

# PATIENT INFORMATION

• KANSAS ORTHOPAEDIC CENTER, P.A.  
 7550 W. VILLAGE CIRCLE, SUITE 1 • WICHITA, KANSAS 67205  
 • SURGERY CENTER OF KANSAS  
 7550 W. VILLAGE CIRCLE, SUITE 2 • WICHITA, KANSAS 67205

DATE

PATIENT'S NAME (LAST)		(FIRST)	(MI)	S.S.#		MARITAL STATUS		SEX
STREET ADDRESS				BOX OR APPT.#		BIRTHDATE	AGE	RACE
CITY			STATE	ZIP CODE	HOME PHONE #	WORK PHONE #		
PATIENT'S EMPLOYER / SCHOOL				PATIENT GOES BY/NICKNAME			FULL TIME	PART TIME
BILLING NAME (LAST)		(FIRST)	(MI)	S.S.#		OTHER FAMILY MEMBERS PREVIOUSLY TREATED HERE		
INSURED'S EMPLOYER			NPP ACKNOWLEDGEMENT SIGNED?		HOW LONG EMPLOYED?	WORK PHONE #		
PATIENT'S ALTERNATE PHONE #								
PRIMARY CARE PHYSICIAN (GIVE FULL NAME)						PHONE #		
PCP ADDRESS				CITY		STATE	ZIP CODE	
REFERRING PHYSICIAN (GIVE FULL NAME)						PHONE #		
REF. DR. ADDRESS				CITY		STATE	ZIP CODE	
REASON FOR VISIT TODAY (Part(s) of the body)					DATE MEDICAL PROBLEM FIRST NOTICED			
WORKER'S COMP	DATE OF INJURY	WERE YOU INJURED ON THE JOB?			HOW			
		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CURRENT JOB <input type="checkbox"/> FORMER JOB						
ACCIDENT/INJURY	DATE OF ACCIDENT	WAS AN AUTOMOBILE INVOLVED?		PLACE OF ACCIDENT (STATE)	HOW			
		<input type="checkbox"/> YES <input type="checkbox"/> NO						
#1				#2				
#3				#4				
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM?			IF YES, WHERE TAKEN (HOSPITAL, ETC.)				DATE X-RAYS TAKEN	
<input type="checkbox"/> YES <input type="checkbox"/> NO								
<b>INSURANCE SET INFORMATION</b>								
1) Health								
2) W/C								
3) Auto								
4) Liability								
5) Other								
6) Auto Maxed								

**IMPORTANT: PLEASE READ THE INFORMATION ON THE BACK OF THIS SHEET, YOUR SIGNATURE REQUIRED.**

**KANSAS ORTHOPAEDIC CENTER, P.A.  
PLEASE READ**

As part of your care, the physician may suggest referral to Surgery Center of Kansas or Kansas Spine Hospital. We want you to know that some of the physicians have an investment interest in these facilities. Should you wish, you may obtain surgery or services elsewhere. We believe, however that our investment and supervision of these facilities assures you the finest, most responsive care available.

Payment is due at the time of service. While the office submits insurance, the patient remains responsible and must furnish accurate insurance information.

All services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees (subject to carrier contractual arrangements), regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our patient representatives.

**INSURANCE AUTHORIZATION AND ASSIGNMENT; TREATMENT AUTHORIZATION;  
AUTHORIZATION TO RELEASE INFORMATION**

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to the above named provider(s) for any services furnished me by that provider(s). I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable to related services. If my care is covered by Workers' Compensation, I authorize release of medical information to my employer and/or case manager. I authorize the above named groups to release any medical information necessary to my insurance company.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, provider(s) agrees to accept the charge determination of the Medicare/Other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Other insurance company.

In the event that a health care worker is suspected to have been exposed to my blood or body fluids or in the event that my illness requires such care that health care worker exposure to my blood and body fluids is likely, I consent to have the above provider(s) determine by serological testing whether or not my blood contained contagious viruses. I understand the information obtained from such tests will only be exposed as necessary to adequately protect my own health and the health of my family as well as the health care personnel who may become involved in my treatment, except as otherwise required by law. (see KSA 65-6002 (a)).

I hereby consent to treatment by the above provider(s) and certify that no guarantee/assurance has been made regarding results.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ATTENTION MEDICARE PATIENTS ONLY  
(TO BE COMPLETED FOR ALL MEDICARE PATIENTS)  
MEDICARE SECONDARY PAYER QUESTIONNAIRE**

NAME \_\_\_\_\_ DATE OF SERVICE \_\_\_\_\_

*(If any answer to questions 1a. through 5. is YES, the corresponding section of the "Other Insurance" form must be filled out completely.)*

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Is the patient a Veteran? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Did the VA refer you here for treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Does the patient have a VA "fee basis ID Card?" .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a Federal Black Lung card? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is this medical condition due to an accident of any kind? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, was it: <input type="checkbox"/> Work Related <input type="checkbox"/> Auto <input type="checkbox"/> Injured in own home <input type="checkbox"/> Other |                          |                          |
| 4. Is the patient covered by a health insurance plan through their own current employment or that of a family member (Not retiree coverage?) .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is the patient currently in a Skilled Nursing Facility .....   | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, Facility Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**ONE TIME AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the above named groups for any services furnished me by that physician(s). I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Service (CMS) and its agents any information needed to determine these benefits for the benefits payable for related services.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

*Retain this Form in Patient's File*

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DATE
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PATIENT NAME (LAST)	(FIRST)	(MI)	BIRTHDATE	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED
OCCUPATION			MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP		PHONE #	

REFERRING PHYSICIAN

REASON FOR TODAY'S VISIT

DRUG ALLERGIES & REACTION TO DRUGS: (REACTION, E.G., HIVES, RASH, ETC.)

