Orthopedic Health of Kansas City, P.C.
Orthopedic Surgery

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We want to welcome you to our office.

For your convenience, we have enclosed our patient information and history forms which you should complete prior to your appointment. To expedite your check-in, bring the completed forms with you at the time of your office visit, as well as your insurance card(s). If your insurance plan requires a co-payment and/or a referral form from your primary care physician, this should be presented at the time of your visit.

It is very important for our doctors to have copies of all recent tests and diagnostic studies pertaining to your problem at the time of your visit. Please contact your primary care physician or referring doctor to obtain copies of these records. These records include: chart notes, x-ray film and reports, MRI film and reports, CT film and reports, arthrogram reports, as well as operative reports from any previous surgery on the affected part of your body. If you have had any x-rays or MRIs, bring in the actual films as well as the report(s). These may be obtained from the radiology department in which the study was performed. *PLEASE DO NOT MAIL XRAYS OR MRIs.*

If you arrive without the requested medical history documents **completed** and your films, you may be asked to reschedule your appointment to a future date. If you are on any medications, please bring a list of your medications and dosage.

Call our office with any questions, at (816) 561-3003.

Thank you for choosing our physicians.

Welcome To Our Office!

Name: _____ DOB:_____
First Middle Last

Preferred Name: _____ Sex: Male or Female SSN: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ Cell: (____) _____

Email: _____ Contact by: Phone, Letter, Email

May we phone, email or send text messages to confirm appointments: YES NO
May we leave a message on your home phone or cell phone: YES NO
May we discuss your medical condition with any member of your family: YES NO

*If Yes, please name members allowed:*_____

Referring Physician: _____ PCP: _____

Preferred Pharmacy: _____

Complete this section only if someone other than the patient is the insured or is financially responsible:

Responsible/Insured party: _____ Relationship to patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: (___) _____

SSN: _____ DOB: _____ Sex: Male or Female

In case of emergency, contact: _____ Relationship:_____
Phone: (____) _____

How did you hear about our practice: _____

Date of Injury:_____ Location of Accident: Home, Work, Other: _____
Description of Accident: _____
Did you report the accident to your employer: YES NO
Did the injury happen as a result of an auto accident? YES NO
If auto accident, please list the liability insurance information: _____
_____

Our office will file insurance for all reimbursable services to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay and non-covered service amounts. See our complete financial policy for details.

Please initial and sign below. Initials
I authorize the release of any medical information necessary to process my claim. _____
I authorize the physician to view prescription medication history for treatment purposes. _____
I authorize payment of medical and surgical benefits to Orthopedic Health of KC, PC. _____

_____ Date: _____
Signature of patient or responsible party

Orthopedic Health of Kansas City, P.C.
Patient Medical History

Name_____Date_____DOB:_____
Age_____Marital Status_____Right or Left Handed_____
Occupation (if retired, former occupation)_____
Reason for appointment_____
Date symptoms began_____
List Current Symptoms_____
What treatment, if any, have you had for these symptoms? _____

Have x-rays been taken? Yes No Date_____By Whom_____

Past Medical History

Disease or Disorder	You	Family	Disease or Disorder	You	Family
Diabetes	____	____	Vein Trouble	____	____
Stroke	____	____	Blood Clots	____	____
Thyroid problems	____	____	Bleeding disorders	____	____
Dizziness	____	____	Hiatal Hernia	____	____
Fainting	____	____	Ulcers	____	____
Seizures	____	____	Blood in bowel	____	____
Cough	____	____	Hepatitis/Jaundice	____	____
Chronic Bronchitis	____	____	Other liver disease	____	____
Asthma	____	____	Kidney disease	____	____
Shortness of Breath	____	____	Malignant hyperthermia	____	____
Pneumonia	____	____	Anesthesia problems	____	____
Tuberculosis	____	____	Other Lung problems	____	____
Chest Pain	____	____	Menstrual problems	____	____
Heart Disease	____	____	Gout	____	____
Pacemaker	____	____	Psoriasis	____	____
High Blood Pressure	____	____	Rheumatoid arthritis	____	____
Irregular Heart Beat	____	____	Lupus	____	____
Cancer	____	____	Sickle Cell Anemia	____	____
GERD	____	____	Elevated Cholesterol	____	____
HIV/AIDS	____		COVID	____	____
MRSA infection	____		Other _____		

1. List all past operations, serious illnesses & hospitalizations, including dates:_____
   _____
2. List all medications you are currently taking. Please indicate dosage, times per day and reason for the medication (if none at this time please state “none”) Please include over the counter medications and herbal medications in this list_____
   _____
3. List any allergies to medications or foods and the reaction they cause_____
   _____
4. Do you have any metal allergies or sensitivities, including rashes when you wear jewelry? Yes or No
   If yes, what is the reaction?_____
5. Do you use alcohol? Yes No What type?_____ How Often?_____
   Do you use tobacco? Yes No What type?_____ How Often?_____
   Do you use illicit drugs? Yes No What type? _____ How Often? _____
6. Family History Alive Deceased Cause of Death
   Mother_____
   Father_____
   Siblings_____
   Children_____