PATIENT INFORMATION

• **KANSAS ORTHOPAEDIC CENTER, P.A.**
7550 W. VILLAGE CIRCLE, SUITE 1 • WICHITA, KANSAS 67205
2450 N. WOODLAWN BLVD • WICHITA, KANSAS 67220
101 E. FULTON ST • GARDEN CITY, KANSAS 67846

• **SURGERY CENTER OF KANSAS**
7550 W. VILLAGE CIRCLE, SUITE 2 • WICHITA, KANSAS 67205

DATE

PATIENT'S NAME (LAST) (FIRST) (MI)	PATIENT S.S.#	MARITAL STATUS	SEX
STREET ADDRESS		BIRTHDATE	AGE

CITY	STATE	ZIP CODE	DAYTIME PHONE #	WORK PHONE #
PATIENT'S EMPLOYER / SCHOOL		PATIENT GOES BY/NICKNAME	ALTERNATE PHONE #	RELATIONSHIP
EMAIL		NAME/LOCATION OF PHARMACY		

SUBSCRIBER/BILLING NAME (LAST) (FIRST) (MI)	SUBSCRIBER/BILLING S.S.#

SUBSCRIBER'S EMPLOYER	SUBSCRIBER'S BIRTHDATE	SUBSCRIBER'S RELATIONSHIP TO PATIENT

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) RIGHT LEFT BILATERAL	INJURY DATE/MEDICAL PROBLEM FIRST NOTICED

IF INJURY, WHAT STATE DID INJURY OCCUR?	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO ☐ CURRENT JOB ☐ FORMER JOB	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO

IF INJURY, HOW DID INJURY OCCUR?

#1	#2
#3	#4

WERE X-RAYS/MRI TAKEN OF THIS INJURY OR PROBLEM? ☐ YES ☐ NO	IF YES, WHERE TAKEN (HOSPITAL, ETC.)	DATE X-RAYS/MRI TAKEN

INSURANCE SET INFORMATION - OFFICE USE ONLY

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, Kansas Spine and Specialty Hospital, Kansas Surgery and Recovery Center or Precision Surgery Center or use the products of Stryker Orthopaedics. We want you to know that some of the physicians have an investment interest in these organizations. Should you wish, you may obtain surgery or services elsewhere. We believe, however that our investment and supervision assures 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 authorize release of information regarding appointment dates, times and restrictions to the patient's school as requested.

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 hearby 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?	☐	☐
	a. Did the VA refer you here for treatment?	☐	☐
	b. Does the patient have a VA "fee basis ID Card?"	☐	☐
2.	Do you have a Federal Black Lung card?	☐	☐
3.	Is this medical condition due to an accident of any kind?	☐	☐
	If yes, was it: ☐ Work Related ☐ Auto ☐ Injured in own home ☐ 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?)	☐	☐
5.	Is the patient currently in a Skilled Nursing Facility or Home Health Care?	☐	☐

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**_____

PATIENT HEALTH HISTORY

DATE

PATIENT NAME (LAST) (FIRST) (MI)	BIRTHDATE	AGE	SEX ☐ M ☐ F	☐ RIGHT HANDED ☐ LEFT HANDED
OCCUPATION	MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP		PHONE #	
REFERRING PHYSICIAN				
REASON FOR TODAY'S VISIT				

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

	Y	N		Y	N
LATEX ALLERGY	☐	☐	METAL ALLERGY	☐	☐
SLEEP APNEA	☐	☐	02/CPAP USER	☐	☐

HAVE YOU HAD A PNEUMONIA VACCINE? Y ☐ N ☐ DATE

CURRENT MEDICATIONS: (IF INSULIN DEPENDENT DIABETIC - LIST TYPE OF INSULIN, UNITS TAKEN & TIMES OF DAY)

MEDICINE NAME	DOSE	FREQUENCY	MEDICINE NAME	DOSE	FREQUENCY
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

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				KNEE					
BACK				OTHER					

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

TODAY'S DATE	SURGERY DATE	TESTS ORDERED	VITAL SIGNS			DATE OBTAINED
DOCTOR		YES NO	B/P	PULSE	RESP	REVIEWED DATE
PROCEDURE		EKG ☐ ☐ CHEST XRAY ☐ ☐ LAB ☐ ☐ AIRWAY EVAL ☐ ☐	HGT	WGT	A/O	REVIEWED DATE
		ASSESSMENT OBTAINED & REVIEWED BY: (MA SIGNATURE)				
☐ SCK ☐ SFR ☐ STJO ☐ WES ☐ KSH ☐ STER ☐ SC ☐ GHH ☐ PREC OTHER_____		ASSESSMENT OBTAINED & REVIEWED BY: (PA/DR SIGNATURE)				

