Rory Dunham, DO
9060 Harmony Drive Ste. B
Midwest City, OK 73130
405-759-2562 (o)
405-703-4870 (f)
www.dunhamortho.com

DUNHAM ORTHOPAEDICS

PATIENT INFORMATION

Date	Referring Physician	Referring Physician Phone	
Last	First	Middle	Sex: ☐ Male ☐ Female
Address	City	State	Zip
Home Phone	Age / DOB	Marital Status S M W D DEP	SS#
Employer/School	Address	City	State / Zip
Work Phone	Cell Phone	Pager	Email
Nearest Relative		Relation	Contact Number

RESPONSIBLE PARTY INFORMATION

Spouse/Parent	Relation to Patient	Home Phone	
Address	City	State	Zip
Employer	SS# / DOB	Age	Work Phone

INSURANCE INFORMATION (Provide cards to copy)

Primary Insurance	Insurance Type ☐ Group ☐ Individual ☐ COBRA		
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex ☐ Male ☐ Female	Insured's SS#
Insured's Employer		Insured's Phone	

Secondary Insurance	Insurance Type ☐ Group ☐ Individual ☐ COBRA		
Insured's Name on Card		ID#	Group#
Insured's DOB	Relation to Insured	Insured Sex ☐ Male ☐ Female	Insured's SS#
Insured's Employer		Insured's Phone	

OTHER INFORMATION

I authorize the release of medical information required to process all claims on my behalf. I also authorize payment of insurance benefits from those claims be made payable to: Dunham Orthopedics. I am financially responsible for any charge not covered by my insurance.

_____ _____

Patient or Authorized Person Date

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DUNHAM ORTHOPAEDICS

NEW PATIENT QUESTIONNAIRE

Date			
Name		Phone	
Age	Sex	Height	Weight
Race/Ethnicity		Language	
Family Physician		Referred By	
Reason for Visit		Is this injury work related?	
☐ Right ☐ Left ☐ Bilateral		Occupation	
Date of Onset/Injury (insurance requires approximate date) Month_____ Day _____ Year _____			
Hand Dominance ☐ Right ☐ Left	Current Level of Function 0 – 100 (0 being the worst)	Current Level of Pain 0 – 10 (10 worst)	
Have you seen a doctor in the past for this problem? ☐ Yes ☐ No Who, When & Where?			
Explain your condition or how your injury occurred:			
What treatment have you had> (please check all that apply) ☐ Rest ☐ Medication ☐ Therapy ☐ Injections Other: _____			
Have you had any previous diagnostic test? ☐ MRI ☐ X-ray ☐ CT Scan Other: _____			
CHECK ANY MEDICAL PROBLEMS LISTED THAT YOU HAVE OR HAVE HAD IN THE PAST (CHECK ALL THAT APPLY)			
☐ NO KNOWN MEDICAL PROBLEMS	☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE/HEART ATTACK	
☐ LIVER DISEASE/HEPATITIS	☐ DIABETES	☐ COPD/EMPHYSEMA	
☐ ULCERS	☐ CANCER	☐ TUBERCULOSIS	
☐ THYROID DISEASE	☐ IMMUNE DISORDERS	☐ BONE INFECTION	
☐ PERIPHERAL VASCULAR DISEASE	☐ ASTHMA	☐ SEIZURE DISORDER	
☐ STROKE	☐ SLEEP APNEA	☐ OVERWEIGHT/OBSITY	
OTHER _____			
Tobacco Usage: ☐ Yes ☐ No packs per day_____ How many years_____ Alcohol Usage ☐ None ☐ Occasional ☐ Daily ☐ > 4 drinks a day			
HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)			
☐ NONE KNOWN	☐ CANCER	☐ LUEKEMIA	☐ CORONARY ARTERY DISEASE
☐ RHEUMATIC FEVER	☐ DIABETES	☐ HYPOTHYROIDISM	☐ HIGH BLOOD PRESSURE
☐ TUBERCULOSIS	☐ COLITIS	☐ STROKE	☐ BLEEDING TENDENCY
☐ ASTHMA	☐ SEIZURES	☐ OTHER _____	
WHAT SURGERIS HAVE YOU HAD IN THE PAST (CHECK ALL THAT APPLY)			
☐ NO PREVIOUS SURGERY	☐ HYSTERECTOMY	☐ MASTECTOMY	☐ APPENDECTOMY
☐ HERNIA REPAIR	☐ CABG/OPEN HEART	☐ GALLBLADDER	☐ CATARACT EXTRACTION
☐ PROSTATE SURGERY	☐ LUMBAR SPINE SURGERY	☐ TONSILLECTOMY	OTHER: _____

