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

KEVIN M. MOSIER, MD ***BRAD R. MEISTER, MD*** ***BRANDON L. MORRIS, MD***

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

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

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

Home Phone: _____ Cell Phone: _____Work Phone: _____

Employer Name: _____Employer Address: _____

Referred By: _____Contact number: _____
CHIEF COMPLAINT FOR APPOINTMENT: _____

Person financially responsible for patient: (*Complete only if person financially responsible differs from patient.*)
Guarantor Name: _____DOB:_____SS#:_____
Relationship to Patient:_____Address:_____Phone#:_____

Emergency contact:
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 Kevin M Mosier, MD, Brad R Meister, MD, Brandon L. Morris, MD, and/or their physician extenders.
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 Kevin M Mosier, MD, Brad R Meister, MD, Brandon L. Morris, MD, and/or their physician extenders 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 Name: _____

Primary Medical Physician: _____ Phone:_____

Specialist (*i.e. Cardiologist, Nephrologist. etc.*) _____

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 ☐ Stroke ☐ Cancer (type) _____

☐ Blood Clots ☐ Lung disease ☐ Heart Attack ☐ Hepatitis ☐ HIV/AIDS ☐ 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: Circle 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:_____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy (available on our website) 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*.

☐ **Yes** ☐ **No** A message may be left at the cell/home number I have listed.
Phone # _____

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

_____

_____

_____

_____

_____
Patient Name (Type or Print)

_____ _____
Signature *Date*