RECURRENT ORTHOPAEDIC PROBLEMS

CURRENT MEDICATIONS: (IF INSULIN DEPENDENT DIABETIC - LIST TYPE OF INSULIN, UNITS TAKEN & TIMES OF DAY)					
MEDICINE NAME	DOSE	FREQUENCY	MEDICINE NAME	DOSE	FREQUENCY
1.			4.		
2.			5.		
3.			6.		

TESTS DONE WITHIN LAST SIX MONTHS				
	YES	NO	WHERE DONE	COMMENTS
BLOOD WORKUP / CBC				
MRI				
X-RAY DONE (KIND)				
COMPLETE PHYSICAL				
EKG				
TREADMILL TEST				
OTHER				

PREVIOUS OPERATIONS									
	YES	NO	DATE		YES	NO	DATE	RIGHT	LEFT
TONSILLECTOMY				CARPAL TUNNEL RELEASE					
APPENDECTOMY				SHOULDER					
GALLBLADDER				HIP					
HYSTERECTOMY				OTHER					
BACK									

CORONARY ARTERY BYPASS SURGERY  Yes  No Date \_\_\_\_\_ Number of Grafts \_\_\_\_\_ Hospital \_\_\_\_\_

HAVE YOU OR ANY FAMILY MEMBER EVER HAD ANY PROBLEM WITH ANESTHESIA?  YES  NO (If Yes) please explain \_\_\_\_\_

HOSPITALIZATIONS (OTHER THAN ABOVE)		
DESCRIPTION OF ILLNESS / REASON	YEAR	HOSPITAL

*Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance.*

**COMPLETE FRONT AND BACK OF THIS FORM**

OFFICE USE ONLY							
TODAYS DATE	SURGERY DATE	TODAY'S TEST		VITAL SIGNS		DATE OBTAINED	
		YES	NO	B/P	PULSE	RESP.	
DOCTOR		EKG . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	HGT	REG	A/O
PROCEDURE		CHEST X-RAY . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	WGT	IRREG	
		LAB . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	ASSESSMENT, OBTAINED & REVIEWED BY: (SIGNATURE)		REVIEWED DATE
							REVIEWED DATE
							REVIEWED DATE
							REVIEWED DATE
							REVIEWED DATE

SCK  SFRMC  SJMC  WMC  Riverside

# PERSONAL / FAMILY HISTORY

HISTORY OF	PERSONAL			FAMILY			
	YES	NO	WHEN	MEMBER	YES	NO	WHEN
PACEMAKER							
HEART ATTACK							
CHEST PAIN / ANGINA							
HEART MURMUR							
HEART PALPITATION							
IRREGULAR HEART BEAT							
CONGESTIVE HEART FAILURE							
ENLARGED HEART							
SHORTNESS OF BREATH							
HIGH BLOOD PRESSURE							
LOW BLOOD PRESSURE							
HEADACHE							
STROKE							
SCARLET FEVER							
RHEUMATIC FEVER							
FAINTING							
PHLEBITIS / BLOOD CLOTS							
OTHER CARDIAC / HEART PROBLEMS							
ASTHMA / EMPHYSEMA							
BRONCHITIS							
COUGH / CHRONIC - OR IN A.M.							
COLD / FLU LAST 3 MO.							
LUNG DISEASE							
TUBERCULOSIS							
PLEURISY							
PNEUMONIA							
SINUSITIS							
ARTHRITIS							
BACK DISORDERS							
DEGENERATIVE JOINT DISEASE							
SWOLLEN / PAINFUL JOINTS							
DIABETES							
THYROID DISEASE / TROUBLE							
EPILEPSY / SEIZURES / CONVULSIONS							
KIDNEY DIALYSIS							
KIDNEY INFECTION / BLADDER PROBLEMS							
CANCER							
LEUKEMIA							
LUPUS DISEASE							
SICKLE CELL							
HITAL HERNIA							
STOMACH / BOWEL PROBLEMS							
ULCER							
GLAUCOMA							
HEPATITIS / YELLOW JAUNDICE							
CIRRHOSIS OF LIVER							
HIV / AIDS							
PSYCHIATRIC HISTORY							
OTHER							

<p style="text-align: center;"><b>SOCIAL HISTORY</b></p> <p>SMOKE            <input type="checkbox"/> NO        <input type="checkbox"/> YES        _____ PACK(S) PER DAY</p> <p>ALCOHOL        <input type="checkbox"/> NEVER    <input type="checkbox"/> RARELY    <input type="checkbox"/> SOCIALLY    <input type="checkbox"/> DAILY</p> <p>RECREATIONAL DRUGS <input type="checkbox"/> NEVER    <input type="checkbox"/> RARELY    <input type="checkbox"/> SOCIALLY    <input type="checkbox"/> DAILY</p>	<p>PATIENT'S SIGNATURE</p>  <p>DATE SIGNED</p>
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