

### PATIENT INFORMATION

Patient ID# \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Email: \_\_\_\_\_  
 Primary Phone Number: \_\_\_\_\_ Cell Phone    Home    Work (circle one)  
 Alternate Phone Number: \_\_\_\_\_ Cell Phone    Home    Work (circle one)

**Sex:**      **Marital Status:**

Male     Single     Divorced     Widowed

**Ethnicity**

Hispanic or Latino     Unreported

**Who Is Filling Out This Form?**

Self       Husband       Wife  
 Partner       Child       Parent

**Race**

Unreported or refused to report     White  
 American Indian or Alaskan Native     Asian  
 Black or African American

**Preferred Communication Method:**

US Mail     Work Phone     Secure Email

**Preferred Language**

English     Spanish     Other

### EMERGENCY CONTACT INFORMATION

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_  
**Relation To You:**  Husband     Wife     Partner     Child     Parent     Grandparent     Other Relative     Friend  
**Primary Phone Number:** \_\_\_\_\_ Cell Phone    Home    Work (circle one)

### HEALTH INSURANCE INFORMATION

I do not have health insurance, I will be self paying.

Name of Primary Insurance Co: \_\_\_\_\_  
(Examples: Aetna, Blue Cross Blue Shield, Cigna, United Healthcare, etc.)  
 Policy Holder Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**Guarantor Information (for minors only)**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**I ACCEPT PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES FOR SERVICES RENDERED TO ME. I AUTHORIZE PAYMENTS OF MEDICAL INSURANCE**

Signature of Patient/Insured: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	PATIENT ID	DATE
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### HISTORY OF PRESENT ILLNESS

What body part are you here for?: \_\_\_\_\_ Date of First Symptoms: \_\_\_\_\_

Which side are you here for?:  Lt  Rt  Both (Which is worse?:  Lt  Rt)

Is this an injury or an accident?  Yes  No

When were you injured? \_\_\_\_\_ Where were you injured? \_\_\_\_\_

How were you injured? \_\_\_\_\_

Is there an attorney involved?  Yes  No If Yes, Attorney's Name and Phone #: \_\_\_\_\_

Auto related?  Yes  No Work Comp related?  Yes  No Name of Work Comp Adjuster: \_\_\_\_\_

### WORK STATUS

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please Indicate Your Current Work Status:

Working Full time  Working Part time  Seeking Employment

Not Working by Choice (Retired, Homemaker, Student, Etc.)

Physically Unable to Work Due to Musculoskeletal Problem

Physically Unable to Work Not Due to Musculoskeletal Problem

How long have you been out of work? \_\_\_\_\_

### OTHER DOCTORS YOU'VE SEEN

I have not seen any doctors in the past year.

Primary Care Doctor's Name: \_\_\_\_\_ (First) \_\_\_\_\_ (Last)

Information on Other Doctors, Specialists, or Other Care Providers You've Seen:

Name of Doctor and Specialty:

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

### OUTSIDE TESTS

Have you had any imaging studies done?  Yes  No

X-Rays?  Yes  No If so, Where? \_\_\_\_\_

MRI?  Yes  No If so, Where? \_\_\_\_\_

CT Scan?  Yes  No If so, Where? \_\_\_\_\_

EMG/NCT?  Yes  No If so, Where? \_\_\_\_\_

Bone Scan?  Yes  No If so, Where? \_\_\_\_\_

CT/Myelogram?  Yes  No If so, Where? \_\_\_\_\_

Discogram?  Yes  No If so, Where? \_\_\_\_\_

Dexa Scan?  Yes  No If so, Where? \_\_\_\_\_

**FINANCIAL POLICY**

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. We require you to read and sign this policy before any treatment can be rendered.

**MISSED APPOINTMENT:** We reserve the right to charge a fee of \$50 for all missed appointments that are not cancelled with a 24-hour advance notice. This fee will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next appointment. Multiple missed appointments or cancellations in any 12-month period may result in discharge from the practice.

**SURGERIES:** We reserve the right to charge a fee of \$200 for a surgery that is cancelled by the patient within 1 week of the scheduled surgery. A fee of \$50 will be charged to the patient each time the surgery is rescheduled upon the patient's request. If the patient misses surgery without notice, we reserve the right to charge a fee of \$1,500. These fees are not billable to insurance or reimbursable and must be paid before we can schedule any further appointments or surgeries. If you are requesting a refund of your surgery deposit, you will receive your refund less any applicable fees.

