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 (Please Do Not Mail):

- ☐ **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: _____

☐ Brookings, SD	☐ Madison, SD	☐ Sibley, IA	☐ Tyndall, SD
☐ Creighton, NE	☐ Marshall, MN	☐ Sioux Falls, SD	☐ Wagner, SD
☐ Dakota Dunes, SD	☐ Mitchell, SD	☐ Spirit Lake, IA	☐ Yankton, SD
☐ Huron, SD	☐ Rock Valley, IA	☐ D1	☐ Woodlake

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

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

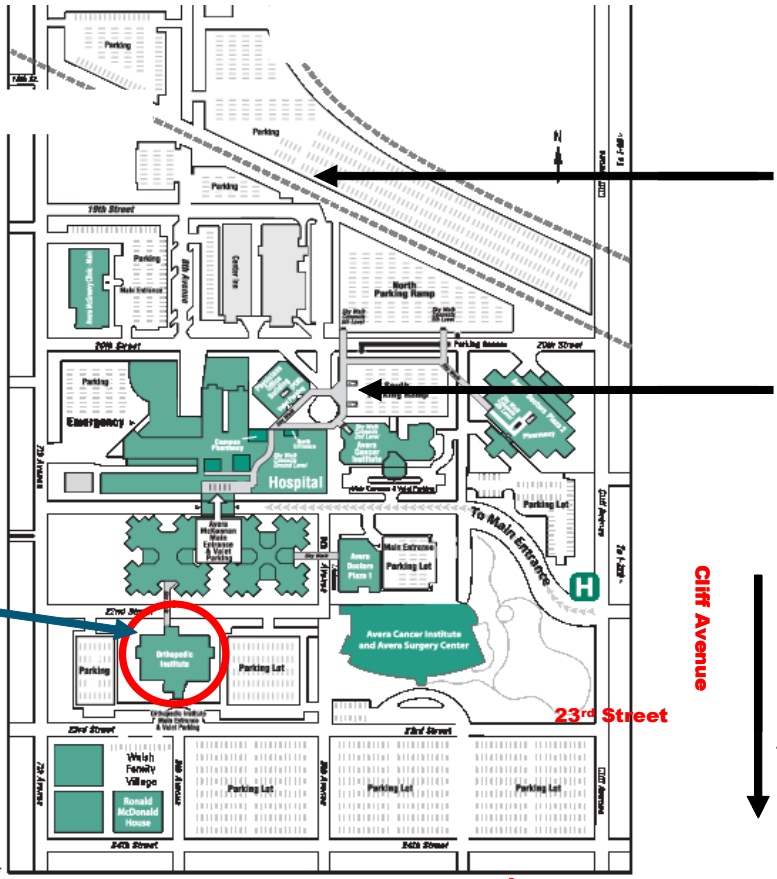
Sioux Falls, South Dakota

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

Map to OI 08/10

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

ORTHOPEDIC INSTITUTE

810 E. 23rd Street
Sioux Falls, SD 57105

PATIENT NAME (Please Print Full Legal Name)
First Name: _____ MI: _____
Last Name: _____
Preferred Name: _____
Date of Birth _____/_____/_____ Age _____
☐ Male ☐ Female
Last 4 digits of Social Security #: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Preferred Method of Contact:
☐ Cell Phone ☐ Home Phone

Patient Status:
☐ Single ☐ Married ☐ Other
If Married, Name of Spouse: _____

Preferred Language: _____ ☐ Decline
Choose One:
Race: ☐ American Indian ☐ Asian ☐ Black
☐ Native Hawaiian ☐ White ☐ Decline

Choose One:
Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin
☐ Decline

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

Who is Responsible for Payment (if other than patient)?:
_____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Employer: _____
Relationship to Patient: _____

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

Name of person to contact in case of emergency:
_____
Cell: _____ Home: _____

If current resident of a nursing home or swing bed facility:
Facility Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Facility Phone: _____

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:

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: ____________________
Chart: ____________________
Date: ____________________

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, 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 Institute with the following person(s):

Name: ____________________ Relationship: ____________________
Name: ____________________ Relationship: ____________________
Name: ____________________ Relationship: ____________________
Legal Guardian Primary: ____________________ Legal Guardian Secondary: ____________________

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

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: ☐ Cell ☐ Home

AUTHORIZATION TO PAY ORTHOPEDIC INSTITUTE

All patients are expected to pay their insurance co-pay to Orthopedic Institute upon registration for every visit. A co-pay is an agreement between the patient and their insurance company and between the insurance company and Orthopedic Institute. Inability to pay the designated co-pay may result in rescheduling of the appointment.

Patients that are self-pay or have deductibles higher than $2,000 will be expected to pay a deposit before a surgery; an MRI, EMG, etc. will be scheduled. The deposit amount will be calculated by the Accounts Receivable Department.

All patients are expected to pay their patient responsibility balances to Orthopedic Institute in a timely fashion. Patient balances with little or no patient activity within 72 days will be subject to additional action.

Patients may be charged a no-show fee of $40 if a 48-hour notice is not given for therapy appointments.

All Medicaid patients are responsible to have a referral sent from their listed Primary Care Provider before the date of service. Failure to do so will result in rescheduling of the appointment until the referral is received by Orthopedic Institute.

E-PRESCRIBING AUTHORIZATION (Please check only 1 box)

#1 ☐ I agree that Orthopedic Institute 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 Summary Notice of Privacy Practices and declined a copy.

