CAPSTONE
ORTHOPEDICS & SPORTS MEDICINE

Tel 620-259-2325
Fax 620-259-2337
1818 E 23rd Avenue Suite 1, Hutchinson, KS 67502

Patient Name : _____ ____ _____ **SS# :** _____
(First) (MI) (Last)

Date of Birth: _____ **Sex:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address: _____ **P.O. Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( )_____ **Cell:** ( )_____ **Email:** _____

Employer: _____ **Work Phone:** ( )_____

Spouse Name: _____ **Spouse DOB:** _____ **Spouse Phone:** ( )_____

Emergency Contact: _____ **Relationship:** _____ **Phone:** ( )_____

Primary Physician: _____ **Referring Physician:** _____

Pharmacy & Location: _____ **Phone:** ( )_____

I give permission for Capstone Orthopedics & Sports Medicine to contact the patient's pharmacy for a list of medications: ☐ **Yes** ☐ **No**

Race: ☐ Hispanic ☐ Asian ☐ Caucasian ☐ Black/African American ☐ American-Indian or Alaskan Native ☐ Other: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Ethnicity (Nationality-cultural background): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other: _____

-Person Responsible for Payment of Account-

Name: _____ **Relationship:** _____

Address: _____ **Home Phone:** ( ) _____

City, State, Zip: _____ **Other Phone:** ( ) _____

-Complete if Student or Under the age of 18-

Father Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ **DOB:** _____

Mother Information

Name: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

SS#: _____ **DOB:** _____

-Assignment of Benefits-

I authorize payment of benefits directly to Capstone Orthopedics & Sports Medicine (Capstone Orthopedics). I understand that I am financially responsible for all charges not covered by my authorization.

-Acknowledgement of Receipt of Privacy Notice-

The signature below acknowledges receipt of a copy of Capstone Notice of Privacy Practices (HIPPA Privacy Notice).

-E-Mail / Cell Phone Communications-

By providing Capstone Orthopedics with my cell phone number and/ or email address, I hereby grant to Capstone Orthopedics, and its agents or independent contractors, my consent to receive communications for treatment-related purposes (such as appointment reminders, registration instructions, surveys, etc.) and billing/ payment purposes on any and all cell phone number I list or use (even if unlisted) or via e-mail. This includes automated, artificial voice, and prerecorded phone calls. I understand communications by text and/ or e-mail are not considered secure communications and I can opt out of receiving further communications by these methods.

-Authorization for Medical Care-

I hereby authorize Capstone Orthopedics & Sports Medicine to provide me medical treatment for any and all conditions they deem appropriate. I understand the physician or other provider will review the recommendations for testing and/or treatment they deem appropriate for my medical needs based on their professional judgement.

-Financial Policy-

I have read, understand, and agree to the financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

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-Referral Waiver-

I acknowledge in the course of my treatment, Capstone Orthopedics & Sports Medicine, may refer me to other health care facilities and/or providers for diagnostic tests, treatment, or consultation. Capstone Orthopedics & Sports Medicine will notify me when such a referral occurs. Capstone Orthopedics & Sports Medicine assumes no responsibility for knowing if the facility or provider I am referred to is contracted with my insurance plan. Should Capstone Orthopedics and Sports & Medicine make such a referral, it is my responsibility to verify my insurance coverage, eligibility, pre-certification (if applicable), and whether the facility or provider I am referred to contracts with my insurance company. Capstone Orthopedics & Sports Medicine is not responsible should my insurance process claims at the non-contracting level for the referred service(s).

-Communication Preferences-

By signing below, *I give permission to the person(s) listed to receive LIMITED information about my care.* I understand my healthcare provider will utilize their professional judgement to ensure that information is shared with family/friends in order to assist with my continuing care. Any request for information not directly relevant to participation in care and any requests for copies of medical records will require a signed HIPAA complaint authorization. This permission will be considered valid for one year unless otherwise revoked in writing.

-Release of Information-

I hereby authorize Capstone Orthopedics and its staff to release any and all information to insurance companies needed to secure payment of benefits. In addition, I authorize Capstone Orthopedics to release my protected health information to myself, to my primary care or referring physician(s), and to consulting physicians ay information used for treatment.

Note: If you want to give an individual more access to your health information than offered below, you must complete a valid authorization form stating in detail the nature of the information you want released (see receptionist).
Please indicate your preferences below:

1. ☐ Do NOT share ANY information with anyone.
2. Please identify below individual(s) you would like us to share information with and mark the appropriate boxes regarding the type(s) of information we can share with each respective individual(s).

Name: _____ Relationship: _____
☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Name: _____ Relationship: _____
☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

Physicians/Providers:

☐ You may also share information, including medical records, with the following physicians/providers who participate in my care:

Name: _____ Name: _____

College or High School Athletic Department: _____
☐ Appointment Dates and Times ☐ Relevant Test Results & Treatment Recommendations ☐ Billing Information

_____ _____ _____
Signature of Patient or Personal Representative **Printed Name** **Date**

If Personal Representative, relationship to patient: _____

Patient: DOB: Office Visit Date:

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Description of the symptoms: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness Other: _____

Shoulder:	☐ Right ☐ Left	Pelvis:	☐ Right ☐ Left	Neck:	☐
Upper Arm:	☐ Right ☐ Left	Hip:	☐ Right ☐ Left	Upper Back:	☐
Elbow:	☐ Right ☐ Left	Thigh:	☐ Right ☐ Left	Mid Back:	☐
Forearm:	☐ Right ☐ Left	Knee:	☐ Right ☐ Left	Low Back:	☐
Wrist:	☐ Right ☐ Left	Lower Leg:	☐ Right ☐ Left	Buttocks:	☐
Hand:	☐ Right ☐ Left	Ankle:	☐ Right ☐ Left	Tail Bone:	☐
Thumb:	☐ Right ☐ Left	Foot:	☐ Right ☐ Left		
Index Finger:	☐ Right ☐ Left	Great Toe:	☐ Right ☐ Left		
Middle Finger:	☐ Right ☐ Left	2nd Toe:	☐ Right ☐ Left		
Ring Finger:	☐ Right ☐ Left	3rd Toe:	☐ Right ☐ Left		
Small Finger:	☐ Right ☐ Left	4th Toe:	☐ Right ☐ Left	5th Toe:	☐ Right ☐ Left

History of Present Illness

1. **How did the symptoms start?** ☐ Acute (Sudden) ☐ Chronic Condition (Gradual Onset)
   When did the symptoms start? (ex: 2 days, 4 months, or an exact date): _____
2. **Is your problem the result of an injury or accident?** ☐ Yes ☐ No
   ☐ Injury at Work ☐ Auto Accident ☐ Sports Injury ☐ Prior Surgery ☐ Other Injury
   Injury Date (ex: mm/dd/yyyy): _____
   Brief description of the injury: _____
3. **Are you represented by an attorney?** ☐ Yes ☐ No
4. **Have you had a problem like this before?** ☐ Yes ☐ No
5. **Rate the pain (10 being the most pain).** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. **Do the symptoms wake you from sleep?** ☐ Yes ☐ No
7. **Please describe the symptoms.** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting
8. **What is the timing of the symptoms?** ☐ Constant ☐ Intermittent (comes & goes)
9. **Is the problem getting better or worse?** ☐ Getting Better ☐ Getting Worse ☐ Unchanged
10. **What makes the symptoms worse?**
    ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Lying in Bed ☐ Moving ☐ Twisting
    ☐ Running ☐ Walking ☐ Athletics ☐ Standing ☐ Gripping ☐ Lifting ☐ Reaching Overhead
11. **Are there any other symptoms associated to this problem?**
    ☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking
    ☐ Locking ☐ Popping ☐ Tingling ☐ Weakness ☐ Giving Way
12. **Have you been seen in ER for this problem?** ☐ Yes ☐ No
    Treating ER: (ex. St. Luke's Health) _____. Date seen: _____
13. **Have you had prior treatment by another provider?** ☐ Yes ☐ No Physician's name: _____
14. **Have you had any prior testing for this problem?**
    ☐ None ☐ X-rays ☐ MRI ☐ CAT Scan ☐ Bone Scan ☐ Nerve Test (EMG)
15. **Prior Treatments:**
    ☐ Ice ☐ Heat ☐ Rest ☐ NSAIDs ☐ Muscle Relaxers ☐ Chiropractor ☐ Physical Therapy ☐ Surgery
    ☐ Home Exercise Program ☐ Injections ☐ Bracing ☐ Tens Unit ☐ Other/Comments: _____.

