

Surgical Specialists of Oklahoma, PLLC Neurosurgery Division

**North office
3705 N.W. 63rd
Suite 212
OKC, OK 73116
Phone- (405) 608-4300
Fax (405) 608-4302**

**South Office
4221 S. Western
Suite 5020
OKC, OK 73109
Phone- (405) 636-7412
Fax- (405) 644-6101**

**Yukon Office
1205 Health Center Pkwy
Suite 100
Yukon, OK 73066
Phone-(405)717-5400**

**Stewart C. Smith, M.D., FACS ♦ Kevin V. Kelly, M.D. ♦ Will Beringer, D.O.
♦ Brett Horst, PA-C ♦ Gavin Christie, PA-C ♦ Chico Rogers, PA-C**

Dear New Patient:

Please fill out the enclosed forms completely and bring them with you to your appointment with:

_____ **on** _____ **at** _____ **AM/PM.**

Also, you will need to bring any and all films (MRI, CT, X-Rays) as well as the radiologist report pertaining to the film. PLEASE NOTE: Your appointment will need to be rescheduled without all necessary films.

If this is a workers compensation claim, we must have the following information:

- **Employer name, address, phone number.**
- **Complete description of accident including date, time and location.**
- **Your employer's verification of injury, policy number, and claim number.**
- **Your employers' workers compensation insurance carrier and telephone number.**

If this is a motor vehicle accident, we must have the following information:

- **Complete description of accident including date, time, and location.**
- **Auto insurance carrier, policy number, agents name, telephone number, and address.**
- **Insurance claim number.**

If you fail to bring any and all of the above information with you, we will treat your visit as private pay and you will be required to pay for your visit at the time of service. Also, all insurance co-pays are required at the time of service. Our office accepts the following forms of payment: cash, check, Visa, Mastercard, or American Express.

If you have any questions regarding this appointment, or if you need to reschedule this appointment, please call our office between 8:00 A.M. and 4:00 P.M. Thank you.

Welcome to Surgical Specialists of Oklahoma, PLLC.

If you are a surgical candidate, please note that the common post-operative visits occur 2 weeks after surgery unless you are having out of the ordinary problems or complications. When you schedule your 2-week follow up appointment, you will typically see the nurse. If you are having unusual problems, the physician or PA will be notified, which at that point the decision will be made of who will follow up with you.

The next appointment will typically be 4 weeks after your 2-week post-op visit. At this appointment the Physician himself or his P.A will either see you. Again, if you are having unusual problems or complications, the physician will be notified if it is the P.A. who visits with you on this date.

If you schedule an appointment and fail to cancel within 24 hours, we may charge you up to \$100.00 for this visit. Please avoid this situation by canceling your appointment within 24 hours.

Phone calls will be returned within 48 hours, unless they are emergencies by the physician or his P.A.

We will make every effort to take care of you the best possible way we can and are looking forward to having you as our new patient.

Thank you for choosing Surgical Specialists of Oklahoma, PLLC

Patient Information Sheet

SURGICAL SPECIALISTS OF OKLAHOMA, PLLC

EXCELLENT SURGEONS. EXCELLENT CARE.

Date: _____ - _____ - _____ **Please Print**

Patient Name: _____ Sex: M F

Date of Birth: _____ - _____ - _____ Age: _____ SSN: _____

Marital Status: (Circle One) M S D W Race: _____

Patient Address: _____

City: _____ ST: _____ Zip: _____

Home Ph: (_____) Work Ph: _____ Cell/Pgr: _____

Email Address: _____

Referring Physician: _____ Phone: (_____)

*Primary Care Physician: _____ Phone: (_____)

*May we contact your primary care physician? _____ Yes _____ No

Employer: _____ Work Address: _____

City: _____ ST: _____ Zip: _____

Emergency Contact: _____ Phone: (_____)

(Nearest Relative - Not living at home)

Do you have insurance? (Check One) Yes _____ No _____ ***** Please present insurance card to receptionist. *****

Name of Primary Insurance: _____ Secondary: _____

Policy Holder Name: _____ Policy Holder Name: _____

SSN: _____ SSN: _____

Date of Birth: _____ Date of Birth: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Work Ph: (_____) Work Ph: (_____)