**REGARDING HMOs, PPOs, and MANAGED CARE PROGRAMS:** We do not participate in some of these programs. Please check with your insurance company to see if we are providers of your plan. It is your responsibility to obtain initial referral forms, etc., required by your particular insurance company. This also includes follow-up visits and visits to other physicians in our group. Please be aware that if you are seen out of network, you are liable for the difference in coverage benefits. Also, some HMO/PPO/ managed care primary care physicians require all X-rays be taken at their office only. Check with your physician before your appointment.

**COPAYS:** You will be expected to pay your copay prior to seeing your physician. If you are unable to pay, you will be required to reschedule your appointment.

**REGARDING PATIENTS WITH NO INSURANCE:** Payment is due at the time of service.

**REGARDING MEDICARE:** All of our providers are participating physicians with Medicare. We will file all charges (including X-rays, braces, etc.) with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance, you will only be billed for the 20% not paid by Medicare or any deductible that has not been met.

**COMPLETION OF FORMS (Disability, FMLA, Physician Statements, Etc.)** A charge will be assessed per form. Prepayment is required before the form(s) will be completed.

**REGARDING WORKMEN'S COMPENSATION/AUTO/LIABILITY:** Our office requires authorization prior to initial visit. If authorization is not received, our office will call on the initial visit and try to obtain it. If we cannot obtain authorization, we will ask for your health insurance information. Also, you will be responsible for all fees until the case has been settled. **WE DO NOT BILL ATTORNEYS IN WORK COMP, AUTO, AND/OR LIABILITY CASES.**

**MINOR PATIENTS:** If you are a minor, your parents and/or guardian need to accompany you to our office before treatment can be rendered. You need to make arrangements prior to being seen with your parent and/or guardian for payment to be made at the time of treatment.

**X-RAY:** For your convenience, we do have X-ray facilities in the building. If X-rays are indicated in your treatment, charges are handled in the same manner as the physician charges. If you have had X-rays taken somewhere else, please bring them with you to your appointment.

**LAB:** In the event we need to have a lab drawn, our office uses an outside laboratory service. You will receive a separate bill for the lab services.

**PAYMENT FOR SERVICE:** All patients must complete a patient information form and provide insurance information, if appropriate, or make payment arrangements prior to leaving the clinic.

- Payment in full: Payment in full is expected and can be made by cash, check, or credit card.
- Payment plan: If you are unable to pay the account in full, financial arrangements will be established based on the following guidelines. When establishing a payment plan, the patient (or their guarantor) will sign a contract agreement with the 1<sup>st</sup> payment due upon signing the contract. This approach requires a minimum payment of \$25. The contract will specify the dollar amount of subsequent payments and the day of the month the payments will be made. When you set up a payment plan, you will continue to receive a monthly statement. If you miss one (1) payment and fail to bring the account current by the due date of the following payment, the account will be referred to the clinic's collection agency.

- Patient Due Balances of \$500 or less will be set up on a 90-day payment plan.
- Patient Due Balances of \$501 – \$1,000 will be set up on a 180-day payment plan.
- Patient Due Balances of \$1,000+ will be set up on a 1-year payment plan.

**UNIFORM APPLICATION OF POLICY:** This policy will apply to all patients, employees, or others who present themselves for services [at anytime, including any future visits].

It is always your responsibility to see that your account is paid, regardless of insurance or any other circumstances (such as litigation). The patient is responsible for costs associated with collecting said owed balances, including but not limited to collection agency fees, attorney fees, and court costs. I have read, understand, and agree to adhere to the above Financial Policy.

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Signature of Patient or Responsible Party

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Date

Patient ID # \_\_\_\_\_

## Kansas Joint & Spine Specialists Controlled Substance Treatment Agreement

Your physician may prescribe a controlled substance medication for pain management. This treatment agreement is a platform for communication allowing us to work together in good faith and for you to understand the importance of this medication in allowing you to function better. We expect to be partners in creating the best treatment plan for your pain management. If you cannot agree with the following points, it will result in discontinuing the controlled substance.