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Patient Name: _____

Have you ever been addicted to or dependent on drugs or pain medication?
☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Have you had the pneumococcal vaccine? ☐ Yes ☐ No

Have you ever had an adverse reaction / problem with anesthesia?
☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

_____

_____

DUNHAM ORTHOPAEDICS

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MEDICATION/ALLERGY SHEET

NAME: _____ DOB: _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? (BOTH PRESCRIPTION AND NON-PRESCRIPTION)

MEDICATION	DOSE	# TIMES A DAY

CHECK ANYTHING LISTED BELOW TO WHICH YOU ARE ALLERGIC

☐ NO KNOWN DRUG ALLERGIES	☐ CODIENE
☐ PENICILLIN	☐ IODINE/BETADINE
☐ TETRACYCLINE	☐ RADIOGRAPHIC DYES
☐ SULFA	☐ ADHESIVE TAPE
☐ MORPHINE	☐ ERYTHROMYCIN
☐ OTHER	

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REVIEW OF SYSTEMS

NAME: _____ DOB: _____

PLEASE CHECK ALL THAT CURRENTLY APPLY

GENERAL CONSTITUTIONAL	EYES AND VISION	EARS, NOSE, THROAT
☐ GOOD GENERAL HEALTH	☐ WEAR GLASSES/CONTACTS	☐ SWOLLEN GLANDS IN NECK
☐ RECENT WEIGHT CHANGE	☐ BLURRED/DOUBLE VISION	☐ EARACHES OR DRAINAGE
☐ FATIGUE	☐ EYE DISEASE OR INJURY	☐ SINUS PROBLEMS
☐ FEVER	☐ GLAUCOMA/CATARACT	☐ RINGING IN EARS
		☐ HEARING LOSS
		☐ NOSE BLEED
RESPIRATORY	**CARDIOVASCULAR**	**GASTROINTESTINAL**
☐ SHORTNESS OF BREATH	☐ SWELLING OF EXTREMITIES	☐ CHANGE IN BOWEL MOVEMENTS
☐ ASTHMA OR WHEEZING	☐ IRREGULAR HEARTBEAT	☐ NAUSEA/VOMITTING/DIARRHEA
☐ FREQUENT COUGHING	☐ HEART TROUBLE	☐ LOSS OF APPETITE
☐ SPITTING UP BLOOD	☐ CHEST PAINS	☐ CONSTIPATION
		☐ BLOOD IN STOOL
		☐ ULCERS
GENITOURINARY	**MUSCULOSKELETAL**	**NEUROLOGICAL**
☐ BURNING PAINFUL URINATION	☐ JOINT PAIN/STIFNESS/SWELLING	☐ LOSS OF CONSCIOUSNESS
☐ STRAIN WITH URINATION	☐ WEAKNESS OF MUSCLE JOINTS	☐ LIGHT HEADED OR DIZZY
☐ FREQUENT UNINATION	☐ CHANGE IN HAT OR GLOVE SIZE	☐ NUMBNESS OR TINGLING
☐ BLOOD IN URINE	☐ MUSCLE PAIN OR CRAMPS	☐ SEIZURE OR STROKE
☐ KIDNEY STONES	☐ DIFFICULTY WALKING	☐ SEVERE HEADACHES
☐ INCONTINANCE	☐ COLD EXTREMITIES	☐ HEAD INJURY
☐ FREQUENT UTI	☐ BACK PAIN	☐ PARALYSIS
		☐ TREMORS
MEMORY LOSS/CONFUSION	**ENDROCRINE**	**LYMPHATIC/HEMATOLOGICAL**
☐ MEMORY LOSS/CONFUSION	☐ EXCESSIVE THIRST OR URINATION	☐ EASILY BRUISE OR BLEED
☐ SLEEP PROBLEMS	☐ GLAND/HORMONE PROBLEM	☐ SLOW TO HEAL AFTER CUT
☐ NERVOUSNESS	☐ HEAT/COLD INTOLLERANCE	☐ TRANSFUSION REACTONS
☐ DEPRESSION	☐ CHANGE IN SKIN COLOR	☐ PHLEBITIS/BLOOD CLOTS
	☐ THYROID DISEASE	☐ SWOLLEN GLANDS
	☐ RASH OR ITCHING	☐ ANEMIA
	☐ DIABETES	
	☐ DRY SKIN	

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PHARMACY INFORMATION

Please provide us with your preferred pharmacy information. We will only refill prescriptions to the pharmacy we have on file for you.

