

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



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

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

Interventional Pain Management
 J.T. Brunz, MD

Physical Medicine
 K.C. Chang, MD

Outreach Clinics
 Brookings, SD
 Creighton, NE
 Dakota Dunes, SD
 Huron, SD
 Madison, SD
 Marshall, MN
 Mitchell, 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 (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.
 - 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

APPOINTMENT			
Day: _____	Date: _____	Time: _____	
<input type="checkbox"/> Brookings, SD	<input type="checkbox"/> Madison, SD	<input type="checkbox"/> Sibley, IA	<input type="checkbox"/> Tyndall, SD
<input type="checkbox"/> Creighton, NE	<input type="checkbox"/> Marshall, MN	<input type="checkbox"/> Sioux Falls, SD	<input type="checkbox"/> Wagner, SD
<input type="checkbox"/> Dakota Dunes, SD	<input type="checkbox"/> Mitchell, SD	<input type="checkbox"/> Spirit Lake, IA	<input type="checkbox"/> Yankton, SD
<input type="checkbox"/> Huron, SD	<input type="checkbox"/> Rock Valley, IA	<input type="checkbox"/> D1	<input type="checkbox"/> 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

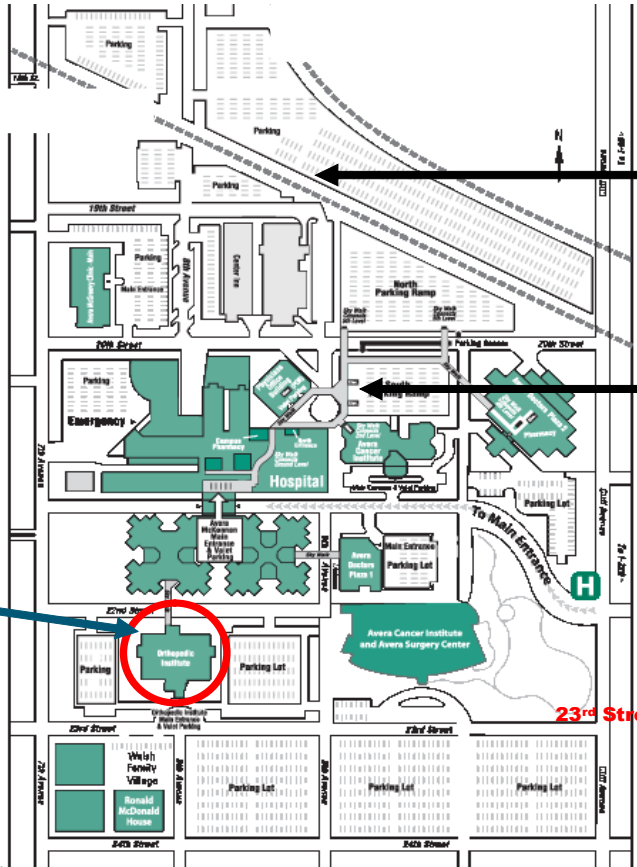


ORTHOPEDIC INSTITUTE

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

Cliff Avenue Exit on I 229

ORTHOPEDIC INSTITUTE



Sioux Falls Surgical Hospital

Avera McKennan Hospital

Cliff Avenue

To Cliff & I-229

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

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



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

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: _____

Patient Status:

Single Married Other
If Married, Name of Spouse: _____

FOR ALL PATIENTS

PRIMARY INSURANCE INFORMATION:

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

Preferred Language: _____ Decline

Choose One:

Race: American Indian Asian Black
 Native Hawaiian White Decline

Choose One:

Ethnicity: Hispanic Origin Non-Hispanic Origin
 Decline

SECONDARY INSURANCE INFORMATION:

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

Employed: Yes No Retired

If Employed, Employer's Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Work Phone: _____
Occupation: _____

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

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: _____

IMPORTANT: PLEASE COMPLETE THE SECOND PAGE

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: _____
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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: _____



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.

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

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.

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

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: _____
_____	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: _____
_____	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: _____