1. You will take the medication exactly as prescribed and will not change the medication dosage and/or frequency without the approval of your physician, physician assistant, and/or nurse practitioner.
2. You will keep regularly scheduled appointments with your physician, physician assistant, and/or nurse practitioner. There may be times when your medication will need a refill between visits. In this instance, please call our staff at least 1 to 2 days before your medication runs out. Refill requests will only be taken Monday – Thursday from 8 AM to 5 PM. Your physician, physician assistant, and/or nurse practitioner on call will not refill any pain meds after hours or over the weekend. This is not considered an emergency and will not be treated as such.
3. The controlled substance pain medication prescribed is being given in order to control pain and allow you to function better. If there are any changes to your activity level or your physical condition, the treatment may be changed or discontinued.
4. You will be ready to taper or discontinue the controlled substance pain medication as your condition improves.
5. You agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.
6. We expect you not to accept or seek controlled substance medications from other physicians or healthcare providers outside of our practice.
7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for your orthopedic condition.
8. You agree that Kansas Joint & Spine Specialists may request and use your prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.
9. You understand that it is important to use one pharmacy for all prescriptions in order to provide consistency.
10. You understand that lost, stolen, or misplaced prescriptions will not be replaced. All patients are expected to act responsibly with their medication. This medication is prescribed for you and only your needs for pain control. To allow others to use your pain medication is illegal and will not be tolerated by your physician or our practice.
11. You understand that if you are taking controlled substances (pain medication) on a schedule that is more frequent or in greater dose than can be prescribed per hospital/surgery center protocols, that you may not receive as much pain medicine. You understand that this may make your recovery/rehabilitation much more difficult.

**Using illegal and recreational drugs is dangerous with prescription medications.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH
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### REVIEW OF SYSTEMS

Please check the boxes below that describe your current symptoms:

#### GENERAL HEALTH

- Denies General Health Symptoms
- Recent Weight Gain of More Than 10 Pounds
- Fevers
- Night Sweats
- Recent Weight Loss of More Than 10 Pounds
- Seen Primary Care Physician in the Last Year
- Chills

#### RESPIRATORY

- Denies Respiratory Symptoms
- Wheezing
- Pneumonia
- Chronic Cough
- Sleep Apnea

#### BLOOD/ONCOLOGY

- Denies Hematologic/ Oncologic Symptoms
- Blood Thinning Medications
- Blood Transfusion
- Easy Bruising
- Organ Transplant

#### CARDIAC

- Denies Cardiac Symptoms
- Chest Pain
- Shortness of Breath

#### GASTROINTESTINAL

- Denies Gastrointestinal Symptoms
- Nausea
- Diarrhea
- Abdominal Pain
- Vomiting
- Liver Problems

#### KIDNEY AND BLADDER

- Denies Genitourinary Symptoms
- Abnormal Kidney Function
- Pain With Urination
- Frequent Urinary Infections

#### MUSCLES, BONES & JOINTS

- Denies Musculoskeletal Symptoms
- Hip Pain
- Joint Swelling
- Muscle Weakness
- Shoulder Pain
- Knee Pain
- Muscle Cramps
- Fibromyalgia
- Spine Pain
- Wrist or Hand Pain
- Joint Pain
- Lupus

#### NERVOUS SYSTEM

- Denies Neurological Symptoms
- Headaches
- Tremors
- Poor Speech
- Changes in Vision
- Denies Skin Symptoms
- Rash
- Dryness
- Itching
- Lesions

#### SKIN

- Denies Mental Health Symptoms
- Sleep Disturbance
- Feeling Hopelessness

#### OTHER

Any other symptoms our providers need to be aware of?

#### MENTAL HEALTH

- Denies Endocrine Symptoms
- Thyroid Problems
- Increased Thirst

#### ENDOCRINE SYSTEM

# PATIENT MEDICAL HISTORY

10100 East Shannon Woods Circle, Suite 100 | Wichita, KS 67226

1101 North Rock Road, Suite 300 | Derby, KS 67037

Tel: (316) 219-8299 | (888) 397-7362 | Fax: (833) 438-1945



EXCEPTIONAL ORTHOPAEDIC CARE BEGINS HERE

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AGE	HEIGHT	WEIGHT
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Please check the boxes that describe your previous medical history:

## RHEUMATOLOGIC

- Arthritis
- Gout
- Osteoporosis
- Lupus

## NEUROLOGIC

- Alzheimer's Disease
- Migraines
- Multiple Sclerosis
- Parkinson's Disease
- Stroke
- Epilepsy
- Seizures
- Fainting Spells

## MENTAL HEALTH

- Anxiety
- Depression

## ENDOCRINE

- Diabetes Type 1
- Diabetes Type 2
- Hypoglycemic
- Thyroid Problems

## CANCER

- Cancer

What type of cancer?

