MD WEST | ONE
ORTHO • NEURO • EXCELLENCE

Patient Information

Patient Legal Name _____ _____ _____ Sex ☐ M ☐ F
(LAST) (FIRST) (MIDDLE)

Address _____ City _____ State _____ ZIP _____

SS# _____ Age _____ DOB _____ Race _____ Ethnicity _____

☐ Primary Phone _____ ☐ Cell _____ ☐ Work _____
***Check Preferred Contact Number**

Employment Status: ☐ Yes ☐ No ☐ Retired Employer _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other Spouse _____ Phone _____

Contact Email _____ Primary Pharmacy _____
(i.e. Walgreens 90th & Dodge)

Referring Physician _____ Family Physician _____
(please include first & last name) ***(please include first & last name)***

Do you reside in a skilled nursing facility? ☐No - ☐Temp ☐Facility Name _____ Phone _____

If Patient is a Minor or Student: School Attended _____

Mother's Name _____ Phone _____

Father's Name _____ Phone _____

Emergency Contact *(Nearest relative or friend in case of emergency)*

Full Name _____ Phone _____ Relationship _____

Health Insurance Information

Primary Ins. _____ Policy # _____ Group # _____

Policy Holder _____ SS# _____ DOB _____ Co-pay _____

Secondary Ins. _____ Policy # _____ Group # _____

Policy Holder _____ SS# _____ DOB _____ Co-pay _____

_____

Responsible Party _____ SS# _____ DOB _____

Address _____ City _____ State _____ ZIP _____

Employer/Address _____ Relationship to Patient _____

☐ Primary Phone _____ ☐ Cell _____ ☐ Work _____
***Check Preferred Contact Number**

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Release of Health Information I authorize MD West ONE, P.C. to release my health & billing information to:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Appointment Reminders In the event I am unreachable, I authorize MD West ONE, P.C., to leave a message regarding my appointment time, changes or scheduling information on my answering machine, voicemail or with the person answering the phone.

Preferred Method of contact for appointment reminders or changes: ☐Phone ☐Email ☐Text ☐Other_____

Policy Notice Receipt of Acknowledgement (initial each)

_____ I acknowledge that I was offered a copy of the **Notice of Privacy Practices**.
initial

_____ I acknowledge that I was offered a copy and agree with the terms of the **Financial Policy.**
initial

_____ ***(if applicable)*** _____

Work Comp/Auto Accident Information

Carrier_____ Claim #_____ Date of Injury____/____/____ ☐Work Comp ☐MVA

Address _____ City_____ State_____ ZIP_____

Employer Name/Address_____

Case Manager _____ Phone_____ Fax_____

Claims Adjustor_____ Phone_____ Fax_____

****Third Party Payor Agreement****
I hereby authorize MD West ONE, P.C., to furnish third party payors with any information concerning the medical care, treatment and billings. I hereby assign to MD West ONE, P.C., all payments for medical services to be rendered to me or my dependents, and I authorize direct payment for such benefits to MD West ONE, P.C., by any third party payor. I also agree that if any dispute arises between MD West ONE, P.C., and myself, the laws of the State of Nebraska shall govern, and all disputes between MD West ONE, P.C., and myself must only be litigated in the appropriate court in Douglas County, Nebraska, and I consent to personal jurisdiction and venue being proper in the appropriate court located in Douglas County, Nebraska.

_____ _____ _____
Signature of patient or authorized legal guardian/agent Date Print Name

MDWest ONE, PC

Adult Medical History
(15 and older)

Medical History Information Sheet

Patient Name: _____ **Sex:** ☐ Male ☐ Female

DOB: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Visit Information

Primary Care Physician: _____ Referring Physician: _____

Reason for Visit: _____ Date of Injury: ___/___/___

Pain Quality: ☐ Dull / Ache ☐ Sharp / Stabbing ☐ Throbbing ☐ Shooting ☐ Pressure ☐ Electric ☐ Click / Pop

Severity: None 0 1 2 3 4 5 6 7 8 9 10 Intolerable Duration of Pain: _____ Location of Pain: _____

☐ R ☐ L

Pain Aggravated By:

☐ Standing ☐ Walking ☐ Lying ☐ Stooping
☐ Sleeping ☐ Working ☐ Stairs ☐ Bending
☐ Sitting ☐ Driving ☐ Lifting ☐ Turning

Treatments Attempted: ☐ **NONE** ☐ **Other** _____

☐ Pain Medications ☐ Anti-Inflammatory ☐ Rest
☐ Wheelchair ☐ Physical Therapy ☐ Ice
☐ Injections/ESI ☐ Chiropractic Care ☐ Surgery

