NEW PATIENT INTAKE FORM

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

Date of Birth: _____SSN: _____-_____-_____ Sex: ☐ Male ☐ Female ☐ Other

Home Address: _____

City: _____ State: _____ Zip: _____

Primary phone number: _____ Email: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone: _____

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: _____

First and Last Name of Primary Care Physician: _____

Address of Primary Care Physician: _____

Phone Number of Primary Care Physician: _____

Preferred Pharmacy Name: _____ Address of Pharmacy: _____

AUTO INSURANCE INFORMATION

Are you here due to a motor vehicle accident? ☐ Yes ☐ No

If yes, are you a Kansas resident? ☐ Yes ☐ No

WORK COMP INFORMATION

Is this a work-related injury? ☐ Yes ☐ No

If work-related, employer's name: _____

Employer's phone number: _____

PHI RELEASE FORM

We understand that communicating with you about your healthcare is important. Thus, you need to authorize us to communicate with designated individuals regarding your healthcare. This includes complete health records including, but not limited to, diagnoses, lab results, other test results, imaging, treatment, and billing records for all conditions. I give consent for sharing protected health information (PHI) to:

- ☐ Please **do not** discuss my medical information with anyone other than myself. I understand that checking this does not prevent Sano from disclosing my medical or billing information as may be otherwise allowed under state and federal privacy laws.

- ☐ I authorize Sano to share my protected health information with designated individuals listed below.

Contact Name: _____ Relation: _____

Contact Phone: _____

Contact Name: _____ Relation: _____

Contact Phone: _____

Consent for sharing protected health information with individuals listed. Select all that apply.

- ☐ I authorize communication over the phone.
- ☐ I authorize communication via secure text.
- ☐ I authorize in-person communication.
- ☐ I authorize individuals to pick up information on my behalf.
- ☐ I authorize detailed messages to be left on voicemail.

***Disclaimer: This authorization form expires three years from the signed date. I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing.**

Print Patient Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____Today's Date: _____

Print Guardian Name: _____ Relationship to Patient: _____

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 at https://www.sanoorthopedics.com/patient-forms/ 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: This consent form is an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). By signing below, I (or my authorized representative) authorize Sano to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to assess and maintain my health effectively. I understand that it is the responsibility of my individual healthcare providers to explain the reasons for any treatment, the available treatment options, and the common risks and anticipated burdens and benefits associated with these options. I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or 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: _____

SOCIAL HISTORY

Nicotine Use: ☐ Never used ☐ Current Use ☐ Former Use Date stopped: _____

Alcohol Use: ☐ Does Not Drink Alcohol ☐ <7 drinks/week ☐ 7-14 drinks/week ☐ >14 drinks/week

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

If yes, name of drug: _____ ☐ Edible ☐ Inhaled ☐ Injected

HISTORY OF PRESENT ILLNESS / REASON FOR VISIT

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

Approximate date of onset/injury: _____

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 last 12 months that pertains to your visit today?

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

Where were tests completed? _____

PERSONAL MEDICAL HISTORY

Please select all that apply:					
☐	Alzheimer's/Dementia	☐	Cancer	☐	Gout
☐	Seizures	☐	Heart disease	☐	Lupus
☐	Stroke/TIA	☐	Heart attack	☐	Rheumatoid arthritis
☐	Migraines/Headaches	☐	High blood pressure	☐	Osteoporosis
☐	Anxiety/Depression	☐	Diabetes Type 1 or 2	☐	Osteoarthritis
☐	Sleep apnea	☐	Peripheral neuropathy	☐	History of fractures
☐	Pulmonary embolism	☐	Liver disease	☐	Esophageal reflux/Stomach ulcers
☐	Blood Clot (DVT)	☐	Kidney disease	☐	Multiple Sclerosis (MS)
☐	Clotting Disorder	☐	HIV	☐	Parkinson's
☐	COPD	☐	MRSA Infection	☐	Other: _____

HOSPITALIZATIONS

Have you ever been hospitalized overnight for a medical condition? ☐ Yes ☐ No

Reason for being hospitalized: _____

SURGICAL HISTORY

Surgery (inpatient and outpatient):	Date/Facility/Surgeon:

FAMILY MEDICAL HISTORY

FATHER: ☐ Blood clots (DVT) ☐ Cancer ☐ Clotting disorder ☐ Pulmonary embolism ☐ Stoke/TIA

MOTHER: ☐ Blood clots (DVT) ☐ Cancer ☐ Clotting disorder ☐ Pulmonary embolism ☐ Stoke/TIA

VITALS

Height: _____ feet _____ inches Weight: _____ pounds

ALLERGIES

Medication allergies AND the associated reaction: _____

_____

MEDICATIONS

Include Prescriptions, Over the Counter, and Supplements	
Medication Name:	Dose/Strength/Frequency: