WELCOME!

Overland Park Surgical Specialists & Sports Medicine
12200 W 106th St, Suite #400
Overland Park, KS 66215
Phone (913) 541-5500 Fax (913) 541-7474

Orthopedics	Neurosurgery	General & Trauma	Sports Medicine & Concussion
Daniel Farrell, M.D.	Robert Beatty, M.D.	Don Fishman, M.D.	Lori Boyajian-Oneill, D.O.
Molly Black, M.D.	Justin Davis, M.D.	Adam Kaye, M.D.	Dana Brewington, M.D.
Christina Nickell, PA-C			
Melissa Short, PA-C			

At Overland Park Surgical Specialists and Sports Medicine, we are dedicated to providing you with the best patient care and customer service that you could possibly receive. We want your experience with us to be a pleasant one! So we can care for you in a more thorough and timely manner, please see "Things to Remember" for your upcoming appointment.

Patient's Name: _____

Appointment Date: _____

Day: _____ Time: _____

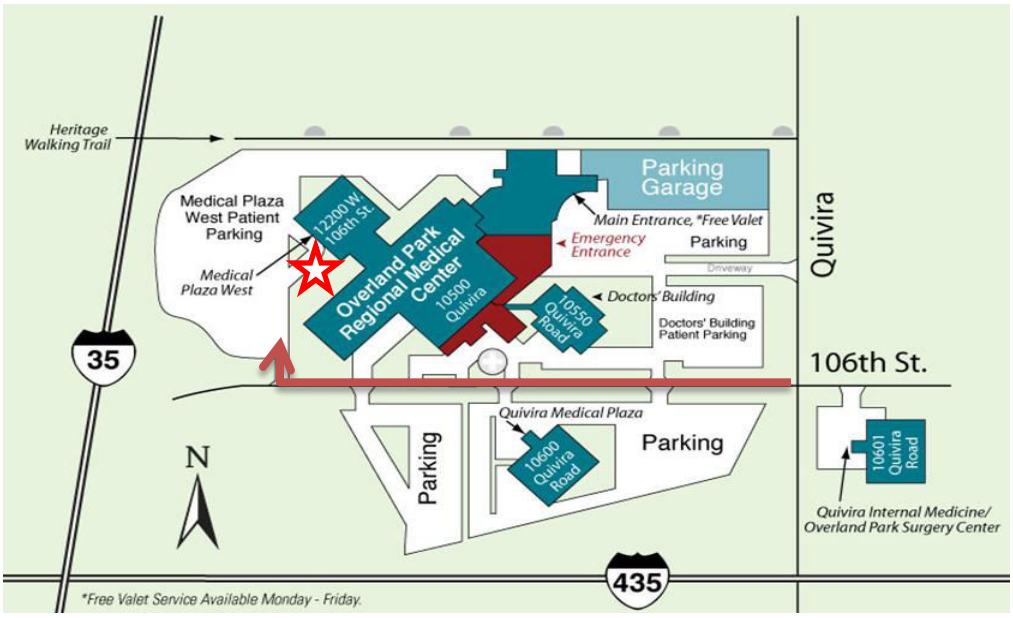
Provider: _____

Things to Remember…

- ✓ Complete ALL PAGES of paperwork attached
- ✓ Please arrive 30 minutes prior to your scheduled appointment time
- ✓ If required by your insurance, a referral must be requested before your appointment date
- ✓ Bring Photo ID, Insurance Cards, and Co-Pay if required by your insurance
- ✓ Bring a list of current medications and allergies
- ✓ Bring any **X-Rays, MRI's, and CT scans** with written results

We look forward to seeing you soon!

We are pleased that you have chosen Overland Park Surgical Specialists & Sports Medicine for your care.



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Driving Directions: http://oprmc.com/locations/ (Follow the directions to #11, Pharmacy, Medical Plaza West)

From the North by I-35:

1) Take I-35 South to **US-69 South at Exit 225B**
2) **Take the 103rd Street/ I-435 West / I-435 East exit. Keep right** to take the 103rd Street exit
3) **Turn Right on 103rd Street** heading West
4) **Turn Left on Quivira Road** heading South
5) **Turn Right on 106th Street** heading West
6) **Take the sixth right** to enter the parking lot behind the main hospital

From the East by I-435:

1) Head West on I-435 to the **Quivira exit, Exit 82**
2) Take a **Right on Quivira**, to head North
3) Take your **first left onto 106th Street** heading West
4) **Take the sixth right** to enter the parking lot behind the main hospital

From the West by I-435:

1) Head East on I-435 **to Quivira Road, Exit 82**
2) **Keep left on the ramp,** turn left and head North on Quivira Road
3) **Turn left at 106th Street** (The second intersection) to head West
4) **Take the sixth right** to enter the parking lot behind the main hospital

From the South by I-35:

1) Head North on I-35, **merge onto I-435 at Exit 222A** to head East
2) Take I-435 **to Quivira Road, Exit 82**
3) **Keep left on the ramp,** turn left and head North on Quivira Road
4) **Turn left at 106th Street** (The second intersection) to head West
5) **Take the sixth right** to enter the parking lot behind the main hospital

From the South by US-69:

1) Head North on US-69
2) Take the I-435 West exit
3) Continue on I-435 West to **Quivira Road, Exit 82**
4) **Keep right on the ramp. Take a right at Quivira Road** to head north
5) **Turn left at 106th Street** to head West
6) **Take the sixth right** to enter the parking lot behind the main hospital

HCA MIDWEST HEALTH

OVERLAND PARK SURGICAL SPECIALISTS & SPORTS MEDICINE

Please check the box next to the name of the provider you are scheduled to see:

- ☐ Daniel Farrell, M.D.
- ☐ Molly Black, M.D.
- ☐ Justin Davis, M.D.
- ☐ Robert Beatty, M.D.
- ☐ Adam Kaye, M.D.
- ☐ Don Fishman, M.D.
- ☐ Christina Nickell, PA-C
- ☐ Melissa Short, PA-C

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI_____

Address: _____ Home Phone ( )_____

City: _____ ST: _____ Zip: _____ Cell Phone ( )_____

Email Address: _____ **Marital Status:**

Date of Birth: _____/_____/_____ Single Married Divorced Separated Widowed

Social Security Number: _____ - _____ - _____ **Race:**

Gender: ☐ Male ☐ Female ☐ Other ☐ African Amer/Black ☐ American Indian/Alaska Native

Ethnicity: ☐ Hispanic, Latino, or Spanish Origin ☐ Caucasian/White ☐ Native Hawaiian/other Pacific Islander

☐ Not Hispanic, Latino or Spanish Origin ☐ Multi-racial ☐ Other: _____

Previous names used / Maiden name _____

Responsible Party _____ **Relationship:** _____ **Phone:** _____

INSURED NAME: _____ **Date of Birth:** ____/____/____ **Relationship:**_____
(this is the person who carries the insurance)

Emergency Contact: _____ **Phone:** _____

Relationship:_____

Patient Employer: _____ **Phone:** _____

Primary Care Physician: _____ **Phone:**_____

Referring Physician (*If Applicable)*: _____ **Phone:**_____

Pharmacy: Name:_____ **Phone**: _____

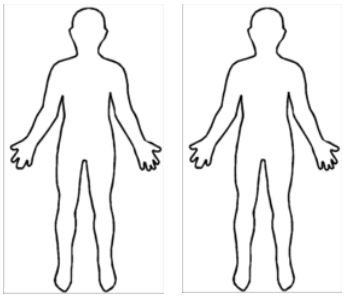
Location: _____

On a scale of 1 – 10 with 10 being the most severe, circle the number that best describes the severity of your pain.

1 2 3 4 5 6 7 8 9 10

Indicate location of pain or numbness on the diagram.

FRONT **BACK**



"X" for pain areas

"O" for numb areas

TODAY'S VISIT/HISTORY OF PRESENT ILLNESS

Describe the reason for your visit today: _____

_____

Have you received a diagnosis from another physician? What? _____

What are your current symptoms? _____

_____

How long does the problem last? **5 Minutes** **Hours** **Always Present**

Do your symptoms improve or get worse with activity (standing, sitting, lying down, etc)? _____

_____

Is this problem the result of an accident? **YES** **NO**

Date of Injury: _____

Work Related? YES NO **Auto Related? YES NO** **Involving attorney? YES NO**

When did you first notice the problem? _____

Have you had treatment for this problem? YES NO

If Yes, please indicate treatment: **Physical Therapy** **Chiropractic** **Surgery** **Injections**