OR

#2 ☐ The undersigned hereby acknowledges receipt of the Orthopedic Institute Summary Notice of Privacy Practices attached Notice of Privacy Practices.

AUTHORIZATION FOR ELECTRONIC COMMUNICATION (Please check only 1 box)

#1 ☐ I agree and consent to receive electronic communication sent to me by Orthopedic Institute.

OR

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

E-Mail Address: ______________________________

SIGNATURE: ______________________________ DATE: ____________

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

Form 106.2 10/17

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

MEDICARE PATIENTS ONLY

MEDICARE
LIFETIME BENEFICIARY CLAIM AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Orthopedic Institute for any services furnished me by that provider. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated on approved claim forms or electronically submitted claims, my signature authorizes the releasing of information to the insurer or agency shown.

I authorize Orthopedic Institute to appeal Medicare claims on my behalf.

I authorize Orthopedic Institute to inquire on processing claims and/or claim payments on my behalf.

_____ _____
Patient Signature Date

_____ _____
Guardian/Legal Representative & Relationship Date

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 (Check 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

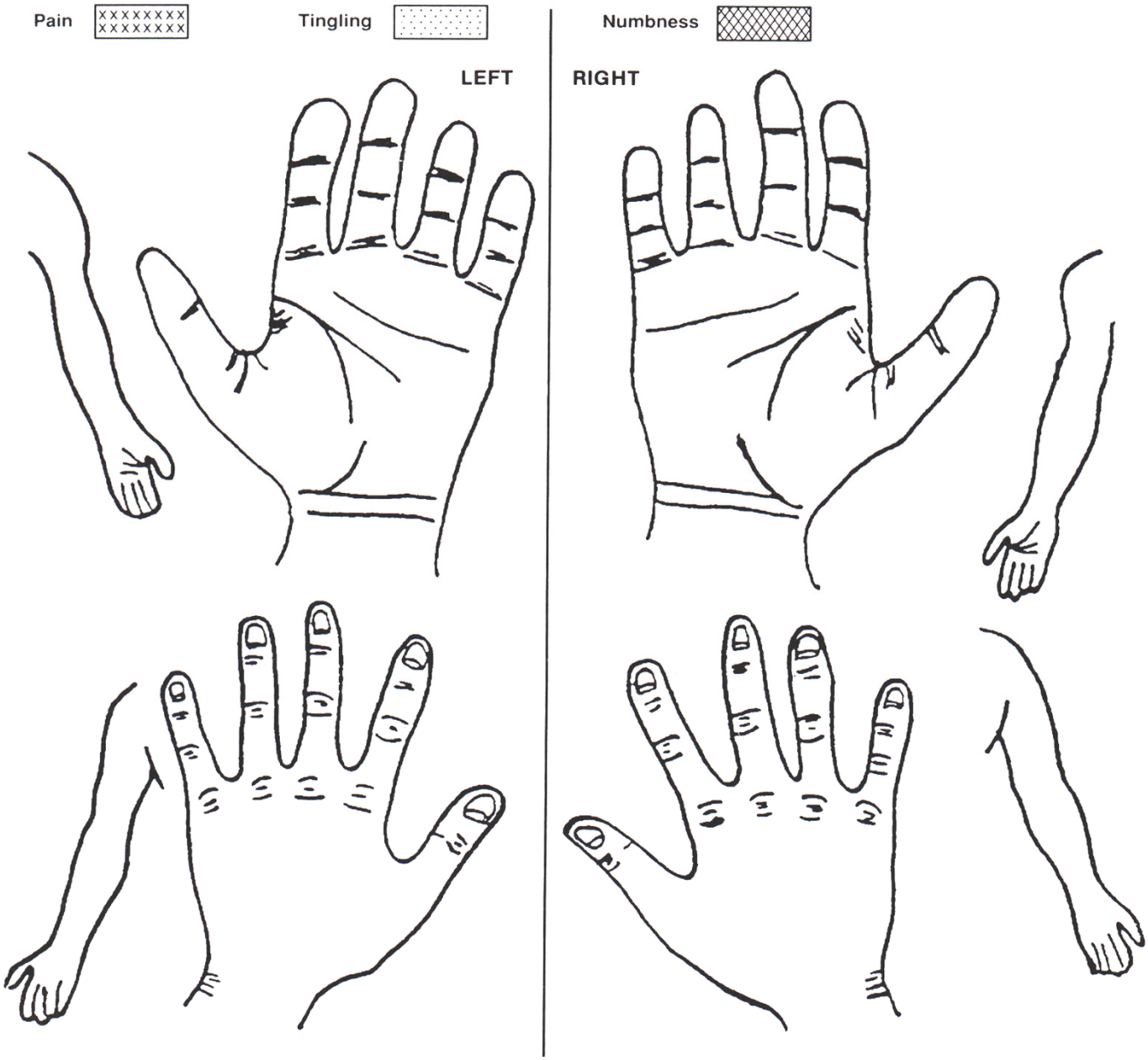
Name: _____
DOB: _____
Chart: _____
Age: _____
Date: _____

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 father/mother or siblings and indicate relationship to you.

Allergies:	Father/Mother	Sibling	Heart problems:	Father/Mother	Sibling
Bleeding tendencies:	Father/Mother	Sibling	High blood pressure:	Father/Mother	Sibling
Cancer:	Father/Mother	Sibling	Kidney problems:	Father/Mother	Sibling
Diabetes:	Father/Mother	Sibling			

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: _____