Past Medical History

Please note all health issues you are currently experiencing

☐ Heart Disease ☐ Pacemaker/Defibrillator ☐ Kidney Disease ☐ Liver Disease ☐ Chronic Headaches
☐ Malignant Hyperthermia ☐ Lung Disease ☐ Diabetes ☐ Hepatitis/Jaundice ☐ Thyroid Problems
☐ Hypertension ☐ Pulmonary Embolism ☐ Rheumatoid Arthritis ☐ Stomach Ulcers ☐ HIV/AIDS
☐ DVT (Blood Clots) ☐ Asthma ☐ Osteoarthritis ☐ Recurrent Infections ☐ Other _____
☐ High Cholesterol ☐ Depression ☐ Gout ☐ Cancer _____

Surgical History ☐ NONE

Please list all previous surgeries and approximate dates of surgery

Surgery:	Date:	Surgery:	Date:
	___/___/___		___/___/___
	___/___/___		___/___/___
	___/___/___		___/___/___
	___/___/___		___/___/___

☐ history of anesthesia reaction (describe): _____

Medications ☐ NONE

Please list all current medications including over-the-counter medications, vitamins, herbal supplements, and prescribed drugs

Medication:	Dose:	Medication:	Dose:

Allergies ☐ NONE KNOWN

Known Drug Allergies:

☐ Latex ☐ Shellfish ☐ Diagnostic Dyes ☐ Metal ☐ Codeine ☐ Acetaminophen ☐ Aspirin
☐ Antibiotics (please list) _____
☐ Other _____

MDWest ONE, PC

Adult Medical History
(15 and older)

Social History

Occupation Current: ☐ Disabled Reason for Disability:
Past: ☐ Retired

Do you currently live alone? ☐ No ☐ Yes - Relationship:

Have you ever been a smoker? ☐ No ☐ Yes - Packs / Day Quit: Months Ago Years ago

☐ Cigarettes ☐ Cigars ☐ e-Cigarettes/Vape Pen ☐ Chewing Tobacco ☐ Nicotine Gum ☐ Other:

Do you drink alcohol? ☐ No ☐ Yes - ☐ Social ☐ Moderate - 1-2 drinks/day ☐ Frequent - 3 or more drinks/day

Any recreational drug use? ☐ No ☐ Yes - Please List:

Family History

Please note health issues affecting mother, father, sister or brother and indicate which family member is affected

☐ Blood Clots ☐ Aneurysm ☐ Arthritis ☐ Other
☐ Heart Disease ☐ Stroke/TIA ☐ Hip Disorders ☐ Cancer - Type:
☐ Respiratory Disorders ☐ Diabetes ☐ Autoimmune Family Member:
☐ High Blood Pressure ☐ Neurological Disorders ☐ Malignant Hyperthermia

Review of Systems

Please check all that apply

Constitutional	☐ Weight Loss	☐ Weight Gain	☐ Fatigue	☐ Decreased Appetite
	☐ Chills	☐ Fever	☐ Night Sweats	
Eyes	☐ Blurred Vision	☐ Vision Loss	☐ Eye Pain	☐ Eye Redness
	☐ Double Vision	☐ Glasses	☐ Contacts	
Ear, Nose & Throat	☐ Hearing Loss	☐ Ringing in the Ear	☐ Sinus Pressure	☐ Sore Throat
	☐ Swollen Glands			
Cardiovascular	☐ Chest Pain	☐ Palpitations	☐ Hand / Foot Swelling	☐ Leg Pain w/ Walking
Respiratory	☐ Cough	☐ Wheezing	☐ Snoring	☐ Shortness of Breath
Gastrointestinal	☐ Nausea / Vomiting	☐ Diarrhea	☐ Constipation	☐ Abdominal Pain
	☐ Stool Incontinence			
Genitourinary	☐ Burning w/ Urination	☐ Urinary Frequency	☐ Urinary Urgency	☐ Blood in Urine
	☐ Urinary Incontinence			
Musculoskeletal	☐ Bone Pain	☐ Muscle Pain	☐ Joint Pain	☐ Joint Swelling
	☐ Arm Pain	☐ Arm Weakness	☐ Leg Pain	☐ Leg Weakness
Integumentary	☐ Skin Rash	☐ Itching	☐ Hives	
Neurologic	☐ Headaches	☐ Weakness	☐ Numbness	☐ Memory Loss
	☐ Tingling	☐ Balance Difficulty	☐ Seizures	☐ Poor Arm / Leg Coordination
Psychological	☐ Depression	☐ Anxiety	☐ Irritability	☐ Sleep Disturbance
	☐ Suicidal Ideation			
Endocrine	☐ Heat Intolerance	☐ Excessive Thirst	☐ Excessive Hunger	
Hematologic	☐ Easy Bleeding	☐ Easy Bruising	☐ Bleeding Disorders	
Immunological	☐ Seasonal Allergies	☐ Recurrent Infections		

Other important health information:

Signature

Patient Signature _____ **Date**