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Past Surgical History

Select all previous hospitalizations/surgeries: ☐ None

☐ Aneurysm	☐ Hysterectomy
☐ Aortic Bypass/ Vascular	☐ LAP Band / Gastric Bypass
☐ Appendectomy	☐ Lumpectomy
☐ Cataract (Eye) Surgery	☐ Mastectomy
☐ Cancer/Malignancy	☐ Cholecystectomy (Gallbladder)
☐ Heart Surgery	☐ Stents
☐ Hernia Repair	☐ Tonsillectomy

Other Surgery: _____

Orthopedic Surgery:	**Right**	**Left**
Knee Arthroscopy:	☐	☐
Shoulder Arthroscopy:	☐	☐
Carpal Tunnel Release:	☐	☐
Rotator Cuff Repair:	☐	☐
Total Hip Replacement:	☐	☐
Total Knee Replacement:	☐	☐
Total Shoulder Replacement:	☐	☐

Spinal (Back) Surgery-Indicate Level: _____

Medical Questions:

Select all that apply:

☐ Metal in body ☐ Claustrophobic ☐ Pregnant ☐ Sleep Apnea ☐ Use a CPAP ☐ Snores

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months: ☐ None for all

				None
1) CON	☐ Weight Loss	☐ Loss of Appetite	☐ Fatigue	☐
2) EYE	☐ Blurred Vision	☐ Double Vision	☐ Vision Loss	☐
3) ENT	☐ Hearing Loss	☐ Hoarseness	☐ Trouble Swallowing	☐
4) CARDIO	☐ Chest Pain	☐ Palpitations		☐
5) RESP	☐ Chronic Cough	☐ Pneumonia	☐ Shortness of Breath	☐
6) GI	☐ Heartburn, Ulcers	☐ Nausea, Vomiting	☐ Blood in Stool	☐
7) GU	☐ Painful Urination	☐ Blood in Urine	☐ Kidney Problems	☐
8) SKIN	☐ Frequent Rashes	☐ Skin Ulcers	☐ Lumps ☐ Psoriasis	☐
9) NEURO	☐ Frequent Falls	☐ Loss of Coordination	☐ Numbness	☐
	☐ Change in Bowel	☐ Change in Bladder	☐ Dizziness	
10) PSYCH	☐ Depression/Anxiety	☐ Drug/Alcohol Addiction	☐ Sleep Disorder	☐
11) ENDO	☐ Fever	☐ Heat or Cold Intolerance	☐ Night Sweats	☐
12) HEM	☐ Easy Bleeding	☐ Easy Bruising	☐ Anemia	☐

Family History

Have any direct relatives had any of the following disorders? ☐ None for all

Father:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		
Mother:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		
Sibling:	☐ None	☐ Diabetes	☐ Heart Disease	☐ Hypertension	☐ Bleeding Problems
	☐ Epilepsy	☐ Connective Tissue	☐ Muscular Dystrophy	☐ Stroke	☐ Osteoporosis
	☐ Cancer	☐ Rheumatoid Arthritis	☐ Unknown		

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Social History

1. **Do you smoke tobacco?** ☐ Current smoker ☐ Former ☐ Never ☐ Smokeless Tobacco ☐ Recreational Drug Use
2. **Do you drink alcohol?** ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never ☐ Former
3. **Martial History:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partnership
4. **Employment Status?** ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Medical History

Select any problems you currently have or have had in the past. ☐ **NONE OF THESE APPLY TO ME**

☐ Aids/HIV	☐ Congestive Heart Failure	☐ Gout	☐ Heart Attack: year_____
☐ Alcoholism	☐ COPD	☐ Hepatitis: Type____	☐ Rheumatoid Arthritis
☐ Anemia	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Seizure disorder
☐ Arthritis	☐ Depression	☐ Hypertension	☐ Sleep Apnea
☐ Asthma	☐ Diabetes	☐ Lupus	☐ Inflammatory Bowel Disease
☐ Atrial Fibrillation	☐ Drug Abuse	☐ Kidney Disease	☐ Stomach Ulcer
☐ Cancer: Type_____	☐ Blood Clot/DVT	☐ Liver Disease	☐ Thyroid Problems
☐ Stroke	☐ GERD	☐ Osteoporosis	☐ Other:_____

Allergies

☐ Sulfa Allergy ☐ Penicillin Allergy ☐ Latex Allergy ☐ Iodine/Dye Allergy

Do you have any other medication allergies? ☐ Yes ☐ No If yes, list below with the reaction to the allergy:

_____

Medications

Please provide a current list of your medications if available.

