Premier Orthopaedics of Lawton, P.L.L.C.
WAYNE A. JOHNSON, M.D., P.C.
904 SW 38th St.
Lawton, OK 73505
Phone (580) 353-8600
Fax (580) 353-8607

Thank you for choosing Dr. Johnson as your Orthopaedic Surgeon. Please complete the attached forms and bring to your appointment, as well as the following:

- Insurance card(s) and photo I.D.
- Copays/Deductible/Patient portion
- A list of all medications you are currently taking; including over the counter and herbal medications.
- Originals or copies of all X-Rays films, MRI's, CAT Scans, Bone Scans, etc. and Reports. Copies of all other tests involving this problem (e.g. EMG or nerve testing).
- Notes from any other Doctor that has previously seen you for this problem.

WORKERS COMP. INJURYS???
You are required to provide the following Additional Information
PRIOR TO YOUR APPOINTMENT

- Address and phone number of your Employer's Workman's Comp Carrier (insurance)
- Name and phone number of the case worker/adjuster involved with your case.
- Date of injury
- Claim number assigned to your case

Please note: Dr. Johnson will not be able to see you without the above listed information.

Please review Dr. Johnson's Financial Policy enclosed. If you are without insurance coverage, you will be responsible for payment in full at the time of service.

If you should have any questions, please feel free to call the office at 580-353-8600.

Thank you,
Wayne A. Johnson, M.D.

Appointment
Day_______________
Date _______________
Time _______________

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PATIENT INFORMATION

Name: ______________________ Patient ID #: ______________ Sex: [ ]M [ ]F

Address: ______________________ Date of Birth: ______________

______________________ Social Security #: ______________

City,State,Zip: ______________________ Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Phone: ______________ [ ]Home [ ]Work [ ]Other Referring Physican: ______________

Phone: ______________ [ ]Home [ ]Work [ ]Other Primary Physician: ______________

PATIENT EMPLOYMENT [ ]Employed [ ]Retired [ ]Unem ployed [ ]

Employer: ______________________

Phone: ______________________

Address: ______________________

City,State,Zip: ______________________

CONTACTS

Name, Phone & Relationship ie. Family, Pharmacy etc

____

____

____

GUARANTOR [ ]Same as Patient

Name: ______________________

Address: ______________________

____

City,StateZip: ______________________

EMPLOYMENT

Employer: ______________________

Phone: ______________________

Social Security #: ______________________

Date of Birth: ______________________

PRIMARY INSURANCE [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______________________ Company: ______________________

Insured Phone: ______________________ Social Security #: ______________________

Date of Birth: ______________________ Insured ID: ______________________

Patient's Relationship to Insured: ______________ Policy Group: ______________________

SECONDARY INSURANCE [ ]Same as Patient [ ]Same as Guarantor [ ]Other

Insured Party: ______________________ Company: ______________________

Insured Phone: ______________________ Social Security #: ______________________

Date of Birth: ______________________ Insured ID: ______________________

Patient's Relationship to Insured: ______________ Policy Group: ______________________

REASON FOR MEDICARE AS 2nd INSURANCE

- ☐ Working Age Beneficiary or spouse with Employer Group Health Plan
- ☐ No-fault Insurance including Auto is Primary
- ☐ Worker's Compensation is Primary
- ☐ Other Liability Insurance is Primary
- ☐ Disabled Beneficiary under age 65 with Group Health Pla
- ☐ Veteran's Administration

PATIENT RELEASE

Release: I hereby consent to the release of information provided to, or generated by Premier Orthopaedics of Lawton, P.L.L.C. to my primary care physician, referring physician, physical thearpist, attorney, insurance carrier(s), agency or other party with a bonafide, pertinent interest via verbal, written, or fax/e-mail communication. A copy or scanned image of my signature shall be as valid as the original.

Assignment: I hereby assign medical benefits otherwise payable to me to Premier Orthopaedics of Lawton, P.L.L.C. I understand and agree I am financially responsible for any unpaid balance for services rendered along with legal fees incurred in collecting payment from me. If applicable, I understand I am responsible for all copays, deductibles, co-insurance and balances.

Verification: I hereby verify that all the above information is true and correct as of the date signed below.

Patient Signature: ______________________________ *Date:* ______________

Parent or Legal Guardian if Minor

Board Certified Orthopaedic Surgeon
Team Physician Lawton/Ft. Sill Cavalry (CBA),
Cameron University

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Sports Medicine/Work Comp Injuries
Knee, Shoulder, Hand, Ankle Injuries

New Patient Information

Name ______________________ Date ____________

Were you referred here? ☐ No ☐ Yes By whom ____________________

Age ____ Height ________ Weight ________ B/P________Temp________ Pulse________

☐ Right handed ☐ Left handed ☐ Ambidextrous Occupation ________________

What is the main reason for the visit? ☐ pain ☐ numbness ☐ mass ☐ other ________________

Where is the location of the symptoms? ☐ Right ☐ Left Area of body ____________________

When did the symptoms begin? ________________

How did the problem start? ☐ no specific injury ☐ car accident ☐ fall ☐ work related ☐ sports

Please explain: ____

What is the quality of the symptoms: ☐ sharp ☐ dull ☐ burning ☐ throbbing ☐ aching

How severe are the symptoms: ☐ mild ☐ moderate ☐ severe

What is the duration of symptoms: ☐ intermittent (comes and goes) ☐ constant

Do the symptoms wake you from sleep? ☐ yes ☐ no

What makes the symptoms worse? ☐ all activity ☐ lifting ☐ exercise ☐ gripping ☐ other ________

Since the symptoms started, it is ☐ getting better ☐ getting worse ☐ unchanged

The symptoms also include: ☐ pain ☐ weakness ☐ swelling ☐ stiffness ☐ numbness/tingling

Which treatments have you tried?

