscle cramps
- ☐ muscle weakness
- ☐ myalgia
- ☐ neck pain
- ☐ stiffness

Psychiatric:
- ☐ altered mental status
- ☐ depression
- ☐ hallucinations
- ☐ hypervigilance
- ☐ insomnia
- ☐ memory loss
- ☐ nervous/anxious
- ☐ substance abuse
- ☐ suicidal ideas
- ☐ thoughts of violence

Allergy/Immuno:
- ☐ environmental Allergies
- ☐ HIV exposure
- ☐ hives
- ☐ persistent infections

OFFICE USE:

Height: _____ **Weight** _____ **BP:** _____ **Pulse** _____ **Resp** _____

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Allergies

Select and/or list all **ALLERGIES** to any medications **and** the reactions:

☐ **No Known Drug Allergies** ☐ **Codeine** ☐ **Penicillin** ☐ **Sulfa Antibiotics** ☐ **Iodine/Betadine**
☐ **Latex** ☐ **Tetracycline** ☐ **Radiographic Dyes** ☐ **Morphine** ☐ **Adhesives**
☐ **NSAIDS**

Any other allergies not listed (specify):

Allergen (Medications, Foods, etc)	Reaction (hives, itching, anaphylaxis, etc)

PHARMACY INFORMATION

Please note we ***CANNOT*** send medications to Sam's Club/Wal-mart

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

CURRENT MEDICATIONS

Alternatively, you can provide a printed list of your current medications

☐ I **DO NOT** take any medications

Pain Management Physician (if you have one): _____

MEDICATION	DOSE	FREQUENCY	REASON FOR TAKING

Patient Name: _____ Date of Birth: _____ Date Completed: _____

PAST MEDICAL HISTORY

Please check any previously diagnosed medical problems

- ☐ Anemia
- ☐ Asthma
- ☐ Blood clots
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ COPD
- ☐ Crohn's disease
- ☐ Diabetes type 1
- ☐ Diabetes type 2
- ☐ Factor V Leiden
- ☐ Factor deficiency
- ☐ Fibromyalgia
- ☐ GI bleeding
- ☐ Gout
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Heart burn / Reflux
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High cholesterol
- ☐ HIV / AIDS
- ☐ Immune deficiency
- ☐ Irritable bowel syndrome
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Lupus
- ☐ MRSA infection
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Pneumonia
- ☐ Psoriatic arthritis
- ☐ Pulmonary embolism
- ☐ Rheumatoid arthritis
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Stomach ulcers
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid disease
- ☐ Ulcerative colitis
- ☐ Other Medical Problem: _____

Past Surgical History

DATE	SURGERY PERFORMED	SURGEON	HOSPITAL

Patient Name: _____ Date of Birth: _____ Date Completed: _____

Family History

Have any of your family members had any of the following problems?

Relationship	No Known Problems	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes	Drug abuse	Early Death	Hearing Loss	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental illness	Mental retardation	Miscarriages/Stillborn	Stroke	Suicide Attempts	Vision loss	Other Medical History
Father																							
Mother																							
Sister																							
Brother																							
M. Grandmother																							
M. Grandfather																							
P. Grandmother																							
P. Grandfather																							
Other Relative: _____																							

Social History

Sexual Activity:
Sexually active ☐ Yes ☐ Not Currently ☐ Never ☐ Defer
Comments: _____

Tobacco:
Smoking: ☐ Never ☐ Former ☐ Every Day ☐ Some Day
Smokeless: ☐ Never ☐ Former ☐ Every Day ☐ Some Days

Alcohol:
Alcohol Use ☐ Yes ☐ No ☐ Defer Drinks per Week: _____

Drugs:
Drug Use ☐ Yes ☐ No ☐ Defer Drug type: _____

Are you experiencing pain today? ☐ Yes ☐ No

If yes, how would you rate your pain on a scale of 1-10? _____

Are you fully vaccinated for COVID? ☐ Yes ☐ No Date of last dose (MM/DD/YYYY): _____

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of The Physicians' Group, LLC (TPG) to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of The Physicians' Group, LLC (TPG) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of TPG charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, its agents and its employees from liability in connection with the release of the information contained within.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at TPG. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release TPG from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand that a photocopy of this document is as valid as the original.

SIGNED_____ DATE _____

(patient)

OR _____

(nearest relative or responsible party)

_____ Policyholder's Signature_____

(relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

The Physicians' Group

Authorization to Release Information via Phone/Family/Friends

Patient Name:_____ DOB:_____

I hereby authorize confidential communications from the physicians or staff of TPG regarding my healthcare, treatments, appointments, prescriptions, etc. to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone _____ Work Phone _____
Cell Phone _____ Other _____

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____
Name _____ Relation _____

I understand that this authorization will remain in effect until I revoke the authorization in writing.

_____ _____
Patient Signature Date

TPG STAFF ONLY

Documented by: Initials _____ Date: _____

The Physicians' Group, LLC

FINANCIAL POLICY

Thank you for choosing The Physicians' Group, LLC (TPG) as your premier healthcare provider. At TPG, we are dedicated to providing the highest quality, most cost-effective care. We specialize in adult and pediatric orthopedics, sports medicine, running injuries, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine surgery, and hand surgery.

In addition to accepting traditional insurance plans and Medicare, we are contracted with a number of Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring your current insurance card(s), or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express, or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office to make financial arrangements. Please be aware that charge for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

There is a $35 charge for any FMLA, disability, or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing us to participate in your care.

Sincerely,

The Physicians' Group

My signature below acknowledges receipt of this financial policy:

Signed_____ Date_____

(signature of person financially responsible for payment)

Relationship if other than patient_____

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, this information is being provided to you to help you make an informed decision about your health care.

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

Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of The Physicians' Group's Notice of Privacy Practices. This Notice describes how The Physicians' Group 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

_____ Signature of Parent or Guardian (if applicable)

_____ Print Name of Patient

_____ Print Name of Parent or Guardian

Date:_____

CONSENT TO DISCUSS DIAGNOSIS & TREATMENT WITH ATHLETIC TRAINER

 I authorize The Physicians' Group to discuss my diagnosis and treatment with my school's athletic training staff.

I have read the statement above. I acknowledge my agreement by signing below.

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

Date:_____