Tricare patients: please note that we are able to call-in, fax or e-prescribe prescriptions to military post/base pharmacies. Please provide us with a civilian pharmacy that accepts your insurance.

PHARMACY: _____

ADDRESS: _____

PHONE: _____

All questions must be filled in, please do not leave anything blank.

I _____ understand that I can only use one pharmacy for prescriptions to be called in from this office.

Patient Signature: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I _____, acknowledge that I have received a copy of the Notice of Privacy Practices ("Notice") This Notice describes how Dunham Orthopedics may disclose my protected health information, certain restrictions on the use and disclosure of my health information and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient

ACCESS TO MEDICAL RECORDS

The person or persons listed below may have access to my medical records

Name	Relation to patient
Name	Relation to patient
Name	Relation to patient
Name	Relation to patient

CONSENT TO DISCUSS DIAGNOSIS AND TREATMENT WITH ATHLETIC TRAINER

☐ I authorize Dunham orthopedics to discuss my diagnosis and treatment with me school's athletic training staff. I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreements by signing below.

_____ _____
Patient Date

_____ _____
Parent or Guardian Date

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices ("Notice"):

- The Notice tells me how Dunham Orthopedics (Practice) will use protected health information for the purposes of treatment, payment for treatment and healthcare options.
- The Notices explains in more detail how the practice may use and share protected health information other than treatment, payment and healthcare options.
- The practice will also use and share protected health information as permitted or required by law.
- If I am a patient receiving health services at the Practice, I consent the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice's Notice of Privacy Practices.

Patient Name (print): _____Patient Date of Birth: _____

This form must be signed by either the patient or by the patient's personal representative.
If this form is signed by the patient representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the patie**nt:**

_____

_____

_____ _____
Signature of Patient or Patient Representative Date

Current contact information for patient or personal representative signing this form:

Name (print): _____

Address: _____

Telephone: _____ Email: _____

FOR PRACTICE USE ONLY

I attempted to obtain the signature of the patient or the patient representative on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ I could not communicate with the patient ☐ The patient refused to sign

☐ The patient was unable to sign because _____

☐ Other: _____

_____ _____ _____
Signature Practice Staff Member Name (please print) and Title Date

This form should be placed in the patient's medical record

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Patient Name: _____ DOB: _____
(please print)

The purpose of this agreement is to prevent misunderstanding about certain medicines that patient will be taking for pain management and/or anxiety management. This is to help both the patient and their provider comply with the law regarding controlled medications. Please read this contract thoroughly, as it is a condition of your continued treatment. Your signature will be required.

The use of opioids, benzodiazepines and stimulants may cause addiction, and is only one part of a complete treatment plan.

I agree to the following:

1. I am responsible for my medicines. I will not share, sell or trade my medicine. I will not take medicine not prescribed to me.
2. Forging or altering a narcotic prescription, or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated, and I will be reported to law enforcement authorities.
3. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
4. I will not increase my medication until I speak with my doctor or nurse.
5. My medicine may not be replaced if it is lost, stolen or used up sooner that prescribed.
6. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my schedule appointment if must cancel. If I don't cancel 24 hours prior to my scheduled appointment I may be charged a $50.00 no show fee. Additionally, if I have multiple cancellations, no shows or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
7. I will bring pill bottles with any remaining pills of this medication to each clinic visit.
8. I agree to come to the office for a pill count at any time if asked by my doctor.
9. I will not use illegal or controlled substances including marijuana, cocaine, amphetamines etc.
10. I agree to give a blood or urine sample, if asked, to test for illegal drug and other medication use. I understand that my insurance company may not cover the test, and I will be responsible for the payment. I understand that this test can be very costly. This drug screen may be given at my initial visit and again randomly through the course of my treatment.
11. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
12. I have been informed by my physician about narcotic effects, including the normal physiological effects of tolerance (where I might need to take more medication to achieve the same pain relief) and dependence (an uncomfortable withdrawal reaction which may occur if I stop taking medication abruptly_, and the abnormal effects of addiction (psychological dependence leading to abnormal behavior), which is very rare in patient with genuine pain.
13. I understand that narcotics can adversely affect my judgement in making business decisions, and in operating equipment such as an automobile.
14. I understand that the main treatment goal is to improve my ability to function and/or work, not simply decrease pain. In consideration of that, I agree to help myself by following better health habits such as exercising regularly, achieving optimal weight control and limiting my use of unhealthy like alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome from my treatment.
15. I understand that there will be a trial period for this medication regime. Within this period, my care will be reviewed. If there is no evidence that I am improving, or that progress is being made to improve my function and quality of life, my medication regime will be tapered and my care will be referred back to my primary care physician.
16. Non-payment of services rendered may results in my office visit being rescheduled. Per this agreement, refills will only be provided at regularly scheduled office visits. If my office visit is rescheduled due to non-payment, I will not receive a refill on my medications.