- ☐ none
- ☐ rest — improvement? ☐ yes ☐ no
- ☐ therapy (how long?) ____________ — improvement? ☐ yes ☐ no
- ☐ medications (which ones?) ____________ — improvement? ☐ yes ☐ no
- ☐ injection (how many?) ____________ — improvement? ☐ yes ☐ no
- ☐ splint (what kind?) ____________ — improvement? ☐ yes ☐ no
- ☐ surgery ____________ — improvement? ☐ yes ☐ no

New Patient Form Page 2

Please list your current medications

______________ ______________
______________ ______________
______________ ______________
______________ ______________
______________ ______________

Allergies to medications

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Other ______________

Social History

Smoking: ☐ no ☐ yes ___ packs/day
Alcohol:
☐ none ☐ occasional ☐ frequent
Marital status:
☐ single ☐ married ☐ divorced
☐ widowed

Past Medical History (check all that apply)

- ☐ None / Healthy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Liver disease
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney disease
- ☐ Cancer
- ☐ Stomach ulcers
- ☐ Bleeding probs.

Family History
(check all that apply)

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis

Past Surgical History
(please list your prior surgeries)

______________ date _____
______________ date _____
______________ date _____
______________ date _____
______________ date _____

Do you currently experience any of the following? (check all that apply)

Constitutional
- ☐ weight loss
- ☐ fevers
- ☐ fatigue

Skin
- ☐ rash / itching
- ☐ skin ulcerations

Eyes
- ☐ need glasses
- ☐ blurred vision
- ☐ glaucoma

Ears/Nose/Throat
- ☐ hearing loss
- ☐ nasal congestion
- ☐ sore throat

Cardiovascular
- ☐ chest pain
- ☐ irregular rhythm
- ☐ palpitations

Hematologic
- ☐ bleeding problems
- ☐ blood clots

Respiratory
- ☐ short of breath
- ☐ cough
- ☐ wheezing

Gastrointestinal
- ☐ nausea / vomiting
- ☐ heartburn
- ☐ hepatitis A/B/C

Immunologic
- ☐ allergic reactions
- ☐ frequent infections

Urinary
- ☐ painful urination
- ☐ blood in urine
- ☐ kidney disease

Musculoskeletal
- ☐ arthritis
- ☐ prior fracture
- ☐ osteoporosis

Psychiatric
- ☐ depression
- ☐ anxiety

Neurologic
- ☐ balance problems
- ☐ headaches
- ☐ seizures
- ☐ weakness
- ☐ dizziness

Endocrine
- ☐ thyroid problems

INFECTIOUS DISEASES
- ☐ HIV/AIDS
- ☐ STD
- ☐ OTHER

To my knowledge, the above information is true and accurate.

Patient signature: ______________________ **Date:** ______________

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Premier Orthopaedics of Lawton, P.L.L.C.

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and accountability Act (HIPAA) requires us to give a notice of our privacy practices and to acknowledge your receipt of the notice.

What is the Notice of Privacy Practices?

The Notice of Privacy Practices explains how your protected health information may be used or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

1) I have been provided a copy of the Notice of Privacy Practices:

____________________________ Print Name

________________________ Date of Birth

__________________________________ Signature of Patient or Patient Representative

_________________ Relationship

_____________ Date

2) Can we share your medical information with others listed below to appropriately care for you?

☐ Yes ☐ No ☐ Spouse: Name______________________

☐ Yes ☐ No ☐ Children: Name______________________

☐ Yes ☐ No ☐ Parents: ___________________________

☐ Yes ☐ No ☐ Other: Name ______________________

After you read the privacy notice contact us if you require confidential communication or restrictions of your protected health information and we will have you complete the necessary forms.

Consent to Treat and Release of Medical Records

Authorization for medical treatment: Premier Orthopaedics of Lawton and its Medical Staff are hereby authorized to administer any medical, diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

Disclosure of information: I understand that my medical records and billing information are made and retained by Premier Orthopaedics of Lawton and are accessible to clinic personnel and medical staff. Clinic personnel and physicians in attendance may use and disclose medical information for clinic operations and functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. Premier Orthopaedic of Lawton Practice Management Division is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrieror self-insured employer group liable for any part of Premier Orthopaedics of Lawton charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that Premier Orthopeadis of Lawton advis you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphillis, gonorrhea, Human Immunodeficiency Virus and acquired immune deficiency syndrome (AIDS). By signing this agreement, you are consenting to such disclosures.

Assignment of Insurance: I agree this insurance benefits for Premier Orthopaedics Of Lawton charges payable to the insured are to be made payable to Premier Orthopaedics Of Lawton for my care. Any Payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits .

Precertification Policy: I understand that Premier Orthopeadics of Lawton will assist with insurance percertification requirements which are the responsibility of the policy holder and /or physician, but will not assume responsibility for precertifcation or any impact which it may have on isurance payment.

Financial Responsibility: As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by Premier Orthopeadics of Lawton.

Certification: I hearby certify that I have read each of the abouve statements, have had each item explained to me to my satisfaction, and may receive a copy of this Consent/Release upon request. I further certify that I am the patient or duty authorized by the patient to accept the terms of this Consent/Release. A photocopy of this document has the same effect as an original.

Patient or Responsible Party:	**Relationship**	**Date signed**

Witness

Acknowledgement of notice of privacy practices

A complete description of how your medical information will be used and disclosed by this facility is in our notice of privacy practices, which you should read before signing this agreement. A copy is included your registration packet and is posted throughout the clinic.

I have received a copy of ____________________________Notice of Privacy Practices.

Patient or Responsible Party	**Relationship**	**Date**

Witness

Basis for refusal, if refused: ____