SALINA ORTHO

523 S. Santa Fe Ave.
Salina, KS 67401
785.823.2215
785.823.7459
SalinaOrtho.com

Bradley C. Daily, M.D. | Byron L. Grauerholz, M.D. | Gary L. Harbin, M.D. | Todd M. Herrenbruck, M.D. | Michael J. Johnson, M.D.
Jennifer L. Alexander, APRN | Lindsy Newton, PA-C | Amber Sawyers, PA-C
MRI | PT/OT

# NOTICE OF PRIVACY PRACTICES SUMMARY/ACKNOWLEDGMENT

Maintaining privacy of your health information is very important to us. Attached to this letter you will find our Notice of Privacy Practices. We encourage you to read the entire Notice and ask any questions you may have regarding its contents.

**I acknowledge that I have received a copy of my provider's Notice of Privacy Practices with the effective date of _____.**

_____ _____
*Signature of Patient/Patient Representative* *Date*

_____
*Relationship to Patient*

## ORTHOPAEDIC USE ONLY

A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

___ Patient/Personal Representative refused to sign.

___ Patient/Personal Representative was unable to sign.

___ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

___ Other reason (please specify):_____
_____
_____

_____ _____
Signature of Workforce Member Date

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## PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

I hereby allow Orthopaedic Sports Health Clinic to disclose the following Protected Health Information:

- □ Appointment times and dates
- □ Tests that have been received
- □ Test results
- □ Other health information

To the following people because they are involved with my health care or payment:

- □ Self
- □ Spouse Name:_____
- □ Family friend Name:_____
- □ Child Name:_____
- □ Other Name:_____
- □ Parent/Guardian Name:_____

In the following forms of communication:

- □ Home telephone # _____
- □ Work telephone # _____
- □ Home voice message system _____
- □ Work voice message system _____
- □ Cell phone # _____

Other _____

I authorize Orthopaedic Sports Health Clinic of Salina to furnish any information, reports, or copies of records which may be requested by other doctors, hospitals, insurance companies, etc.

_____

Patient Signature

_____

Date

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# INJURY / ACCIDENT FORM

Patient Name:_____ DOB:_____

Is Office Visit due to Accident or Injury? ☐ **Yes** ☐ **No** **If No – only sign and date at bottom do NOT answer the following questions**

Date of Accident/Injury:_____

How did the injury or condition occur?
_____

_____

Where did the injury or condition occur? ☐ **School** ☐ **Home** ☐ **Work** ☐ **Other**
_____

Was your accident or condition work related? ☐ **Yes** ☐ **No**
Employer_____

If Yes, are you self-employed? ☐ **Yes** ☐ **No**

Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? ☐ **Yes** ☐ **No**

If Yes, type of vehicle involved? Car Truck Motorcycle If motorcycle, are you the owner? ☐ **Yes** ☐ **No**

If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ☐ **Yes** ☐ **No**

Was another party responsible for your injury or condition? ☐ **Yes** ☐ **No**
If Yes, Please Explain
_____

**Signature:**_____ **Date:**_____

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# Patient Payment Consent

I authorize Salina Ortho to maintain my credit/debit card on file for the balance of charges not paid by insurance.

On the 1st or 15th of every month (circle one)

_____Remaining Balance

\- OR -

_____Monthly Not to Exceed $ _____

(Minimum of $100)

Patient Name: _____ DOB:_____

Card Holder Number _____-_____-_____-_____

Card Holder Expiration Date _____-_____

Cardholder Name _____

Cardholder address _____

City _____ State _____ Zip _____

_____ _____

Cardholder Signature Date

*This form is valid until patient or card holder revokes or suspends in writing or via phone.*

** We accept VISA, MasterCard and Discover Credit and/or Debit Cards**

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# HEALTH HISTORY QUESTIONNAIRE

DATE: _____ NAME: _____

DATE OF BIRTH: _____AGE: _____Ht:_____Wt:_____ RIGHT OR LEFT HANDED (Please Circle)