Where is the cancer located?

## RESPIRATORY

- Asthma
- Emphysema
- COPD
- Sinusitis
- Bronchitis
- Sleep Apnea
- CPAP Machine
- Pneumonia
- Oxygen Dependent

## HEMATOLOGIC

- Anemia
- Blood Clotting Disorder
- Sickle Cell Anemia

## GASTROINTESTINAL

- Bowel/Stomach Disorder
- History of Ulcers

## HEPATIC

- Hepatitis
- HIV/AIDS
- Jaundice

## URINARY

- Bladder Disorder
- Dialysis
- Kidney Problems
- Creatinine Higher Than 2

## FEMALE SPECIFIC

- Currently Pregnant
- Not Pregnant

## VACCINATIONS

Influenza (flu) shot?

- Within the Last 6 Months
- 6 to 12 Months
- 12 to 24 Months
- More Than 2 Years Ago
- Never or Can't Remember

Pneumonia shot?

- Within the Last 2 Years
- 2 to 5 Years Ago
- 5 to 10 Years Ago
- More Than 10 Years Ago
- Never or Can't Remember

## OTHER

- Glaucoma
- Hearing Problems
- Vision Problems
- Latex Sensitivity
- Problems With Anesthesia
- Malignant Hyperthermia

## CARDIAC

- High Blood Pressure
- CVA/Stroke
- Palpitations
- Fast Heartbeat
- Irregular Heartbeat
- Heart Murmur
- Deep Vein Thrombosis
- Heart Disease
- Chest Pain
- Metal Heart Valve
- Non-Metal Heart Valve
- Pacemaker/Defibrillator
- Cardiac Stent

What year was stent placed?

What kind of stent?

Are you on medication for the stent?

- Congestive Heart Failure
- Treated in the Last 3 Months?
- Heart Attack
- Treated in the Last 6 Months?
- Short of Breath When You Lie Down?
- Climb a Flight of Stairs Without Panting?

# PATIENT MEDICAL HISTORY - (PG. 2)

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH
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Check boxes below that apply:

## PATIENT'S FAMILY HISTORY

Patient's Mother  Alive  Deceased  Unknown      Patient's Father  Alive  Deceased  Unknown

	Mother	Father	Sister	Brother	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	No History
Aneurysm									
Arthritis									
Bleeding/Clotting									
Breast Cancer									
Cancer (Other Types)									
Colon Cancer									
Depression									
Diabetes Type 1									
Diabetes Type 2									
Heart Disease									
High Blood Pressure									
Mental Illness									
Stroke									

## SOCIAL HISTORY

### What is your smoking status?

- Current Everyday Smoker
- Current Some-Day Smoker
- Former Smoker
- Never Smoker
- Status Unknown

Cigars/Day  Packs/Day  Pipes/Day  Chewing Tobacco

Years of tobacco use?

- 1  2  3  4  5
- 10+  15+  20+  25+

### □ Use recreational drugs?

### □ Use alcohol?

How many drinks per occasion?

- 1  2  3  4 or More  N/A

Comments

- Have you been counseled to quit/cut down on your tobacco use within the last 6 months?

## PATIENT'S SURGICAL HISTORY

- Orthopaedic Surgery?
- Gynecologic Surgery?
- Ear, Nose, or Throat Surgery?
- Cardiac Surgery?
- Urological Surgery?
- Abdominal Surgery?

What type of orthopaedic surgery?

What type of gynecologic surgery?

What type of ear, nose, or throat surgery?

What type of cardiac surgery?

What type of urological surgery?

What type of abdominal surgery?

Surgeries Not Listed Elsewhere:

## PATIENT MEDICAL HISTORY - (PG. 3)

PATIENT NAME (LAST)

(FIRST)

(MIDDLE)

DATE OF BIRTH

## CURRENT MEDICATIONS

Please list all current medications (including any herbal medications and/or supplements):

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## ALLERGIES

Please list any medications that you are allergic to and your reaction to them:

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Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

PATIENT SIGNATURE	DATE	BLOOD PRESSURE	PULSE

# KANSAS **JOINT & SPINE** SPECIALISTS

EXCEPTIONAL ORTHOPAEDIC CARE BEGINS HERE

PATIENT NAME (LAST)	(FIRST)	(MIDDLE)	DATE OF BIRTH
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### PREVIOUS TREATMENTS

- Previous Treatments
- Chiropractic Care
- Heat
- Ice
- Massage

How Often?	How Long?	Date of Last Treatment?
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PREVIOUS INJECTIONS

- Facet Joint
- Cervical Epidural
- Transforaminal Lumbar Epidural
- Lumbar Epidural
- Sacroiliac Joint (SI Joint)
- Nerve Block
- Trigger Point

Date of Last Injection?

_____
_____
_____
_____
_____
_____
_____

- Psychological Consultation for Pain Relief
- Other Remedies Tried
  
- Where did you have your last injection?

### HOW DO ANY OF THE FOLLOWING AFFECT YOUR PAIN?

Sitting .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change	Heat .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change
Standing .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change	Cold .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change
Walking .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change	Massage.....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change
Lying Down .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change	Physical Activity....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change
Rising from a chair .....	<input type="radio"/> Better	<input type="radio"/> Worse	<input type="radio"/> No Change				

### ASSOCIATED SYMPTOMS

Weakness .....	<input type="radio"/>	Arms/Hands	<input type="radio"/>	Legs/Feet	<input type="radio"/>	None
Numbness (loss of feeling) .....	<input type="radio"/>	Arms/Hands	<input type="radio"/>	Legs/Feet	<input type="radio"/>	None
Tingling (falling asleep) .....	<input type="radio"/>	Arms/Hands	<input type="radio"/>	Legs/Feet	<input type="radio"/>	None
Is your pain worse at night? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		
Does your pain wake you up at night? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		
Does coughing affect your pain? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		
Do your legs feel tired or hurt if you walk too far? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		

If yes, answer the following:

How far can you walk? .....	<input type="radio"/>	Less Than 1 Block	<input type="radio"/>	1 to 3 Blocks	<input type="radio"/>	More Than 3 Blocks
Is this relieved by resting your legs? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		
Is this relieved by bending forward? .....	<input type="radio"/>	Yes	<input type="radio"/>	No		

PATIENT NAME (LAST)

(FIRST)

(MIDDLE)

DATE OF BIRTH

Please mark the areas where you experience the following sensations:

