SOUTHEAST KANSAS ORTHOPEDIC CLINIC
1902 SOUTH HWY 59, BDLG D
PARSONS, KS 67357 (620) 421-0881

WILLIAM L. DILLON, MD *KEVIN M. MOSIER, MD* *BRAD R. MEISTER, MD*

*****PLEASE GIVE CURRENT INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST*****

Name:_____SS#_____
(Last) (First) (Middle Initial)
Date of Birth: _____ Age:_____ Sex:M☐F☐(check one)Married☐ Single☐ Divorced☐Widow☐

Mailing Address: _____City: _____ St:_____ Zip:_____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Referred By: _____Contact number: _____
CHIEF COMPLAINT FOR APPOINTMENT: _____
IS THIS WORK RELATED? YES / NO **IF YES YOU MUST HAVE PRIOR AUTHORIZATION**
Is this Auto related?☐YES / NO☐ Policy #: _____Agent/Contact: _____
Date of Accident/Injury: _____Time: _____ Where/How it Occurred: _____
Employer Name: _____Employer Address: _____Phone: _____

Person financially responsible for patient. (COMPLETE ONLY IF RESPONSIBLE PARTY IS DIFFERENT FROM PATIENT.)
Guarantor Name: _____DOB:_____SS#:_____
Relationship to Patient:_____Address:_____Phone#:_____

Who to call for an emergency:
Name: _____Phone#: _____Relationship:_____
Additional Contact Info:_____

PRIMARY INSURANCE INFORMATION:
Plan Name: _____ID#: _____Group#:_____
Policy Holder Name:_____ Policy Holder Date of Birth: _____SS#:_____
Policy Holder Employer: _____Employer Address:_____
Relationship to Patient:_____

SECONDARY INSURANCE INFORMATION:
Plan Name: _____ID#: _____Group#:_____
Policy Holder Name:_____ Policy Holder Date of Birth: _____SS#:_____
Policy Holder Employer: _____Employer Address:_____
Relationship to Patient:_____

Notice: We are committed to providing you with the best possible care. The ultimate responsibility for payment lies with the patient/guarantor. **Payment for services is due at the time of service unless payment arrangements have been approved in advance**. It is the responsibility of the patient to provide current insurance information and to verify that we are participating providers in your network. As a courtesy, Southeast Kansas Orthopedic Clinic submits claims to insurance companies for payment of services. All noncovered services, deductibles, coinsurance and co-pays are the patient's financial responsibility.
I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and other health plans to William L Dillon, MD, Kevin M Mosier, MD, and/or Brad R Meister, MD.
Consent for Health Care: Patient voluntarily consents to such medical care including but not limited to laboratory, diagnostic or medical treatment which may be ordered by the patient's physician or assistants, or designees for medical treatment which they may deem necessary and advisable.
The agreements and assignments will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. I, the undersigned, authorize William L Dillon, MD, Kevin M Mosier, MD, and/or Brad R Meister, MD, to release any information acquired in the course of my examination or treatment to my insurance company (s) or another physician or agents or employees of Southeast Kansas Orthopedic Clinic for the purposes of business operations, payment for health care services rendered and continual treatment or coordination of care.

☐ I acknowledge that I have had the opportunity to read and/or receive a copy of both the Southeast Kansas Orthopedic Clinic's Notice of Privacy Practices and Patient Financial Policy Sheet.

Patient, Parent/Guardian
Signature_____Date:_____

PATIENT MEDICAL INFORMATION Patient Name: _____

Primary Medical Physician: _____ Address _____ Phone: _____

Prior Surgeries/Dates: _____

_____

Past and Current Medical Problems: _____

_____

Current Medications, Name and Dose (prescription, non-prescription, and herbal): _____

_____

Drug and Food Allergies: (please list) _____

_____

Illnesses: (please check if you have any of the following medical problems)

☐ Diabetes ☐ High Blood Pressure ☐ Arthritis ☐ Gout ☐ Cancer (type) _____

☐ Blood Clots ☐ Stroke ☐ Lung disease ☐ Heart Attack ☐ Other _____

Current Weight: _____ lbs Current Height: _____

Weight changes over last 6 months: ☐ Stable ☐ Gain _____ lbs ☐ Loss _____ lbs

Social History:

Dominant Hand: ☐ Right ☐ Left

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
☐ Single	☐ Never	☐ Never	☐ With Family
☐ Married	☐ Rarely	☐ Previously, but quit	☐ With Friends
☐ Divorced	☐ Moderate	☐ Currently	☐ Alone
☐ Widowed	☐ Daily		☐ Other _____

