SALINA ORTHO
Orthopaedics, MRI, PT/OT
523 S. Santa Fe Ave.
Salina, KS 67401
(785) 823-2215
Fax: (785) 823-7459
salinaortho.com

Bradley C. Daily, M.D.
Byron L. Grauerholz, M.D.
Gary L. Harbin, M.D.
Todd M. Herrenbruck, M.D.
Jeffrey L. Horinek, M.D.
Michael J. Johnson, M.D.
Levi W. Kindel, M.D.

Jennifer L. Alexander, APRN
Eric Jusko, PA-C, ATC
Lindsy Newton, PA-C
Amber Sawyers, PA-C, ATC

Notice of Privacy Practices Summary / 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, or online at www.salinaortho.com/patient-forms.html

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

Salina 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 Workforce Member *Date*

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HIPAA Privacy Authorization Form

Authorization for use or Disclosure of Protected Health Information

1. I hereby authorize Salina 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*

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Accident / Injury Form

Email Address: _____

Patient Name: _____

Date of Birth: _____

Is office visit due to an accident or injury? (Circle One)

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

If "YES", are you self employed? YES OR NO

Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? YES OR 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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Health History Questionnaire

Today's Date: _____

Name: _____

Date of Birth: _____

Age: _____

Height: _____

Weight: _____

(Circle One) Right-Handed or Left-Handed?

Pharmacy: _____

Date of Injury: _____

Occupation: _____

Currently Working? YES OR NO

Primary Care Physician: _____

Specialty Doctor: _____

Nursing Home: _____

Phone Numbers

Home: _____

Cell: _____

Work: _____

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

Name of Medication / How Often	Dose	Name of Medication / How Often	Dose

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

Name of Medicine	Describe Allergic Reaction
_____	_____
_____	_____
_____	_____

Advance Care Planning

Do you have a healthcare proxy in the event you are unable to make your own medical decisions?

_____

Designee's name _____ Designee's phone number _____

Have you had any allergic reactions to the following?

Shellfish/Seafood	Yes	Feathers/Eggs	Yes
Iodine or X-Ray Contrast Dye	Yes	Latex or Rubber	Yes
Adhesive Tape	Yes		

Social History

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 Please Circle: Smoke or Chew Average Packs/Day: ___

Use of Street Drugs: YES or NO

Surgical History – Surgeries

Type of Surgery **(Left or Right Side)**	Year Performed	Physician / Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History:

Do you have or have you ever had any of the following?

Osteoarthritis Yes _____

Rheumatoid Arthritis Yes _____

Polio Yes _____

High Blood Pressure Yes _____

High Cholesterol Yes _____

Atrial Fibrillation Yes _____

Heart Disease Yes _____

Heart Bypass Surgery Yes _____

Heart Stent Yes _____

Pacemaker Yes _____

Defibrillator Yes _____

Bleeding Tendency Yes _____

Anemia Yes _____

Blood Clots (DVT), Date_____ Yes _____

Diabetes Yes _____

History Diabetes Foot Ulcers Yes _____

Chronic Open Wound _____ Yes _____

Stroke Yes _____

TIA Yes _____

Peripheral Vascular Disease Yes _____

Thyroid Disease Yes _____

Fibromyalgia Yes _____

Genetic Disorder Yes _____
Type: _____

Diverticulitis Yes _____

Asthma Yes _____

CPAP Machine Yes _____

COPD/Emphysema Yes _____

Tuberculosis Yes _____

Cancer Yes _____
Type: _____

Stomach Ulcers Yes _____

Mental Disorder Yes _____
Type: _____

Depression Yes _____

Migraines Yes _____

Glaucoma Yes _____

Cataracts Yes _____

AIDS or HIV Yes _____

MRSA Yes _____

Auto Immune Disorder Yes _____
Type: _____

Hepatitis Yes _____

Kidney Disease Yes _____

Renal Stent Yes _____

Gastric Bypass Surgery Yes _____

Seizures Yes _____

Do you have routine dental care?

Yes _____

Dentist Name:

_____

Healthy with no medical problems:

Yes _____