



NEW PATIENT INTAKE FORM

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ SSN: _____ - _____ - _____ Sex: Male Female Other

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____

Marital Status: Single Married Divorced Widowed Legally Separated

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined to Specify

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White or Caucasian Other Declined to Specify

Language: English Spanish Other: _____

Are you currently in a Skilled Nursing/Rehab facility? Yes No

If yes, Skilled Nursing/Rehab facility name: _____

Name of Primary Care Physician: _____

INSURANCE INFORMATION

Policy Holder's Full Name: _____ Date of Birth: _____

Policy Holder's SSN: _____ - _____ - _____ *This is requested for insurance verification to prevent delays in billing.

If work-related, employer name at the time of injury: _____

Is this a work-related injury? Yes No

Employer phone at the time of injury: _____

Is this a motor vehicle accident? Yes No

If yes and Kansas resident, please fill in the following information:

*If no and a Missouri resident, please continue to History of Present Illness/Reason for visit below.

Name of auto insurance: _____ Auto insurance phone number: _____

Claims billing address: _____

City: _____ State: _____ Zip: _____

Claim number: _____ Accident date: _____ Kansas PIP: _____



Patient Name: _____ DOB: _____

SOCIAL HISTORY

Occupation/Job Title: _____

Physical demands of job (lifting/standing requirements): _____

Tobacco Use: Never Smoked Occasional Smoker Exposed to Passive Smoke
 Former Smoker Daily Smoker Other Form of Tobacco

Alcohol Use: Does Not Drink Alcohol Occasional Drinker Occasional Heavy Use
 1-2 Drinks Daily 3-5 Drinks Daily Daily Heavy Use

Drug Use: Are you taking any unprescribed drugs, including recreational drugs? Yes No

Exercise: Exercises Regularly Exercises Occasionally Does Not Exercise

HISTORY OF PRESENT ILLNESS / REASON FOR VISIT

Reason for today's visit (body part): _____ Left side Right side Bilateral

Approximate date of onset/injury: _____

Have you been seen elsewhere for this problem? If yes, where? _____
(Primary Care Physician, Urgent Care, Emergency Room)

Have you had any of the following testing within the 12 months that pertains to your visit today?

X-Ray MRI CT EMG Bone Density (DEXA) Other: _____

Where were these tests completed? _____

OBSTETRICAL HISTORY (FOR FEMALES ONLY)

Are you currently pregnant or breastfeeding? Yes No Not Sure

FAMILY MEDICAL HISTORY

	Father	Mother
Blood clots (DTV)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Clotting disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary embolism	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/TIA	<input type="checkbox"/>	<input type="checkbox"/>



Patient Name: _____ DOB: _____

PERSONAL MEDICAL HISTORY

Please select all that apply:					
<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Autoimmune Condition
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Blood Clot (DVT)	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Clotting disorder	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Diabetes Type 1	<input type="checkbox"/>	Diabetes Type 2	<input type="checkbox"/>	Esophageal reflux
<input type="checkbox"/>	Gout	<input type="checkbox"/>	HIV	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	History of fractures	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Migraines/Headaches	<input type="checkbox"/>	MRSA Infection
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Peripheral neuropathy	<input type="checkbox"/>	Pulmonary embolism
<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Sleep apnea
<input type="checkbox"/>	Stomach ulcers	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>	Other: _____

SURGICAL HISTORY

Orthopedic surgical history, select all that apply:	
<input type="checkbox"/> Knee Replacement – circle LEFT or RIGHT	<input type="checkbox"/> Knee Ligament or Meniscus – circle LEFT or RIGHT
<input type="checkbox"/> Shoulder Replacement – circle LEFT or RIGHT	<input type="checkbox"/> Shoulder Rotator Cuff or Labral – circle LEFT or RIGHT
<input type="checkbox"/> Hip Replacement – circle LEFT or RIGHT	<input type="checkbox"/> Hip Surgery (Non-Replacement) – circle LEFT or RIGHT
<input type="checkbox"/> Hand or Wrist Surgery – circle LEFT or RIGHT	<input type="checkbox"/> Elbow Surgery – circle LEFT or RIGHT
<input type="checkbox"/> Foot or Ankle Surgery – circle LEFT or RIGHT	<input type="checkbox"/> Spine Surgery – circle CERVICAL, THORACIC, LUMBAR
<input type="checkbox"/> Fracture Requiring Surgery	<input type="checkbox"/> No Orthopedic Surgeries
<input type="checkbox"/> Other:	

Other surgical history, select all that apply:				
<input type="checkbox"/> Cardiac Stent	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Cancer Removal	<input type="checkbox"/> Gastric Bypass	<input type="checkbox"/> No Surgical History
<input type="checkbox"/> Other:				



PATIENT AUTHORIZATION

All the information provided is complete and accurate to the best of my knowledge. I authorize Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics to release my personal, confidential health and billing information to my emergency contact, guarantor, referring provider, primary care physician, pharmacy, health insurance(s), workers' compensation carrier / agent and attorney. I understand that my photo identification, insurance card(s) and any applicable copayment or general deductible payment are required at the time of the visit.

If insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself for to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment.

Notice of Privacy, Release of Information & Sano Policy Agreement

Sano Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Privacy Policy to help you better understand our policies regarding your personal health information. The Privacy Policy, Controlled Substance Policy, Financial Policy, and Late & No Show Policy are available on our [practice website](#) and copies are available for distribution, if requested.

I certify that I have read and understand the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Authorization for Medical Treatment

I have been informed of the treatment procedures considered necessary and that the treatment / procedures will be directed by a physician and performed by employees of Sano Orthopedics. I understand that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

Insurance Assignment and Financial Acknowledgement

I hereby authorize Sano Orthopedics to furnish information to insurance carriers concerning my care and treatment and assign to the provider all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up-to-date and accurate insurance information. I certify I will pay to Sano any co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay Sano any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____ Today's Date: _____

Print Guardian Name: _____ Relationship to Patient: _____



CONSENT TO TRANSCRIPTION SERVICE

In an effort to focus more attention on you, our patient, we've partnered with a medical transcription company, Robin Healthcare. The transcription service documents the appointment and builds a summary of your visit, including any recommended medications, imaging, diagnostics, and other treatments. This frees your doctor from typing notes during and after the appointment, allowing your doctor to provide more time and attention to you and your needs.

This service consists of live audio and video recording of your appointment and other conversations in the examination room. A light will come on when the device is on, and you should assume that any time the light is on that audio and video data is being transmitted to the transcription service. Identifiable portions of the recordings are used solely to transcribe your appointment, and not for any other purpose.

We and Robin Healthcare take your privacy and data security very seriously, and we have implemented measures designed to secure the information, including the use of HIPAA-compliant AES encryption technology and firewalls for all transmission and storage - the same encryption used by the federal government to protect highly classified information. Recorded segments with no identifiable information may be used for training purposes. Within 30 days, any and all identifiable segments of the recordings are permanently and irretrievably deleted.

We appreciate your understanding and support as medical transcription helps us provide better care to you. Please share this information with any visitors accompanying you as you are responsible for notifying them. If at any point you or any visitors with you wish for the provider to not use this service, notify our team, and it will be turned off immediately.

By signing below, you and any visitors with you expressly consent to this clinical practice and Robin Healthcare to record your visit, transcribe and document your appointment, and permanently destroy all identifiable recordings within 30 days.

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____ Today's Date: _____

Print Guardian Name: _____ Relationship to Patient: _____