Medications _____

Other _____

PAST MEDICAL HISTORY (*PLEASE CHECK ALL THAT APPLY)*

Height _____ **ft** _____ **in** **Weight** _____ **lbs**

- ☐ **Anemia**
- ☐ **Anxiety/Depression**
- ☐ **Anesthesia Complications**
- ☐ **Arthritis (osteoarthritis, rheumatoid)**
- ☐ **Asthma/Lung Disease**
- ☐ **Bleeding Tendency**
- ☐ **Blood Clots**
- ☐ **Broken Bones** _____
- ☐ **Bone/Joint Infection**
- ☐ **Bruise Easily**
- ☐ **Cancer**_____
- ☐ **Carpal Tunnel, Neuropathy**
- ☐ **Circulatory Problems**
- ☐ **Cirrhosis, Jaundice**
- ☐ **Claustrophobia**
- ☐ **Diabetes Type:** ____
- ☐ **Diverticulitis**
- ☐ **Emphysema/COPD**
- ☐ **Fainting**
- ☐ **Gall Stones**
- ☐ **Gastritis**
- ☐ **Glaucoma**
- ☐ **Gout**
- ☐ **Headaches**
- ☐ **Heart Attack/MI**
- ☐ **Heart Condition** _____
- ☐ **Hepatitis**
- ☐ **Hernia (hiatal, inguinal, umbilical)**
- ☐ **HIV**
- ☐ **Hypertension**
- ☐ **Irritable Bowel Syndrome**
- ☐ **Joint Pain or Swelling**
- ☐ **Kidney Disease**
- ☐ **Kidney/Renal Failure**
- ☐ **Liver Disease**
- ☐ **Lumbar Disk Disease**
- ☐ **Lupus**
- ☐ **Lyme Disease**
- ☐ **Multiple Sclerosis**
- ☐ **Muscle Spasms, Tenderness, or Weakness**
- ☐ **Numbness/Tingling (Hands/Feet)**
- ☐ **Obesity**
- ☐ **Osteoporosis**
- ☐ **Parkinson's Disease**
- ☐ **Pneumonia**
- ☐ **Poly/Fibromyalgia**
- ☐ **Rheumatic Fever**
- ☐ **Seizures**
- ☐ **Sickle Cell**
- ☐ **Sinus Problems**
- ☐ **Skin Problems**
- ☐ **Sleep Apnea**
- ☐ **Stroke/TIA**
- ☐ **Swollen Glands**
- ☐ **TB (Tuberculosis)**
- ☐ **Thyroid Problems**
- ☐ **TMJ (Jaw Locks/Pops)**
- ☐ **Ulcers/Reflux/GERD**
- ☐ **Varicose Veins**
- ☐ **Vertigo**
- ☐ **Other**_____

Females Only: **Pregnancy History** **Are you currently pregnant? Yes No** **If Yes, how many weeks?** _____

Total pregnancies _____ **Live births** _____

Complications _____

ALLERGIES

Are you allergic to any drugs or foods? YES NO (Please list below)

Name of Food or Drug	Reaction	Name of Food or Drug	Reaction

CURRENT MEDICATIONS

☐ **Separate medication list provided by patient.**

Name of Drug	Dosage	Frequency	How long have you taken this medication?	Has it helped?

FAMILY HISTORY

Family Member	Alive / Deceased	Age (or age at death)	Please circle any medical issues this family member has experienced.
Father			Cancer Stroke Heart Disease Hypertension TB Diabetes Aneurysm Thyroid Problems Other: _____
Mother			Cancer Stroke Heart Disease Hypertension TB Diabetes Aneurysm Thyroid Problems Other: _____
Brother / Sister			Cancer Stroke Heart Disease Hypertension TB Diabetes Aneurysm Thyroid Problems Other: _____
Brother / Sister			Cancer Stroke Heart Disease Hypertension TB Diabetes Aneurysm Thyroid Problems Other: _____

SOCIAL HISTORY

What is your occupation? _____

Physical occupational duties (lifting, squatting, pulling, etc.): _____

Do you exercise? YES NO **Days per week/type?** _____

Do you drink alcohol? YES NO **Type:** BEER WINE MIXED DRINKS OTHER

Number of Drinks: _____ **Per:** DAY WEEK MONTH

Do you drink caffeinated beverages? YES NO **Type:** COFFEE TEA SODA ENERGY DRINKS

Number of Drinks: _____ **Per:** DAY WEEK MONTH

Do you use tobacco? YES NO **Type of tobacco:** CIGARETTES CIGARS CHEW

How often? DAILY WEEKLY OCCASIONALLY **# of Packs/Day:** _____ **Would you like help quitting?** _____

If previously used tobacco: Quit Date: _____ **Total length of use (in years):** _____

