Yogish Kamath M.D. P.A.

Spine surgery
Brain Surgery
Nerve surgery
Neck and Back pain

Yogish Kamath MD

PATIENT REGISTRATION INFORMATION
Please print and complete all sections below

PATIENT'S INFORMATION: ***Marital Status***: O Single O Married O Divorced O Widowed ***Sex:*** O Male O Female

Race: O White O African American O Asian O American Indian O Native Hawaiian O Other:_____ O Refuse to report

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino O Refuse to report ***Pharmacy:***_____

Preferred Language: O English O Spanish O Other ***School Attending*** (If Student):_____

First Name:_____***MI:***_____***Last Name:***_____

Date of Birth:_____***SSN:***_____ ***Email Address:***_____

Home #:(____)_____***Cell #:***(_____)_____***Work #:***(_____)_____

Mailing Address:_____***City:***_____***State:***_____***Zip:***_____

Date of Injury:_____***Area Injured:***_____***Work Related: Y / N***

RESPONSIBLE PARTY INFORMATION: ***Relationship to Patient:*** O Self O Spouse O Child O Parent O Other:_____

Name:_____***Date of Birth:***_____

Mailing Address:_____***City:***_____***State:***_____

Home Phone:(____)_____***Cell Phone:***(____)_____***Work Phone:***(____)_____

Employer:_____***Occupation:***_____

Work Address:_____***City:***_____***State:***_____***Zip:***_____

INSURANCE INFORMATION: ***Please present insurance cards to personnel.***

Primary Insurance Name:_____

Group #:_____***Policy #:***_____***Subscriber's Date of Birth:***_____

Name of Subscriber:_____***SS#:***_____

Relationship to Patient: O Self O Spouse O Child O Parent O Other:_____

Secondary Insurance Name:_____

Group #:_____***Policy #:***_____***Subscriber's Date of Birth:***_____

Name of Subscriber:_____***SS#:***_____

Relationship to Patient: O Self O Spouse O Child O Parent O Other:_____

EMERGENCY CONTACT: ***Name:***_____***Relationship:***_____

Home Phone:_____***Cell Phone:***_____***Work Phone:***_____

WHAT MADE YOU CHOOSE *OSTC* FOR YOUR CARE? ***Check all that apply:*** O Phonebook O Website O Friend O Doctor
O Physical Therapist/Athletic Trainer O Prior treatment at *OSTC*

Have you ever had an interaction with a staff member of OSTC that made you want to choose OSTC? O Yes O No

Patient/Responsible Party signature:_____Date:_____

Dr. Kamath History and Physical - Page One

Name _____ Date of birth_____
Ht _____ Wt_____ Age _____
Referring Doctor _____ Primary care Doctor_____
What is the reason you are seeing Dr. Kamath today?
PLEASE PROVIDE DETAILS AND BE SPECIFIC

Care Plan (Someone appointed to make medical decisions.)
Do you have an Advance Care Plan? **Y / N** If so, please list name &

relation:_____

Physical Therapy

1. Have you done physical therapy - Yes / No ; when _____ How long _____
2. Where did you do physical therapy? _____
3. Have you done water therapy? Yes / No; Where? _____

Spinal injections / steroid injections /Chiropractic Therapy/ acupuncture

1. Have you done neck or back injections - Yes / No ; Date / when _____
2. Name and location of doctor who did the injections? _____
3. How many injections did you have? _____
4. Have you done chiropractic - Yes / No ; when _____ How Long_____
5. Name of chiropractor and location _____

Heart

1. Have you had - chest pain / heart attack / Congestive heart failure / Irregular heart beat
2. Do you have a heart doctor - Yes / No ; Name _____
3. When did you last see your heart doctor - _____
4. Have you had a stress test – Yes / No - Date _____; Results Okay / not okay
5. Have you had a heart ultrasound – Yes / No – Date _____;Results Okay / not okay

Lungs

1. Do you have - COPD / Bronchitis / Asthma
2. Do you have a Lung Specialist doctor - Yes / No ; Name _____
3. When did you last see your lung doctor - _____
4. Do you use oxygen - Yes / No ; daytime / night / both

Patient Signature _____ Date_____

Dr. Kamath History and Physical - Page Two

Past Medical History (Check all applicable)

___ Alcoholism	___ Anemia	___ Arthritis Rheumatoid	___ Bleeding disorder
___ Blood Clots	___ Cancer of _____	___ Depression	___ Diabetes
___ Seizures	___ Acid reflux	___ Gout	___ Hepatitis
___ HIV/AIDS	___ High Cholesterol	___ High Blood Pressure	___ Kidney stone
___ Osteoporosis	___ Pacemaker	___ Prostate problem	___ Stroke
___ Thyroid problem	___ TB	___ Ulcers	___ Vascular disease
___ Neuropathy	___ Anesthesia problems(provide details) _____		