Work Address: _____ Work Address: _____

City/ST/Zip: _____ City/ST/Zip: _____

Answer the following if patient is under the age of 18

Mother's Name: _____ SSN: _____

Mother's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Address: _____

Father's Name: _____ SSN: _____

Father's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Address: _____

I authorize the following person(s) to receive my protected health information (such as family members):

Name

Relationship

Authorization for services / Please read the following and sign at the bottom of this form

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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HISTORY AND PHYSICAL

PATIENT MEDICAL HISTORY:

Patient Name: _____ Date: _____

Describe in detail your medical problem today: _____

Where were you when your accident/injury/illness occurred? _____

Were you knocked unconscious? Yes No

Auto Accidents Only: Were seat belts in use? Yes No

List in order of occurrence any doctors, hospitals, or therapists that you have seen for your current accident or illness.

Doctor/Therapist	Date	Tests Performed/Treatment	Hospital	Surgery Performed	Released	
					Yes	No

Have you had diagnostic studies for this problem? Please list when and where they were performed.

Test	Check		Date	Facility	Test	Check		Date	Facility
	Yes	No				Yes	No		
X-Ray					X-Ray				
CT Scans					CT Scans				
MRI					MRI				
Bone Scan					Bone Scan				

List any medications and doses that you are taking (Prescription, over the counter, or contraceptive).

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

List **ALL ALLERGIES** (foods, drugs, environment): _____

Are you involved in legal action for this problem? Yes No

Do you have an attorney for this problem? Yes No

If yes, list name, address and phone number. _____

Have you had a previous on-the-job injury? Yes No If yes, when? _____

Have you ever received compensation for work related injuries in the past? Yes No

If yes, when? _____

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REVIEW OF SYSTEMS: Do you currently have, or have you ever had any of the following? Please check each group and circle all that apply.

- Exposure to communicable diseases
- Fever
- Weight Loss
- Swallowing Problems
- Allergies
- Hearing problems
- Heart Disease, Heart Attack, Hypertension, Angina, or Pacemaker
- Asthma, Bronchitis, COPD, Tuberculosis, Pneumonia, or Problems with Anesthesia
- Glaucoma, Cataracts, or Vision Problems
- Bladder Problems or Kidney Problems
- Arthritis
- Difficulty Walking
- Bruising, Swelling, Scars, Tattoos or Skin Problems
- Mental or Emotional Problems
- Stroke, Epilepsy, Seizures, or Loss of Sensation or Function
- Unusual Bleeding, Lumps or Masses
- Liver Problems, Diabetes, Thyroid or Hormone Problems
- Current Immunizations

FAMILY HISTORY: Has any member of your **immediate family** had any of the following?

Check all that apply.

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Problems | _____ |

If a member of your **immediate family** is deceased, please list the cause of death.

SOCIAL HISTORY:

Are you married? Yes No If yes, for how long? _____

If you are not married, do you live alone? Yes No If not, what is your relationship? _____

Did you graduate from high school? Yes No What level of education did you obtain? _____

Are you employed? Yes No What is your occupation? _____

Are you retired? Yes No What was your occupation? _____

Do you use alcohol? Yes No If yes, what and how often? _____

Do you use tobacco products? Yes No If yes, what? _____ Packs/day? _____

WOMEN ONLY: Are you pregnant at this time? Yes No Have you ever been? Yes No

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Use the pictures below to mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark the areas of radiation by using arrows. Include all affected areas.