Name	Dose/Strength	Frequency

Patient: DOB: Office Visit Date:

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Narcotic Medication Consent Form

I hereby consent to the use of narcotic medication prescribed for pain as a means of achieving a higher level of daily functioning. I agree to open, honest and regular communication with my Provider to monitor my use of narcotic medication.

The **potential risks** of narcotic medication include, but are not limited to:

- **Addiction**
- **Interference with Physical and/or Mental Functioning**
  Narcotics may interfere with driving, operating machinery or other requirements of my job. I understand it is my responsibility to avoid these risks.
- **Physical Dependence**
  I understand that abrupt discontinuation of a narcotic drug may cause nausea, vomiting and sweating.
- **Tolerance**
  I understand that in the future, narcotics may no longer work to manage my pain. It will be necessary to slowly taper from the narcotic and to develop other behaviors for pain management (e.g., exercise, healthy diet, stress management, etc.).
- **Pregnancy Risk**
  I understand that narcotic drugs affect a developing fetus and may result in birth defects. I agree to inform my Provider if I am currently pregnant or should become pregnant during the course of my treatment.

Patient Agreement

1. I agree not to take narcotic medications from any other source.
2. I agree to inform my Provider of any other medications I take during this time.
3. I agree to allow my Provider to set the interval at which I may request narcotic prescriptions.
4. I agree to practice pain management behaviors regularly.
5. I agree to provide a urine sample for drug screening, upon request.
6. I will not alter my prescription in any way.
7. I agree to fill my prescription through one pharmacy, and will notify both my Provider and pharmacy of any change.
8. I understand that violation of any of the above may result in the termination of my Provider/patient relationship.
9. Once my dosage is stable, my prescriptions may be transferred to my family physician.
10. I understand that no prescriptions will be processed after noon on Fridays and the office requires 24-hour notice to process refills.

There may be specific risks that pertain to my illness. There is a small chance these risks have gone undiagnosed. I have been given the opportunity to explore alternative methods for evaluation and pain management. I have been allowed to ask any questions regarding my pain control.

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As a result of the increasing awareness of narcotic dependence and abuse, Capstone Orthopedics & Sports Medicine (COSM) will closely manage its patients' use of prescription narcotics in accordance with the following ***policy guidelines****:*

1. For patients referred by a medical practitioner outside of COSM: The referring provider is responsible for managing all pain medications until a final treatment plan has been recommended by a Provider at COSM. The final treatment plan is dependent upon the COSM Provider having all of the diagnostic tests available for his/her review in order to make a diagnosis and recommend a treatment plan. Narcotics are rarely part of the initial treatment plan.

2. For patients who are self-referred to COSM, non-operative: Narcotic pain relievers will rarely be prescribed at the initial consultation. In the event a non-operative management strategy is implemented, and narcotic pain management is required, it will be limited to 10 days.

3. For post-surgical patients: In the event surgery has been performed by a surgeon at COSM, postoperative narcotic pain management by COSM will be limited. Duration of narcotic treatment will vary based on the procedure performed. Careful reassessment will take place for further prescription needs. Much of what we treat is painful, and we want to be sure that your pain and recovery is well managed.

4. If the patient has a pain management provider outside of COSM, then the COSM Provider will coordinate postoperative pain management with that Provider. After the postoperative period, the patient will resume management with that provider. Any patient requesting narcotic pain medications beyond 8-weeks will be referred to a pain management provider.

5. For patients who have a current pain management contract with an outside provider: COSM will not assume refilling baseline narcotics for those patients who are on opiates for chronic pain or under the care of a pain management Provider.

6. Requests for prescription refills: If a patient has not been seen in the offices of COSM during the preceding 3 months, no prescriptions will be written without reassessment of the patient. **Prescription refills may require up to 5 working days.**

I have read and agree to the *Capstone Orthopedics & Sports Medicine* Narcotics Prescription Policy.

I hereby give my consent freely, voluntarily and without reservation.

Patient Name (printed): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Pharmacy Name and Address: _____