Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE
The One To Trust

P.O. Box 5116
810 E. 23rd Street Sioux Falls, SD 57117-5116
605.331-5890 888.331.5890
www.orthopedicinstitutesf.com

Dear Patient:

Thank you for choosing Orthopedic Institute for your orthopedic needs. We strive to provide you with excellent care and to make your visit go as smoothly as possible, please note the following:

Please be sure to bring the following information to your appointment:

- ☐ **Completed forms** enclosed with this letter.
- ☐ **Your insurance card(s)**. As each plan varies regarding approved physicians, please verify with your insurance plan that the doctor you are seeing is in-network with your insurance plans.
- ☐ **Copay**. Insurance copays are due at the time of your appointment. **If you do not have insurance, we will collect a $100 deposit at the time of registration** which will be applied to your account balance.
- ☐ **Previous medical records** relating to your current issue. Please be sure to notify our office of previous records related to your visit by calling 605-331-5890. This includes x-rays, MRI's, CT scans, bone scans, x-ray and MRI reports, clinic notes, and operative notes. Without this information, the doctor may not be able to complete your evaluation and you may need to return for another appointment.
- ☐ **Medications:** Please bring a list of all medications (prescription and nonprescription) that you are currently taking.
- ☐ **Referral**
  Written referrals can be faxed to our Business Office at 605-336-3974.
- ☐ **Workers' Compensation or Motor Vehicle Accident Insurance (MVA):** If your visit is for an injury that occurred on the job or in a motor vehicle accident, the following information is **required** before you can be seen.
  - o Employer
  - o Date of injury
  - o Insurance company name and address
  - o Claim number
  - o Private health insurance card (in case workers' compensation or MVA insurance denies payment)

Completion of the enclosed forms and providing the information requested will assist us in our goal of making your visit a pleasant experience and will ensure that your insurance claim(s) will be submitted accurately and in a timely fashion. Failure to fully complete your forms or bring required information with you may delay your appointment.

We ask that you arrive 15 minutes prior to your scheduled appointment time for x-rays and to complete paper work. If you are unable to keep this appointment, please call us at 1-605-331-5890 at least 24 hours prior to your scheduled appointment time.