Numbness

Pins and Needles

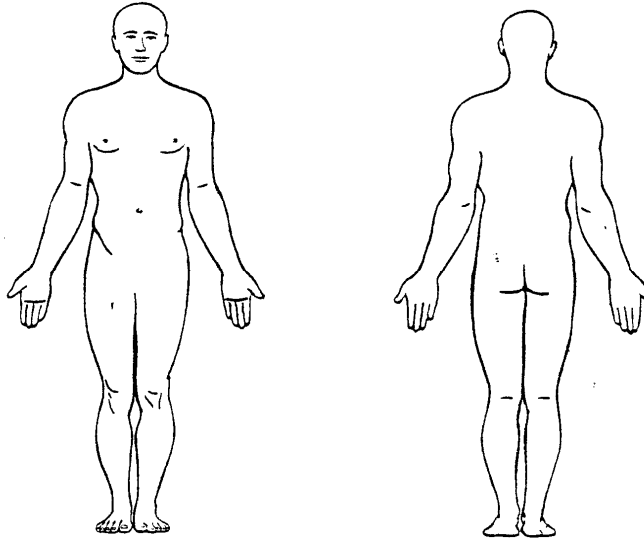
oooo
 oooo
 oooo

Burning

xxxx
 xxxx
 xxxx

Stabbing

////
 ////
 ////



Where is your pain? _____

How long have you been experiencing this pain? _____

When do you most often experience your pain? Morning Afternoon Evening Night

What activity causes or worsens your pain? _____

What have you done to obtain relief from the pain? _____

Do you experience any other symptoms with your pain? Yes No If so, what? _____

On a scale of 1 (NO pain) to 10 (WORST pain), circle the number that best describes your pain.

1 2 3 4 5 6 7 8 9 10

List any medical conditions and/or surgeries that are not related to this accident or injury.

Condition/Surgery	Doctor	Approximate Date	Injured Area of Body	Work Related		Auto Accident		Impairment
				Yes	No	Yes	No	
								%
								%
								%
								%

Financial Policy

SURGICAL SPECIALISTS OF OKLAHOMA, PLLC

EXCELLENT SURGEONS. EXCELLENT CARE.

Thank you for choosing us as your health care provider. The physicians and staff are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This statement of Financial Policy must be read and signed by you prior to any treatment. Furthermore, all patients must complete the Patient Information Form before seeing the physician.

All co-pays, deductibles and co-insurance are due at the time services are rendered.

We accept cash, checks, Visa or Mastercard.

Insurance Coverage:

The balance on your account is still your responsibility whether your insurance company pays or not.

We cannot bill your insurance company unless you give us your insurance information.

Your insurance policy is a contract between you and your insurance company.

If your insurance company has not paid your account in full within 90 days from the date services are rendered, the balance will automatically be transferred to your responsibility.

Please be aware that some, and perhaps all, of the services provided by the physician, a P.A. (Physician's Assistant), or other licensed professional may be non-covered services and not considered reasonable and necessary under your medical insurance.

Due to recent problems with insurance coverages, you must inform us if your insurance or your PCP (Primary Care Provider) changes. If you fail to notify us about any changes, you will be responsible for all charges incurred.

No Insurance Coverage:

If you do not have insurance coverage, you are expected to pay to your account in full before any medical procedures are performed. We accept cash, checks, Visa or Mastercard.

If you are unable to pay your account in full at the time services are rendered, we will accept a payment schedule as follows: 50% in advance, 25% due in 30 days from the date of the procedure, and the remaining balance due in 60 days. (If your bill is \$100.00 or less, then the balance is due in full.)

I, _____, have read the above information and agree

Print your name here

with the terms of the Financial Policy.

Signature: _____ **Date:** _____

Sharing of Medical Information

GENERAL SURGERY DIVISION

Brian R. Boggs, M.D.	Mason P. Jett, M.D.
J. Christopher Carey, M.D.	Sara E. Suthers, M.D.
Josh P. Carey, M.D.	Steven M. Magness, M.D.
Timothy J. Eldridge, M.D.	Herbert L. Meites, M.D.
Christian M. Ellis, D.O.	Alan R. Rowlan, M.D.
Svein M. Holsaeter, M.D.	Theodore A. Ruff, M.D.
Jimmie K. Jackson, M.D.	R. Cullen Thomas, M.D.
	Richard L. Wilson, M.D.

ORTHOPEDIC DIVISION

Charles E. Bryant, M.D.
Bret N. Frey M.D.

CARDIAC - THORACIC DIVISION

Eric Howell, M.D.

PHYSICAL THERAPY DIVISION

Erin Klein, M.S.P.T.
Bobby Chaffee, M.S.P.T.