PHONE#: (H)_____(C)_____(W)_____

OCCUPATION:_____ CURRENTLY WORKING: Y N MARITAL STATUS:_____

PRIMARY CARE PHYSICIAN:_____ SPECIALTY DOCTOR:_____

NURSING HOME: _____ DATE OF INJURY: _____

**PAST MEDICAL HISTORY**:
Do you have or have you ever had……..

| | | | |
|---|---|---|---|
| Osteoarthritis | Yes ____ | Diverticulitis | Yes ____ |
| Rheumatoid Arthritis | Yes ____ | Asthma | Yes ____ |
| Polio | Yes ____ | CPAP Machine | Yes ____ |
| High Blood Pressure | Yes ____ | COPD/Emphysema | Yes ____ |
| High Cholesterol | Yes ____ | Tuberculosis | Yes ____ |
| Atrial Fibrillation | Yes ____ | Cancer, Type: _____ | Yes ____ |
| Heart Disease | Yes ____ | Stomach Ulcers | Yes ____ |
| Heart Bypass Surgery | Yes ____ | Mental Disorder _____ | Yes ____ |
| Heart Stent | Yes ____ | Depression | Yes ____ |
| Pacemaker | Yes ____ | Migraines | Yes ____ |
| Defibrillator | Yes ____ | Glaucoma | Yes ____ |
| Bleeding Tendency | Yes ____ | Cataracts | Yes ____ |
| Anemia | Yes ____ | AIDS or HIV | Yes ____ |
| Blood Clots (DVT), Date_____ | Yes ____ | MRSA | Yes ____ |
| Diabetes | Yes ____ | Auto Immune Disorder | Yes ____ |
| History Diabetes Foot Ulcers | Yes ____ | Type:_____ | |
| Chronic Open Wound _____ | Yes ____ | Hepatitis | Yes ____ |
| Stroke | Yes ____ | Kidney Disease | Yes ____ |
| TIA | Yes ____ | Renal Stent | Yes ____ |
| Peripheral Vascular Disease | Yes ____ | Gastric Bypass Surgery | Yes ____ |
| Thyroid Disease | Yes ____ | Seizures | Yes ____ |
| Fibromyalgia | Yes ____ | Do you have routine dental care? | Yes ____ |
| Genetic Disorder | Yes ____ | Dentist Name: _____ | |
| Type: _____ | | | |

Healthy with no medical problems: Yes ____

Do you get an annual Flu Shot? Yes ____ No ____

Have you had a fall within the last year? Yes ____ No ____

**Please list any other Major Illnesses or Fractures:**

_____ _____
_____ _____
_____ _____

**SURGICAL HISTORY**

Surgeries:

| Type of Surgery **(Left or Right side)** | Year Performed | Physician/Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list any prescription and/or non-prescription medications you are currently taking, including vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications. **Please also include any Diet Medications you are taking** (prescription or over the counter). *Attach another sheet if needed.*

| Name of Medication/How Often | Dose | Name of Medication/How Often | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**MEDICATION ALLERGIES** – Please list medications to which you had hives, skin rash, breathing problems or other allergic reactions.

| Name of Medicine: | Describe Allergic Reaction: |
|---|---|
| | |
| | |

Have you had any allergic reactions to the following:

| | | | |
|---|---|---|---|
| Shellfish/Seafood | Yes___ | Feathers/Eggs | Yes___ |
| Iodine or X-ray Contrast Dye | Yes___ | Latex or Rubber | Yes___ |
| Adhesive Tape | Yes___ | | |

**FAMILY HISTORY** – Please complete information below:

Father: Please Circle: Living or Deceased Age: _____ Cause of Death: _____ Illnesses: _____

Mother: Please Circle: Living or Deceased Age: _____ Cause of Death: _____ Illnesses: _____

Adopted: Please Circle: Yes or No

**SOCIAL HISTORY:**

Use of Alcohol: Yes or No Occasional _____ Social_____ Daily_____

Use of Tobacco: Yes or No or Former Please Circle: Smoke or Chew Average Packs/Day: _____

Use of Street Drugs: Yes or No