Sincerely,
Orthopedic Institute

APPOINTMENT

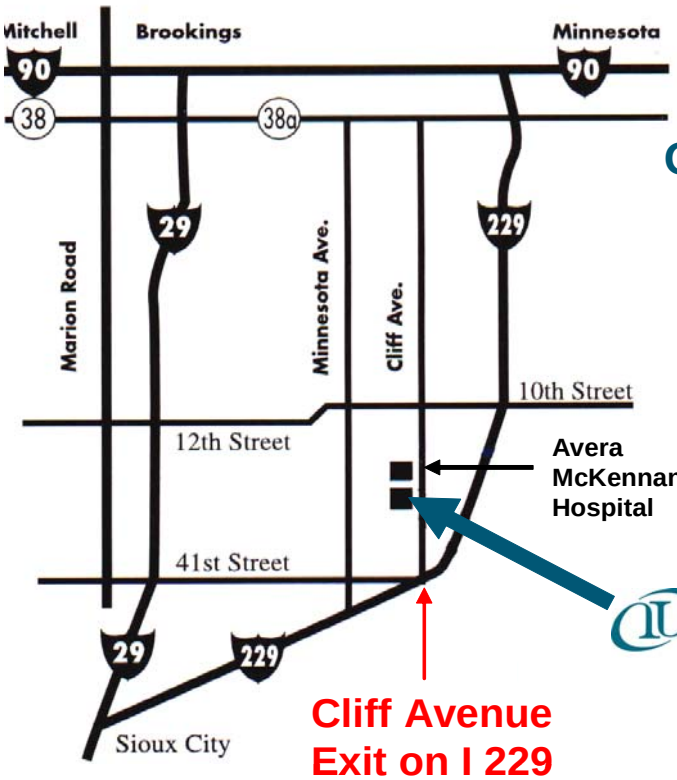
Day: _____ Date: _____ Time: _____

☐	Sioux Falls, SD	Orthopedic Institute, 810 E. 23rd St., 1st Floor (605) 331-5890 or 1-888-331-5890
☐	Brookings, SD	Orthopedic Institute, 407 22nd Ave. (605) 692-7666 or 1-888-331-5890
☐	Mitchell, SD	1204 S. Burr St. (605) 995-1098 or 1-888-331-5890
☐	Yankton, SD	Morgen Square - 1101 Broadway #106 (605) 665-0077 or 1-888-331-5890

At our Sioux Falls location, please check in at our registration area on 1st floor, just past the elevators.

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

Sioux Falls, South Dakota

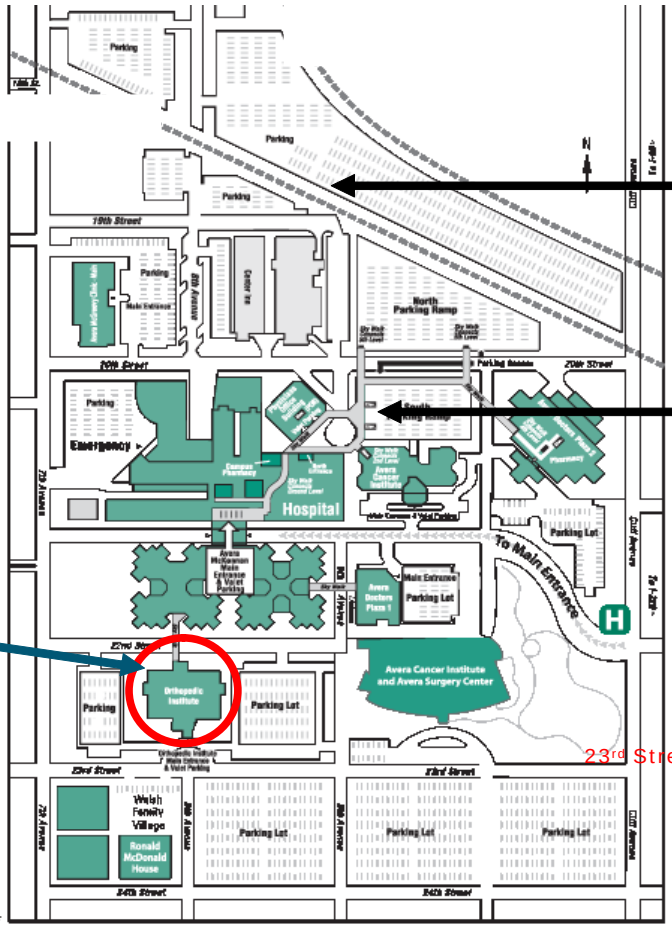


Onsite Parking & Valet Service Available

ORTHOPEDIC INSTITUTE

810 E. 23rd Street
Sioux Falls, SD 57105
605.331.5890

Cliff Avenue Exit on I 229



ORTHOPEDIC INSTITUTE

Cliff Ave Exit from I 229 – North to 23rd Street – West to OI

Name: _____
DOB: _____ Age: _____
Chart: _____
Date: _____

ORTHOPEDIC INSTITUTE

How were you referred for this visit? (Please circle all that apply)

Friend/family member
Physician referral
Yellow Pages
Recommended by the hospital
Web Site
Other: _____

Saw your advertising:
TV
Lecture/Presentation
Newspaper
Radio

PATIENT NAME (Please Print full Legal Name)

First Name: _____ MI: _____
Last Name: _____
Prefer to be called: _____
Date of Birth _____/_____/_____ Age _____
[ ] Male [ ] Female
Last 4 digits of Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Preferred Method of Contact: [ ] e-mail [ ] cell phone
[ ] work phone [ ] home phone [ ] mail

Preferred Language: _____ [ ] Decline
Race: [ ] American Indian [ ] Asian [ ] Black [ ] White
[ ] Native Hawaiian [ ] Decline
Ethnicity [ ] Hispanic Origin [ ] Non-Hispanic Origin
[ ] Decline

Name of Person to Contact in an Emergency?