NEUROSURGERY DIVISION

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Chico Rogers, P.A.-C

Patient name: _____

Social Security Number: _____

Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

This acknowledges I have received the Notice of Privacy Practices from my provider at
SURGICAL SPECIALISTS OF OKLAHOMA, PLLC

Signature: _____ **Date:** _____

This will serve as authorization to release all medical records contained in the medical chart that relates to any physical condition or treatment given by any physician employed by Surgical Specialists of Oklahoma, PLLC to the above named patient. This will also serve as authorization for release of information to referring physicians and the patient's insurance company for insurance claim purposes only.

The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS). Oklahoma Statute: 63 OS 1.502.2

I also authorize you to accept a photo copy of this release and it shall have the same force and effect as if it were the original.

I acknowledge that I understand all of the above information. My signature indicates that I have read this Medical Release and grant the request for Authorization.

Signature: _____ **Date:** ____ / ____ / ____

Medicare Patients Only

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my medical treatment.

Signature: _____ **Date:** ____ / ____ / ____

CONTROLLED SUBSTANCE (NARCOTIC) PRESCRIPTIONS CONTRACT

This is an agreement between _____ (the patient) and Dr. _____ (the doctor) concerning the use of controlled substances include Narcotics, Opioids, Tranquilizers, Barbiturates and some Sleep Medications; for the treatment of chronic pain problems. The medication will probably not completely eliminate my pain, but is expected to reduce it enough that I may become more functional and improve my quality of life.

1. I understand that Narcotics, Opioids, Tranquilizers, Barbiturates and some Sleep Medications are strong medications with potential for addiction. I have been informed of the risks and side effects involved with taking them.
2. In particular with Opioids, I understand that Opioid analgesics could cause physical dependence. If I suddenly stop or decrease the medication, I could have withdrawal symptoms (flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweating, chills) that may occur within 24-48 hours of the last dose. I understand that Opioid withdrawal is quite uncomfortable but not a life threatening condition.

I understand that if I am pregnant or become pregnant while taking these Opioid medications, my child would be physically dependant on the Opioids, and Withdrawal can be life threatening for a baby.

3. Overdose on these medications may cause death by stopping my breathing; this can be reversed by emergency medical personnel if they know I have taken narcotic pain- killers.
4. If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.
5. I understand it is my responsibility to inform the doctor of any and all side effects I have from any one of these medications.
6. I agree to take this medication as prescribed, and not to *change* the amount or frequency of the medication without discussing it with the prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medication, and may be reasons for the doctor to discontinue prescribing to me.
7. I agree that the Narcotics, Opioids, Tranquilizers, Barbiturates and some Sleep Medications will be prescribed by only *one* doctor, and I agree to fill my prescriptions at only *one* pharmacy.
8. I agree to keep my medications in a safe place. Lost, stolen, or damaged medications *will not* be replaced.
9. I agree not to sell, lend, or in any way give my medication to any other person.
10. I agree not to drink alcohol or take mood-altering drugs while I am taking Narcotics, Opioids, Tranquilizers, Barbiturates and some Sleep Medications. I agree to submit a urine specimen at any time that my doctor requests, and give my permission for it to be tested for alcohol and drugs.

11. I agree that I will attend all required follow-up visits with the doctor to monitor these medications, and I understand that failure to do so will result in discontinuation of this treatment. I also agree to participate in other chronic pain treatment modalities recommended by my doctor.
12. I agree that maintenance of my medications is my responsibility and that all refills will be called in 48 hours prior to refill need (two business days). No refills will be made at night, holidays, or weekends. All medications will be called in after 4PM on that business day. If your doctor is not in the office all written prescriptions will be filled when *your doctor* returns to the office.
13. I understand that there is a small risk that Narcotics, Opioids, Tranquilizers, Barbiturates and some Sleep Medications addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood or get high, or be unable to control my use of it. People with past history of alcohol or drug abuse problems are more susceptible to addiction. If this occurs, the medications will be discontinued and I will be referred to a drug treatment program for help with this problem.

I have read the above, asked questions, and understand the agreement. If I violate the agreement, I know that the doctor may discontinue any form of treatment.

Patient signature

Witness (office staff or physician)

Date