Do you use illicit drugs? (Marijuana, cocaine, methamphetamine): ☐ YES / NO ☐

Family History: (Please list any family history medical problems (i.e. heart disease,stroke,diabetes,cancer)

Father: _____ Mother: _____

Siblings: _____ Other: _____

Review of Systems: Check YES or NO if you have any of the following problems:

CONSTITUTIONAL:		EARS/NOSE/THROAT:		EYES:	
Good general health	☐YES / NO☐	Hearing Loss/Ringing	☐YES / NO☐	Wears glasses/contacts	☐YES / NO☐
Recent weight change	☐YES / NO☐	Sinus Problems	☐YES / NO☐	Blurred/double vision	☐YES / NO☐
Night sweats fever	☐YES / NO☐	Nose bleeds	☐YES / NO☐	Eye disease or injury	☐YES / NO☐
Fatigue	☐YES / NO☐	Sore throat/voice change	☐YES / NO☐	Glaucoma/ Cataracts	☐YES / NO☐
CARDIOVASCULAR:		**RESPIRATORY:**		**GASTROINTESTIONAL:**	
Chest pain	☐YES / NO☐	Shortness of Breath	☐YES / NO☐	Nausea/vomiting	☐YES / NO☐
Palpitations	☐YES / NO☐	Cough	☐YES / NO☐	Abdominal pain	☐YES / NO☐
Pacemaker	☐YES / NO☐	Wheezing/Asthma	☐YES / NO☐	Rectal Bleeding	☐YES / NO☐
Swelling hands/feet	☐YES / NO☐	Coughing up Blood	☐YES / NO☐	Bowel problems	☐YES / NO☐
Heart Murmur	☐YES / NO☐	**NEUROLOGICAL:**		Diverticulosis	☐YES / NO☐
MUSCULOSKELETAL:		Frequent Headaches	☐YES / NO☐	**INTEGUMENTARY(SKIN/BREAST):**	
Muscle pain or cramps	☐YES / NO☐	Paralysis or tremors	☐YES / NO☐	Change in hair or nails	☐YES / NO☐
Stiffness/swelling joint	☐YES / NO☐	Convulsions/seizures	☐YES / NO☐	Rashes or itching	☐YES / NO☐
Joint Pain	☐YES / NO ☐	Numbness/tingling	☐YES / NO☐	Breast lump	☐YES / NO☐
Trouble walking	☐YES / NO☐	TIA/Stroke	☐YES / NO☐	Breast pain/discharge	☐YES / NO☐
ENDOCRINE:		**HEMATOLOGIC/LYMPHATIC:**		**ALLERGIC/IMMUNOLOGIC:**	
Excessive thirst/urination	☐YES / NO ☐	Anemia	☐YES / NO☐	Food allergies	☐YES / NO☐
Thyroid disease	☐YES / NO☐	Bleeding disorder	☐YES / NO☐	Aspirin allergies	☐YES / NO☐
Hormone problems	☐YES / NO☐	Enlarged lymph nodes	☐YES / NO☐	Antibiotic allergies	☐YES / NO☐
GENITOURINARY		**REPRODUCTIVE (FEMALE)**		**PSYCHIATRIC:**	
Blood in urine	☐ YES / NO☐	Date of last Period	_____	Insomnia	☐YES / NO☐
Kidney stones	☐ YES / NO☐	Regular Period	☐YES / NO☐	Confusion/Memory loss	☐YES / NO☐
Incontinence	☐ YES / NO☐	Post Menopausal	☐YES / NO☐	Depression	☐YES / NO☐

Patient, Parent/Guardian Signature _____ Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

SOUTHEAST KANSAS ORTHOPEDIC CLINIC

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name:_____

Date of Birth:_____

Signature:_____

Date of signature:_____

YES	NO	
☐	☐	May be contacted by email?
		email:_____
☐	☐	May be contacted by FAX?
		FAX #:_____
☐	☐	May leave message on answering machine?
		Phone #:_____

Please list below any family member or person you authorize to inquire about your medical records or appointments.

_____

_____

_____

_____

FINANCIAL AGREEMENT

Financial agreements may be offered on a case-by-case basis. **Payment at time of service is required for all uninsured patients** or for procedures or durable medical equipment that is deemed noncovered by your insurance. Balances may not be carried for more than 5 months. **SELF PAY NEW PATIENT** visits must be PAID in FULL at time of service.

If this account is allowed by you to be turned over for collections, you may be charged the collection agency's fee, in addition to your Southeast Kansas Orthopedic Clinic balance that is due.

By signing this Financial Agreement, I acknowledge that I have read and understand the agreement stated above.

Patient, Parent/Guardian
Signature_____Date:_____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of Southeast Kansas Orthopedic Clinic's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Type or Print) Date

Signature