

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Chart: \_\_\_\_\_  
 Age: \_\_\_\_\_  
 Date: \_\_\_\_\_



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

Orthopedic Surgeons  
 M.J. Adler, M.D.  
 K.M. Baumgarten, MD  
 W.O. Carlson, MD  
 R.B. Curd, MD  
 E.N. Hermanson, MD  
 T.D. Howey, MD  
 D.C. Johnson, MD  
 M.C. Johnson, DO  
 D.B. Jones, Jr., MD  
 P.A. Looby, MD  
 M.J. McKenzie, MD  
 C.P. Rothrock, MD  
 R.C. Suga, MD  
 E.S. Watson, MD  
 T.M. Zoellner, MD

Interventional Pain Management  
 J.T. Brunz, MD

Physical Medicine  
 K.C. Chang, MD

Outreach Clinics  
 Brookings, SD  
 Creighton, NE  
 Freeman, SD  
 Huron, SD  
 Madison, SD  
 Marshall, MN  
 Mitchell, SD  
 Rapid City, SD  
 Rock Valley, IA  
 Sibley, IA  
 Spirit Lake, IA  
 Tyndall, SD  
 Wagner, SD  
 Yankton, SD

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.
  - Employer
  - Date of injury
  - Insurance company name and address
  - Claim number
  - 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

<b>APPOINTMENT</b>		
Day: _____	Date: _____	Time: _____
<input type="checkbox"/> Sioux Falls, SD	Orthopedic Institute, 810 E. 23rd St., 1st Floor (605) 331-5890 or 1-888-331-5890	
<input type="checkbox"/> Brookings, SD	Orthopedic Institute, 407 22nd Ave. (605) 692-7666 or 1-888-331-5890	
<input type="checkbox"/> Mitchell, SD	1204 S. Burr St. (605) 995-1098 or 1-888-331-5890	
<input type="checkbox"/> 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