Home Phone: Work Phone:

Employed: ☐ Yes ☐ No
If Employed, Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____
Occupation: _____

Student: ☐ Yes ☐ No
If Student, Name of School: _____

Patient Status:
[ ] Single [ ] Married [ ] Child [ ] Other _____
If Married, Name of Spouse: _____

Is this illness/Injury a result of:
☐ Accident/Illness that Occurred at Work
☐ Auto Accident
☐ Accident/Illness Involving Liability
☐ Any Other Accident/Injury
Date of Injury/Accident: _____
State in Which Accident Occurred: _____

Who is Responsible for Payment (if other than patient)?:

Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____
Relationship to Patient: _____

FOR ALL PATIENTS:

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____
Address: _____
Policyholder Name: _____
Policyholder DOB: _____
Policyholder Employer: _____
Relationship to Policyholder: _____
Group #: _____ ID#: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____
Address: _____
Policyholder Name: _____
Policyholder DOB: _____
Policyholder Employer: _____
Relationship to Policyholder: _____
Group #: _____ ID#: _____

FOR ALL MEDICARE PATIENTS

Medicare Eligibility Based On:
☐ Age ☐ Disability ☐ End Stage Renal Disease

1. Do you or your spouse work for a company that provides you with health insurance?
   ☐ Yes ☐ No
2. Are you a nursing home patient:
   ☐ Yes ☐ No
3. Has treatment for this accident/illness been authorized by the Veterans Administration?
   ☐ Yes ☐ No
4. Are you entitled to benefits under the Federal Black Lung Program?
   ☐ Yes ☐ No

IMPORTANT: PLEASE COMPLETE THE SECOND PAGE

Name: _____
DOB: _____ Age: _____
Chart: _____
Date: _____

AUTHORIZATION TO DISCUSS TREATMENT

There may be occasions when you want to give another person the ability to discuss your care at Orthopedic Institute (billing, treatment, appointments, prescriptions, etc.). Examples include spouse, parent (if you are over 18), another family member, adult child, coach, nursing home staff, care provider, etc. This authorization will allow discussion only. It does not authorize the release of medical records. I give my permission for Orthopedic Institute personnel to share information verbally regarding my treatment at Orthopedic Institute with the following person(s):

NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____
NAME: _____ RELATIONSHIP: _____

There may be occasions when Orthopedic Institute needs to contact you to discuss your care. I give permission to contact me by phone at: [ ] Home [ ] Cell [ ] Work

I give permission for Orthopedic Institute personnel to leave messages regarding appointments, treatment, etc., and to release verbal information as described above. Messages may be left on my phone at: [ ] Home [ ] Cell [ ] Work

AUTHORIZATION TO PAY ORTHOPEDIC INSTITUTE, P.C.

I authorize payment directly to Orthopedic Institute, P.C. of benefits payable under this policy. I understand that I will be financially responsible to Orthopedic Institute, P.C. for any charges not covered by this policy. It is the objective of this office to provide our patients with the best available care and facilities at a reasonable cost. In an effort to eliminate the expense of billing and collection, we ask that you pay for these services as they are rendered. A service charge of 1.2% will be added to accounts over 90 days past due. If you have insurance, please understand that this is an agreement between you and your insurance company to pay certain amounts for medical care. Our bill for services is an agreement between you and us. If unusual circumstances should make it impossible to meet our credit terms, please call or personally to discuss the matter with our credit manager. This will avoid misunderstandings and enable you to keep your account in good standing.

E-PRESCRIBING AUTHORIZATION

#1 [ ] I agree that Orthopedic Institute, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

OR

#2 [ ] I do not consent to Orthopedic Institute receiving my prescription medication history.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (Please check only 1 box)

#1 [ ] The undersigned hereby acknowledges that he/she was offered the Orthopedic Institute, P.C. Summary Notice of Privacy Practices and declined a copy.