KAN 1040

MEDICAL HISTORY

REVIEW OF SYSTEMS

CONSTITUTIONAL/ENDOCRINE	Yes	No
FEVER		
CHILLS		
WEAKNESS/FATIGUE		
WEIGHT LOSS OR GAIN		
INSOMNIA		
EXCESSIVE THIRST		
EXCESSIVE URINATION		
COLD/HEAT INTOLERANCE		
NIGHT SWEATS		
CHANGE IN APPETITE		
DIABETES		
THYROID PROBLEMS		
CARDIOVASCULAR		
CHEST PAIN		
PALPITATIONS		
IRREGULAR HEART BEAT		
HEART MURMUR		
CORONARY ARTERY DISEASE		
CONGESTIVE HEART FAILURE		
HEART ATTACK		
HIGH BLOOD PRESSURE		
LOW BLOOD PRESSURE		
ELEVATED CHOLESTEROL		
PACEMAKER		
STROKE		
BLOOD CLOTS		
RESPIRATORY		
COUGH		
COUGHING UP BLOOD		
SHORTNESS OF BREATH		
WHEEZING		
ASTHMA/EMPHYSEMA		
COPD		
PNEUMONIA		
TUBERCULOSIS		
LIVER		
HEPATITIS		
CIRRHOSIS		

GENITOURINARY	Yes	No
BLADDER INFECTION		
FREQUENCY		
BLOOD IN URINE		
INCONTINENCE		
URGENCY		
KIDNEY DIALYSIS		
UTIs		
NEUROLOGICAL		
HEAD INJURY		
FREQUENT HEADACHES		
SEIZURES		
SYNCOPE (FAINTING)		
DIZZINESS		
LIMB NUMBNESS		
TINGLING		
TREMORS		
VERTIGO (LOSS OF BALANCE)		
SWALLOWING DIFFICULTY		
RIGIDITY		
LIMB WEAKNESS		
HEENT		
SORE THROAT		
STIFF NECK		
CHANGE IN VOICE		
SINUS DRAINAGE		
SINUS HEADACHE		
NOSE BLEEDS		
EARACHE/DRAINAGE		
HEARING LOSS		
RINGING IN EARS		
BLURRED VISION/LOSS		
WEAR GLASSES/CONTACTS		
ITCHY/WATERY EYES		
GLAUCOMA		
DENTAL PROBLEMS		

SKIN	Yes	No
SKIN DISCOLORATION		
DRYNESS		
NAIL PROBLEMS		
RASH/HIVES		
ULCERS		
ITCHING		
EASY BRUISING		
UNUSUAL HAIR LOSS		
WOUND HEALING PROBLEMS		
MUSCULOSKELETAL		
ARTHRITIS		
OSTEOPOROSIS		
RHEUMATIC FEVER		
JOINT PAIN/STIFFNESS		
BACK PAIN		
JOINT SWELLING		
MUSCLE SPASMS/CRAMPS		
MUSCLE WEAKNESS		
REDNESS OF JOINTS		
FALLING		
GASTROINTESTINAL		
CHANGE IN APPETITE		
CHANGE IN BOWEL HABITS		
CONSTIPATION		
DIARRHEA		
IRRITABLE BOWEL SYNDROME		
NAUSEA		
HEARTBURN/REFLUX (GERD)		
PSYCHIATRIC		
DEPRESSION		
ANXIETY		
BIPOLAR DISORDER		
SCHIZOPHRENIA		
OTHER		
CANCER		
LEUKEMIA		
STDs		
HIV or AIDS		

FAMILY HISTORY	YES	NO		YES	NO
ANEMIA/BLEEDING			GLAUCOMA		
CANCER			URINARY		
CARDIOVASCULAR			HEPATITIS		
DIABETES			RESPIRATORY/SMOKER		
GI/STOMACH			SEIZURES		

SOCIAL HISTORY				
ALCOHOL	NEVER	RARELY	SOCIALLY	DAILY
RECREATIONAL DRUGS	NEVER	RARELY	SOCIALLY	DAILY
TOBACCO_____PACKS/DAY	YES	NEVER	FORMER	

PATIENT'S SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____DATE: _____