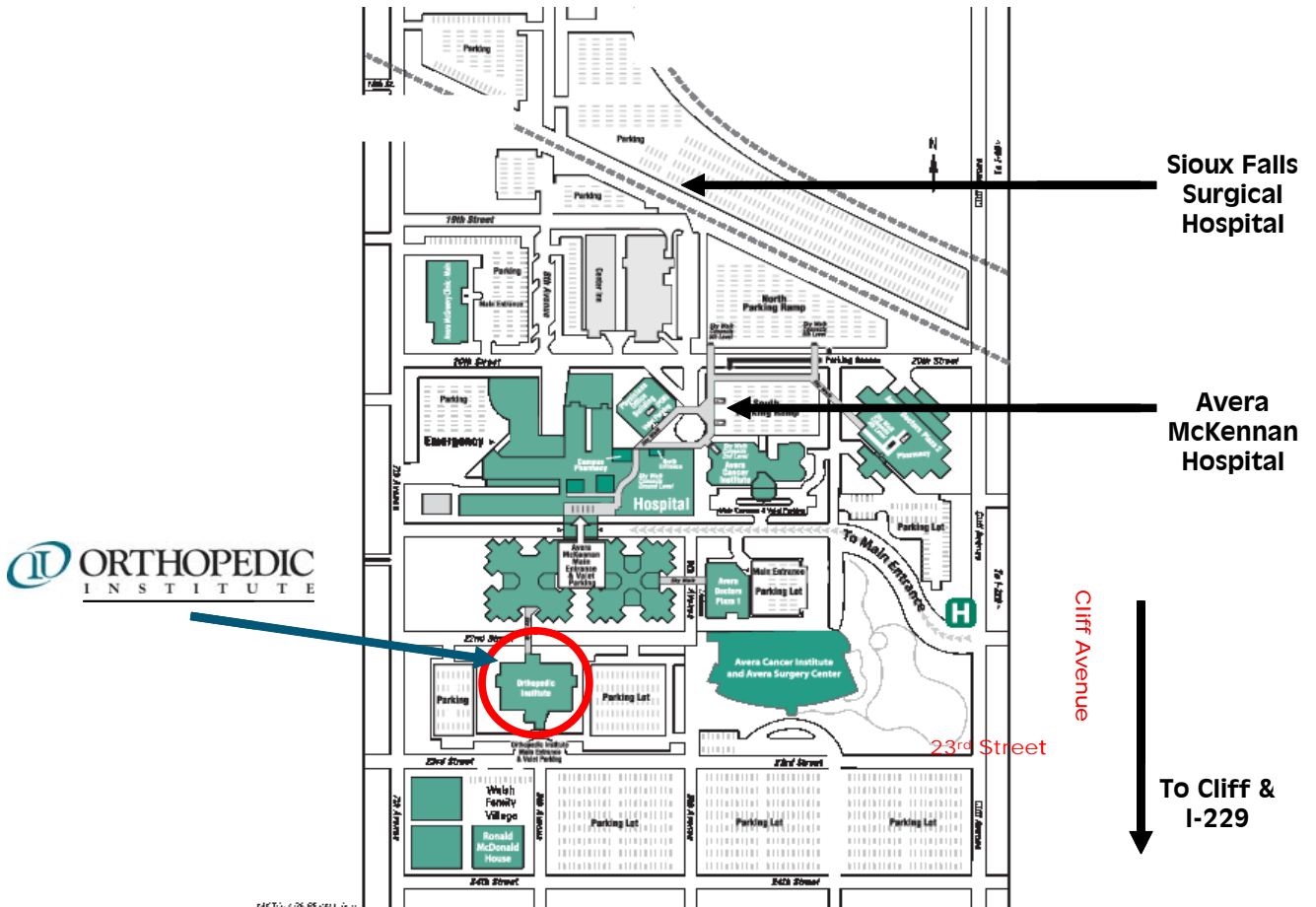
**Cliff Avenue  
Exit on I 229**

**Onsite Parking &  
Valet Service  
Available**



**ORTHOPEDIC  
INSTITUTE**

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



**ORTHOPEDIC  
INSTITUTE**

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

Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Chart: \_\_\_\_\_  
Date: \_\_\_\_\_



**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**

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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: \_\_\_\_\_



### 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: \_\_\_\_\_



## 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: \_\_\_\_\_



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

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

<b><u>GENERAL</u></b> Birth defect Describe: _____ Cancer Describe: _____ Diabetes Emotional difficulty Epilepsy/seizures HIV/AIDS Lymphoma Polio Rheumatic fever Scarlet fever	Thyroid disease <b><u>BLOOD</u></b> Anemia Blood clot Blood transfusions <b><u>CARDIOVASCULAR</u></b> Heart attack Heart problems High blood pressure Pacemaker/defibrillator Stroke <b><u>GI/GU</u></b> Bowel disorder	Gallbladder problems GI bleed Hepatitis/jaundice Hernia Kidney problems Kidney stones Liver problems Reflux disease Ulcer <b><u>ORTHOPEDIC</u></b> Arthritis Fracture Lupus	Nerve compression/irritation Osteomyelitis (bone infection) Rheumatoid arthritis Spinal disc problem <b><u>RESPIRATORY</u></b> Asthma Emphysema Lung disease Pneumonia Tuberculosis (TB) <b>OTHER:</b> _____ _____ _____
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**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.**

<b><u>GENERAL</u></b> Fatigue Fever Change in sleep habits Unplanned weight change <b><u>HEENT</u></b> Blurry or double vision Ear pain Hearing loss Hoarse voice Nosebleeds <b><u>CARDIAC</u></b> Chest pain/discomfort	Heart murmur Irregular heartbeat Leg swelling <b><u>RESPIRATORY</u></b> Cough Shortness of breath Wheezing <b><u>GI/GU</u></b> Belly pain Blood in urine Blood in stool Constipation Diarrhea	Heartburn Incontinence (bladder) Incontinence (bowel) Nausea and/or vomiting Painful urination <b><u>SKIN</u></b> Changes in color Dryness Lesions <b><u>MUSCULOSKELETAL</u></b> Back pain Muscle weakness Muscle cramps	Neck pain Tremors Stiff joints Swollen joints <b><u>NEUROLOGICAL</u></b> Anxiety Decreased memory Depression Dizziness Fainting Headaches Mood swings Numbness and tingling Seizures
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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: \_\_\_\_\_



## 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: _____
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_____	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: _____
_____	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: _____