Kevin M. Mosier, MD
Patrick A. Webster, PA-C

Southeast Kansas Orthopedic Clinic

Health History Questionnaire

Brad R. Meister, MD
John K. Taber, PA-C

Patient Name: _____ SS #: _____

Address: _____ Currently Working? YES ☐ OR NO ☐

_____ Primary Care Physician: _____

Date of Birth: _____Age:_____ Specialty Physician :_____

Phone Numbers Emerg. Contact: _____

Home: _____ Emerg. Contact Ph#: _____

Cell:_____

Work:_____ (Select one) Right-Handed ☐ or Left-Handed? ☐

Date of Injury: _____ Preferred Pharmacy: _____

Social History

Date: _____

Use of Alcohol: ☐ YES or NO ☐ Occasional ☐ Social ☐ Daily ☐

How many times in the past year have you had 5 or more drinks in a day for men, OR 4 or more drinks in a day for women OR any adult older than 65? Choose a number between 0 and 365 _____

Use of Tobacco: ☐ YES or NO ☐ or FORMER ☐ Smoke/Vape ☐ or Chew ☐ Average Packs/Day: ___

Use of Street Drugs: ☐ YES or NO ☐ Living Situation: Alone ○ Family ○ Friend ○ Other ○

Please list any prescription and/or non-prescription medications you are currently taking. Include vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives or cold medications. Please also include any diet medications you are taking (prescription or over the counter). Attach separate page if needed.

Name of Medication / How Often

_____

_____

_____

_____

Medication Allergies- Please list medications to which you had hives, skin rash, breathing problems or other allergic reactions.

Name of Medicine _____

_____

Describe Allergic Reaction _____

_____

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Accident / Injury Form

Patient Name: _____

Date of Birth: _____

Is office visit due to an accident or injury?

YES ☐ OR NO ☐

If you answered "NO" in the previous question –sign and date at the bottom of this page to complete this form.

If you answered "YES" please fill out the entire form.

Exact date the accident or injury occured: _____

How did the accident or injury occur?

_____

_____

_____

Where did the accident or injury occur?

SCHOOL ☐ WORK ☐ HOME ☐ OTHER: _____

Was your accident or injury work related? YES ☐ OR NO ☐

Employer/School name:_____ Occupation: _____

Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? YES ☐ NO ☐

If "YES", what type of vehicle was involved? CAR ☐ MOTORCYCLE ☐ TRUCK ☐

If you selected "MOTORCYCLE", are you the owner? YES ☐ OR NO ☐

Was another party responsible for your injury or condition? YES ☐ OR NO ☐

If "YES", please explain: _____

_____ _____

Signature of Patient ***Date***

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Notice of Privacy Practices Summary /Financial Acknowledgement

Maintaining privacy of your health information is very important to us. We encourage you to read the entire Notice and ask any questions you may have regarding its contents. You may read our Notice of Privacy Practices in person, request a copy via email or mail.

The ultimate responsibility for payment lies with the patient/guarantor. Payment for services is due at the time of service unless payment arrangements have been approved in advance. **It is the responsibility of the patient to provide current insurance information and to verify that we are participating providers in your network.**

I acknowledge that I have received a copy of my provider's Notice of Privacy Practices with the effective date of April 14th, 2003.

_____
Signature of Patient / Patient Representative

_____
Date

_____
Relationship to Patient

SEK Ortho Use Only

A good faith effort was made to obtain a written acknowledgment of his / her receipt of the Notice, but such acknowledgement could not be obtained because:

- ☐ Patient / Personal Representative refused to sign.
- ☐ Patient / Personal Representative was unable to sign.
- ☐ The Patient had a medical emergency and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (please specify):_____
  _____
  _____

_____ _____
Signature of SEK Ortho Staff *Date*

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HIPAA Privacy Authorization Form

Brad R. Meister, MD
John K. Taber, PA-C

Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize SEK Ortho to use and/or disclose my protected health information ("PHI") described below.

2. I hereby authorize the release of PHI as follows **(check all that apply)**:
   - ☐ Appointment dates and times
   - ☐ Tests that have been received
   - ☐ Test results
   - ☐ Other health information

3. In addition to the authorization for release of my PHI described in section 2 of this authorization, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

Name: _____ ***Relationship:*** _____
Address: _____ ***Telephone:*** *( )* _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient *Date*

_____ _____
Print Patient Name *Date of Birth*