OR

#2 [ ] The undersigned hereby acknowledges receipt of the Orthopedic Institute, P.C. Summary Notice of Privacy Practices and attached Notice of Privacy Practices.

E-Mail Address:

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

#1 [ ] I agree and consent to receive all forms of electronic communication, including medical records and billing information, sent to me by Orthopedic Institute.

OR

#2 [ ] I do not consent to electronic communication to and from Orthopedic Institute.

SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT (parent, foster parent, attorney, etc.): _____

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE

PATIENT MEDICAL HISTORY

Nurse's Initials _____

*** FOR OFFICE USE ONLY - TO BE COMPLETED BY OI STAFF ***

Physician: _____ Date: _____ Time: _____

EP NP 2nd Opinion Last OI Appointment: _____ (Date) _____ (Physician/PA)

PATIENT INFORMATION - TO BE COMPLETED BY PATIENT

Name: _____ DOB: _____

Gender: [ ] Male [ ] Female Occupation: _____

Do you use tobacco? Yes No Type: _____ Amount: _____ # of Years: _____

Have you fallen in the last 6 months? [ ] Yes [ ] No

Referring Physician: _____ City: _____ State: _____

Family Physician: _____ City: _____ State: _____

Chiropractor: _____ City: _____ State: _____

If you prefer us **NOT** to send a courtesy copy of today's visit to your Family Physician listed above, please check here: [ ]

If you prefer us **NOT** to send a courtesy copy of today's visit to your Chiropractor listed above, please check here: [ ]

DESCRIPTION OF PROBLEM - TO BE COMPLETED BY PATIENT

Where is your pain? _____ [ ] Right [ ] Left

Date of onset: _____ Type of pain (Circle all that apply): Burning Aching Dull Throbbing

Describe the injury/accident or what caused the pain: _____

What makes the pain worse? _____

What makes the pain better? _____

What is the severity of your pain (please circle one): (Least) 1 2 3 4 5 6 7 8 9 10 (Worst)

Other symptoms (circle all that apply): Numbness Tingling Bruising Night Pains Other: _____

Are you taking any medications for this problem? Yes No If yes, what type? _____

Have you ever received any chiropractic care for this problem? Yes No If yes, for how long? _____

Have you ever received any physical therapy for this problem? Yes No If yes, for how long? _____

Have you ever had surgery in the location of your current pain? Yes No If yes, when? _____

Have you ever had injections for this problem? Yes No If yes, what kind of injection? _____

Have you ever had other tests/treatments for this problem? Yes No If yes, what? _____