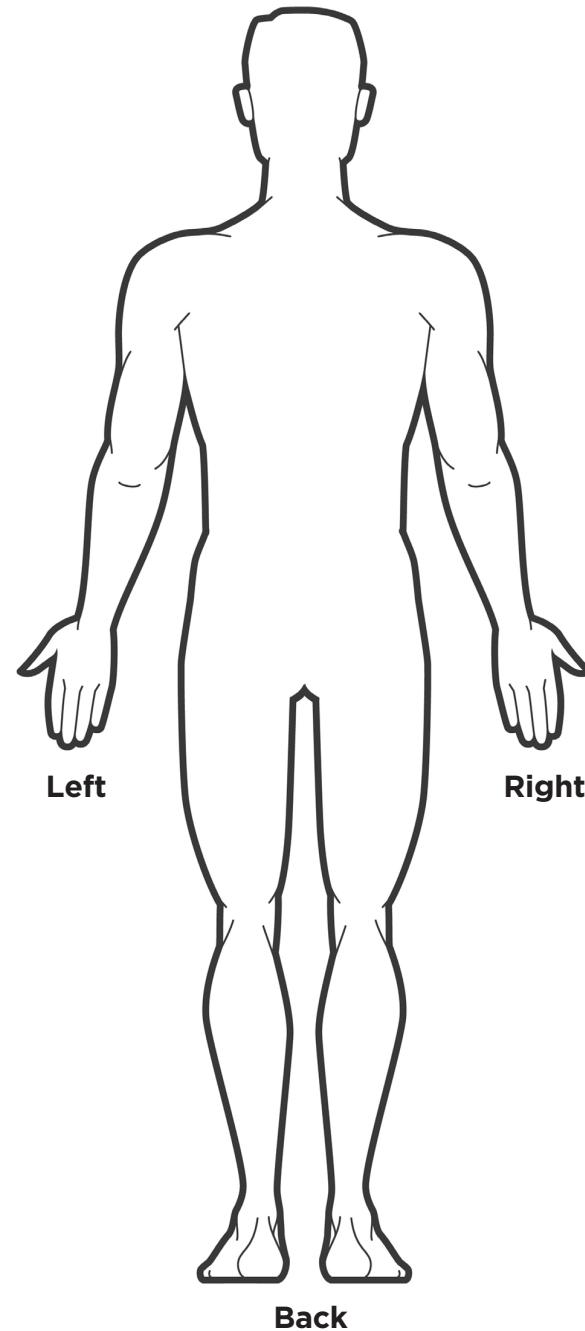
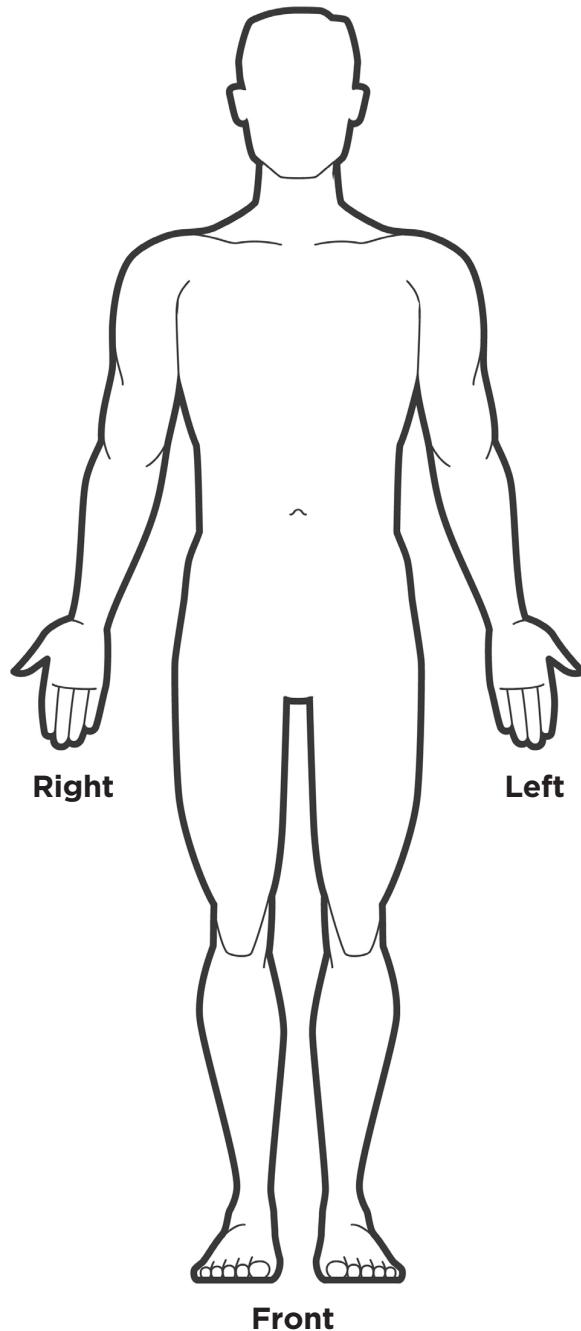
**Ache** 

**Numbness** 

**Pins & Needles** 

**Burning** 

**Stabbing** 



Patient ID # \_\_\_\_\_

## PERMISSION TO GIVE OUT INFORMATION

Please list below only the names of the person and/or persons that you wish to give permission for our staff to speak with regarding your medical and/or financial information.

I, \_\_\_\_\_ hereby grant the physicians and staff of Kansas Joint & Spine Specialists my permission to speak with the following people about my health and well-being.

Effective Date: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone #: \_\_\_\_\_

The following information may be given to the above individual:

- 1. Appointment Time
- 2. Financial Information
- 3. Test/Lab Results
- 4. Medications
- 5. Procedures
- 6. Other information regarding my Health

## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA BROCHURE)

I acknowledge that I have received the attached Privacy Notice.

I understand I may revoke this consent at any time by giving written notice to Kansas Joint & Spine Specialists.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Printed Name: \_\_\_\_\_

In the event the patient is unable to sign, a signature by the designated personal representative is acceptable.

Personal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_