Refills

- I understand that refills of narcotic medication will be given only during my regularly scheduled appointment, or once monthly by telephone if the current prescription has been correctly used. If the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
- I understand that refills will be made only during regular office hours – Monday through Thursday, 8:00am to 4:30pm and Friday 8:00am to 12:00pm. No refills will be available on nights, holidays or weekends. Advance notice of 3 business days is required.
- I must keep track of my medications. No early or emergency refills may be made.
- Prescriptions must be refilled before expiration. In the event the prescription has expired; the prescription must be returned to this office before a new prescription will be written.
- I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines. The name and phone number of the pharmacy is_____.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying this office of any treatment received by the ER or another physician. Patients must notify this office if narcotics have been obtained from another physician.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (a dentist, a doctor from the emergency room, another doctor, etc.), I must bring the medicine to the office in the original bottle, even it there are no pills left. I am not to seek or accept medications from other providers without my doctor's permission.

Termination Agreement

If I break any of the rules, if my drug test results are inconsistent with treatment prescribed by my doctors or if my doctor decides that this medicine is hurting me more than helping me, this medicine will be stopped by my doctor in a safe way, and no refills will be made. Further, my physician may dismiss me as a patient of the practice and ask me to select another physician. Any violation of this contract or counseling received regarding violations will remain a part of my permanent medical record. This contract will remain enforced during the entire course of my treatment plan.

I have talked about this agreement with my doctor and I understand the above rules.

Patient's signature: _____ Date: _____

Physician's signature: _____

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FINANCIAL POLICY

Thank you for choosing Dunham Orthopedics as your healthcare provider. At Dunham Orthopedics, we are dedicated to providing you the highest quality, most cost-effective care. We specialize in adult and pediatric orthopedics, sports medicine, physical medicine & rehabilitation and pain management.

In addition to accepting traditional insurance plans and Medicare we are contracted with numerous Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different and constantly updating provider's participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating full in all referral, prior authorization and per-certification processes. **Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.**

Accurate, up-to-date information is the patient's responsibility; please notify out office of any changes in your insurance or personal billing information. Please bring your current insurance card; or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claims.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express or Master Card. We do have a payment plan for patients who have financial concerns. Please notify our billing office at (405) 419-8444 to make financial arrangements. Please beware that charges for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital ambulatory surgery facilities and some radiology services may be billed separately.

There is a $35 charge for any FMLA or disability forms completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Dunham Orthopedics to participate in your care.

Sincerely,

Dunham Orthopedics and Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____ Date: _____
(signature of person financially responsible)

Relationship if other than patient: _____

DUNHAM
ORTHOPAEDICS

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APPOINTMENT AND NO SHOW LATE POLICY

Appointment No Shows

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you missed your appointment and will need to reschedule for another day.
- The second no show will result in a $50 charge (not covered by insurance) to the patient. This no-show fee has to be paid before an appointment will be scheduled.
- The third no show will result in dismissal from the practice.

Late Policy

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to your appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their schedules appointment on time.
- Non-post-operative patients arriving 10-30 minutes late will be asked to reschedule.
- Any patient arriving more than 30 minutes late will be asked to reschedule.

_____
Signature of Patient

_____
Signature of Parent or Guardian (if applicable)

_____
Print Name of Patient

_____
Print Name of Parent or Guardian

_____
Date

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DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS

Please carefully review the information contained in this notice

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Rory C. Dunham has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your healthcare services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, you physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website(s), communityhositalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

Signature of Patient	Signature of Parent or Guardian (if applicable)
Print Name of Patient	Print Name of Parent or Guardian
Date	