* FOR OFFICE USE ONLY - TO BE COMPLETED BY OI STAFF *

DOMINANT HAND: RIGHT LEFT HT _____ WT _____ BMI _____ [ ] Reported [ ] Measured

PREGNANT: Yes No

Have you ever had x-rays of the problem area? Yes No

Date: _____ Body part x-rayed: _____ Where (facility, city, state): _____

Date: _____ Body part x-rayed: _____ Where (facility, city, state): _____

Date: _____ Body part x-rayed: _____ Where (facility, city, state): _____

Have you ever had an MRI, CT Scan, Bone Scan? Yes No

Date: _____ Body Part Scanned: _____ Where (facility, city, state): _____

Date: _____ Body Part Scanned: _____ Where (facility, city, state): _____

OUTSIDE RECORDS ATTACHED? YES NO

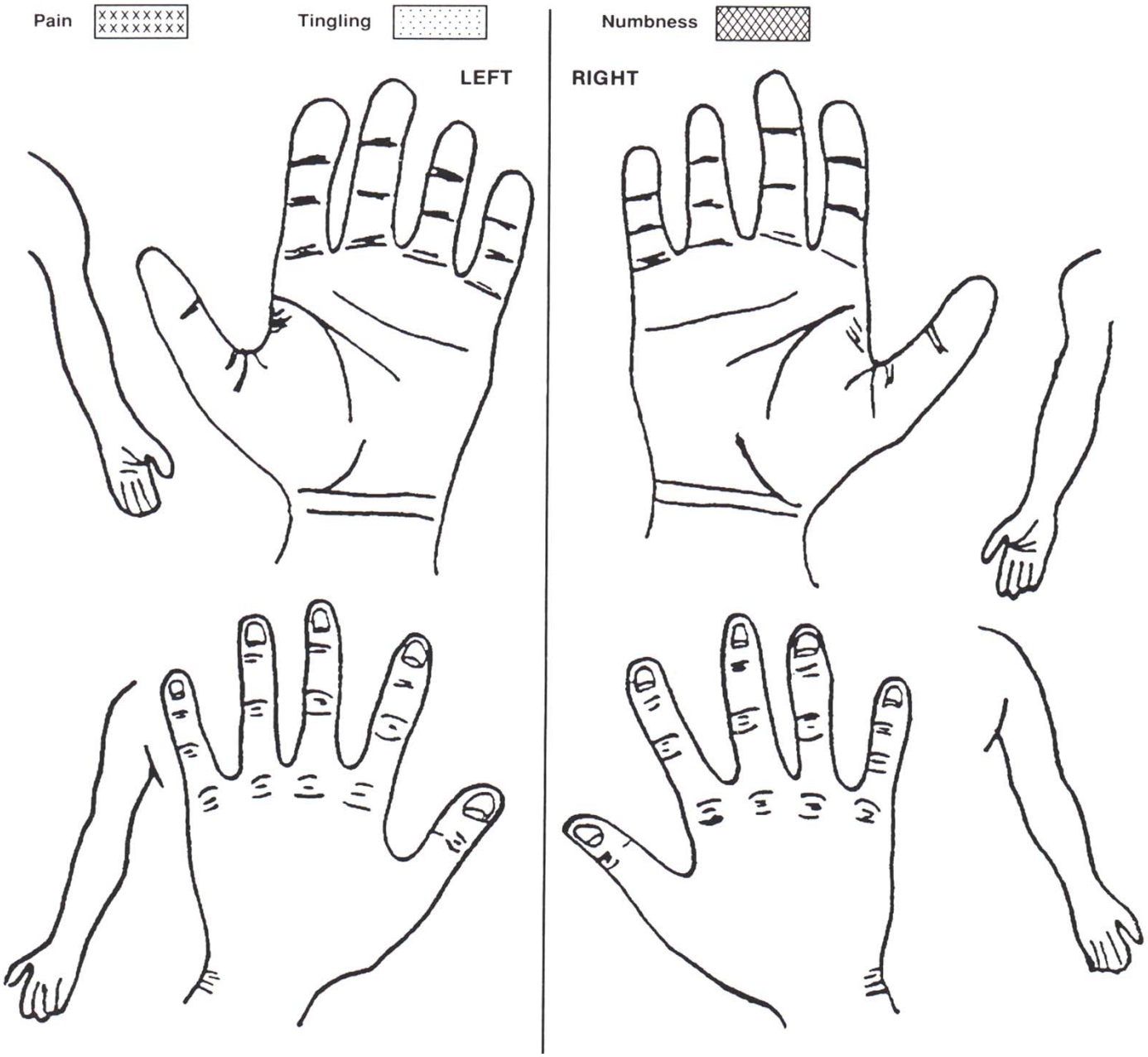
Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE

810 East 23rd Street
P.O. Box 5116
Sioux Falls, SD 57117-5116
Telephone: (605) 331-5890
Toll Free: 1-888-331-5890

WHERE IS YOUR PAIN OR NUMBNESS?

Please mark the drawings below where you feel the pain.
Please use the appropriate symbol. Please include all affected areas.



Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE

PATIENT CHIEF COMPLAINT

This form must be completed in YOUR OWN HANDWRITING BEFORE your examination with your physician.