Do you currently use any other drugs? If Yes, please identify: _____

Have you ever had a problem with substance abuse? _____

PAST SURGICAL HISTORY

- ☐ Aneurysm Month & Year? _____
- ☐ Angioplasty Month & Year? _____
- ☐ Appendectomy Month & Year? _____
- ☐ Cataracts Month & Year? _____
- ☐ Cesarean Section Month & Year? _____
- ☐ Colonoscopy Month & Year? _____
- ☐ Colon Resection Month & Year? _____
- ☐ Gall Bladder Month & Year? _____
- ☐ Heart Surgery Month & Year? _____
- ☐ Hernia Month & Year? _____
- ☐ Hysterectomy Month & Year? _____
- ☐ Laparoscopy Month & Year? _____
- ☐ Lasix Eye Surgery Month & Year? _____
- ☐ Mastectomy Month & Year? _____
- ☐ Prostate Month & Year? _____
- ☐ Rotator Cuff Month & Year? _____
- ☐ Spine (Cervical, Lumbar) Month & Year? _____
- ☐ Stent Placement Month & Year? _____
- ☐ Tonsillectomy Month & Year? _____
- ☐ Total Joints Month & Year? _____
- ☐ Other: _____

PATIENT REVIEW OF SYSTEMS (CHECK ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING)

CONSTITUTIONAL
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other: _____

INTEGUMENTARY/SKIN/BREAST
- ☐ Breast mass
- ☐ Bruising
- ☐ Skin Rash
- ☐ Wound Healing
- ☐ Other: _____

EYES
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Glasses
- ☐ Tears
- ☐ Other: _____

EAR/NOSE/THROAT/MOUTH
- ☐ Dental Problems
- ☐ Hearing Problems
- ☐ Nasal Congestion
- ☐ Sore Throat
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ High BP
- ☐ Palpitations
- ☐ Other: _____

RESPIRATORY
- ☐ Bloody Cough
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Ulcers/Bleeding
- ☐ Other: _____

GENITOURINARY
- ☐ Kidney Problems
- ☐ Loss of Bladder Control
- ☐ Painful Urination
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Broken Bones/Fracture
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Other: _____

NEUROLOGIC
- ☐ Headaches
- ☐ Numbness
- ☐ Tremors
- ☐ Seizures
- ☐ Other: _____

PSYCHOLOGIC
- ☐ Are you Anxious?
- ☐ Are you depressed?
- ☐ Confusion
- ☐ Memory Loss
- ☐ Other: _____

ENDOCRINE
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Severe Thirst
- ☐ Too Hot/Cold
- ☐ Other: _____

HEMATOLOGIC/LYMPATHIC
- ☐ Anemia
- ☐ Blood Clotting Trouble
- ☐ Easy Bruising /Bleeding
- ☐ Lymph nodes
- ☐ Other: _____

ALLERGIC/IMMUNOLOGIC
- ☐ Asthma
- ☐ Eczema
- ☐ Hives
- ☐ Persistent Itching
- ☐ Other: _____

PHYSICIAN USE ONLY:

Physician _____

Date _____ / _____ / _____

I certify that the information noted on the previous pages is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Notice of Privacy Practices Acknowledgement

_____ (Initials) I acknowledge that I have received Overland Park Surgical Specialists & Sports Medicine Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purpose described in the Overland Park Surgical Specialists & Sports Medicine of Privacy Practices.

Release of Information

_____ (Initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Contact Number
1)		
2)		
3)		

Prescription Order Pick Up

I give permission for the following individuals to be able to pick up prescriptions on my behalf:

1) _____ **The person(s) listed will need to provide a valid photo ID**

2) _____ **as well as signing that the prescription(s) were picked up.**

Advanced Directive: YES OR NO (Please Circle)

Patient Name (Printed) _____ **Date:**_____

Patient/Patient Representative Signature: _____

Authorization

_____ (Initials)Patient and/or guarantor are responsible for the charges incurred. It is a courtesy for our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event your insurance company has not paid within 60 days you are responsible for the balance due**. It is also the patient's responsibility to obtain referrals from your primary care physician when required. If the referral is not obtained before the visit, the patient is liable for the payment in full on the date of service.** If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services. **I have fully read and understand the above statement of payment policy.**

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's health care operations purposes (e.g. quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/ information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/ information at that email or text address from the Practice.

_____ (Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/ information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/ feedback/ information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

_____I hereby revoke my request to receive any future appointment reminders/feedback/ and general health via text messages.

_____I hereby revoke my request to receive any future appointment reminders/feedback/ and general health via email.

NOTE: This revocation only applies to communications from this practice.

Patient Name (Print) :_____

Patient/ Patient representative Signature:_____ Date: _____

Patient Name (Printed) _____ Date:_____

Patient/Patient Representative Signature: _____