Chief Complaint/Symptoms: _____

When did you first notice symptoms? _____

Please complete the following section **ONLY** if your chief complaint/symptoms were due to an ACCIDENT or INJURY.

Date of accident/injury: _____

Location or place of accident/injury: _____

Please describe accident/injury (emphasis on who, what, when, why, how): _____

Please describe the symptoms which resulted from the accident/injury: _____

Patient's Signature: _____ **Date:** _____

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE

PATIENT'S MEDICAL, FAMILY, AND SOCIAL HISTORY
REVIEW OF SYSTEMS

Please circle any past and/or present medical problems as they pertain to you.

GENERAL
Birth defect
Describe: _____
Cancer
Describe: _____
Diabetes
Emotional difficulty
Epilepsy/seizures
HIV/AIDS
Lymphoma
Polio
Rheumatic fever
Scarlet fever
Thyroid disease

BLOOD
Anemia
Blood clot
Blood transfusions

CARDIOVASCULAR
Heart attack
Heart problems
High blood pressure
Pacemaker/defibrillator
Stroke

GI/GU
Bowel disorder
Gallbladder problems
GI bleed
Hepatitis/jaundice
Hernia
Kidney problems
Kidney stones
Liver problems
Reflux disease
Ulcer

ORTHOPEDIC
Arthritis
Fracture
Lupus
Nerve compression/irritation
Osteomyelitis (bone infection)
Rheumatoid arthritis
Spinal disc problem

RESPIRATORY
Asthma
Emphysema
Lung disease
Pneumonia
Tuberculosis (TB)

OTHER: _____

Please circle any past and/or present medical problems as they pertain to your parents or brothers/sisters and indicate relationship to you.

Allergies:	Parent	Brother/Sister	Heart problems:	Parent	Brother/Sister
Bleeding tendencies:	Parent	Brother/Sister	High blood pressure:	Parent	Brother/Sister
Cancer:	Parent	Brother/Sister	Kidney problems:	Parent	Brother/Sister
Diabetes:	Parent	Brother/Sister			

Review of Systems: Please circle any symptoms that apply to your current health.

GENERAL
Fatigue
Fever
Change in sleep habits
Unplanned weight change

HEENT
Blurry or double vision
Ear pain
Hearing loss
Hoarse voice
Nosebleeds

CARDIAC
Chest pain/discomfort
Heart murmur
Irregular heartbeat
Leg swelling

RESPIRATORY
Cough
Shortness of breath
Wheezing

GI/GU
Belly pain
Blood in urine
Blood in stool
Constipation
Diarrhea
Heartburn
Incontinence (bladder)
Incontinence (bowel)
Nausea and/or vomiting
Painful urination

SKIN
Changes in color
Dryness
Lesions

MUSCULOSKELETAL
Back pain
Muscle weakness
Muscle cramps
Neck pain
Stiff joints
Swollen joints

NEUROLOGICAL
Anxiety
Decreased memory
Depression
Dizziness
Fainting
Headaches
Mood swings
Numbness and tingling
Seizures
Tremors

Have you ever taken cortisone or steroid type drugs? YES NO
If yes, when? _____ What kind? _____ Dosage: _____
Do you or have you used street drugs? YES NO
If yes, what kind? _____ Average amount per week? _____
Do you drink alcoholic beverages? YES NO
If yes, what type of alcohol? _____ Average amount per week? _____

Patient's Signature _____ **Date** _____

Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

ORTHOPEDIC INSTITUTE

PAST MEDICAL & SURGICAL HISTORY

Please list any Allergies

Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____ Allergy: _____ Reaction: _____

Please list any Past Surgeries

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

Please list any Chronic Illnesses

_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____
_____ Year Diagnosed: _____

Reviewed By: _____ Date: _____ Reviewed By: _____ Date: _____
Reviewed By: _____ Date: _____ Reviewed By: _____ Date: _____
Reviewed By: _____ Date: _____ Reviewed By: _____ Date: _____
Reviewed By: _____ Date: _____ Reviewed By: _____ Date: _____