Surgeries / Hospitalization Complications Year

_____

_____

_____

_____

_____

_____

_____

Drug Allergies Reaction **Drug Allergies Reaction**

_____ _____

_____ _____

Social History

Marital status: Single / Married / Divorced / Widowed Do you live alone – Y / N

Occupation_____

Do you exercise regularly – Y / N times per week ____ Type of exercise ____

Do you smoke? Y / N Packs per day ___ How many years _____

Do you use alcohol? Y / N Drinks per day _____

Do you use drugs? Y / N What drugs_____ Last drug use _____

Family History

Member	Alive/Dead	Diseases
Grandma (Mom's)	A / D	
Grandpa (Mom's)	A / D	
Grandma (Dad's)	A / D	
Grandpa (Mom's)	A / D	
Dad	A / D	
Mom	A / D	
Sibling	A / D	
Sibling	A / D	
Sibling	A / D	
Sibling	A / D	

Patient Signature _____ Date_____

Dr. Kamath History and Physical - Page Three

REVIEW OF SYSTEMS

REVIEW OF SYSTEMS: Please check if you are currently having any of the following:

CONSTITUTIONAL
____night sweats
____recent illness
____fever

EYES
____vision change
____blurred vision
____macular degeneration

EARS, NOSE, THROAT
____dizziness
____sleep apnea-obstruction

CARDIOVASCULAR

____chest pain/pressure
____high blood pressure
____short of breath
____swelling in legs

LUNGS, BREATHING
____asthma
____cough

GASTROINTESTINAL
____diarrhea
____nausea

GENITOURINARY/NEPHROLOGY
____urinary frequency
____urinary incontinence

HAVE THERE BEEN ANY CHANGES TO YOUR

MEDICATIONS SINCE LAST APPOINTMENT? Y / N

IF YES, PLEASE LIST CHANGES:

Patient Signature

MUSCULOSKELETAL
____stiffness
____swelling
____joint pain(s)
____back pain

DERMATOLOGIC
____rashes
____lesions

NEUROLOGIC
____neck pain
____numbness
____seizure
____spasms/spasticity

PSYCHIATRIC
____alcohol abuse
____drug abuse

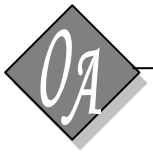
ENDOCRINE
____diabetes type I
____diabtetes type II

HEMATOLOGIC/LYMPHATIC
____abnormal bleeding and bruising
____anemia

ALLERGY/IMMUNOLOGY
____anaphylactic reaction
____food allergy

_____

Date



Orthopaedic Associates, L.L.P.

Orthopaedic Sports Medicine
Arthroscopic Surgery of
Knee and Shoulder
Joint Replacement Surgery
Spine Surgery/Brain Surgery
Nerve Surgery/Neck & Back Pain
M.D.
Kamath, M.D.

Stephen D. Ruyle, M.D.
Steven J. Wilson, M.D.
Brandon A. Perez, M.D.
Michael A. Hames, M.D.
David S. Huang,
Yogish

MEDICATIONS

NAME:_____ DATE:_____

Please list all medications that you currently use, this includes prescription, over-the-counter, herbals, vitamins/minerals, and nutritional supplements. Also, include dosage, frequency, and how administered(oral/injection/other).

MEDICATION	**DOSAGE**	**FREQUENCY**	**ADMINISTERED** (ORAL, INJECTECTION, OTHER)

PLEASE READ AND SIGN

RELEASE OF INFORMATION

I authorize *Orthopaedic Associates (OA), LLP/OSTC/Yogish Kamath, M.D.*, to release any medical information requested by other physicians or representatives of local, state, or federal agencies; insurance companies; or other organizations or entities as may be required by said representatives for treatment or payment of claims arising out of this treatment/hospitalization as are due *Orthopaedic Associates, LLP/OSTC*.

RELEASE OF PRESCRIPTION HISTORY

I understand this information is used in our electronic health records to avoid drug interactions. I authorize *Orthopaedic Associates (OA), LLP/OSTC/Yogish Kamath M.D.* to collect this information.

PRIVATE PAY PATIENTS (PHYSICIAN PATIENT'S ONLY)

I understand that due to not having health insurance, I am responsible for $650.00 deposit prior to being seen by a physician. I understand this is only a deposit and may not cover all charges for this visit.

FINANCIAL RESPONSIBILITY

I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered plus any late charges or interest accrued on delinquent payments and I further agree that all amounts are due upon request and are payable to *Orthopaedic Associates, LLP/OSTC/Yogish Kamath, M.D.,* Wichita Falls, Texas. When the outstanding balance reaches thirty days past due (payment is due on day of service), interest is accrued at 10% APR. This will authorize and direct my lawyer to withhold from any recovery or settlement as a result of injuries, which I may have sustained, the amount of any reasonable professional fee due *OA, LLP/OSTC/Yogish Kamath M.D.,* for serves rendered to me and to remit said amount to the said *OA/LLP/OSTC*. If you have a liability injury, such as a motor vehicle accident or other such injury where there is or will be a liability claim, if we file your insurance for you, then you will be responsible for repaying the insurance company.

INSURANCE ASSIGNMENT

In consideration of services rendered or to be rendered, I hereby assign and transfer to *Orthopaedic Associates, LLP/OSTC/Yogish Kamath M.D.* any benefits payable to or for my benefit under hospitalization, sickness, or accident insurance, and any other insurance coverage; to include major medical or payment of such service rendered. I agree to cooperate, aid, and assist *Orthopaedic Associates, LLP/OSTC/Yogish Kamath M.D.* in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment. I further assign and transfer to said *Orthopaedic Associates, LLP/OSTC/Yogish Kamath M.D.* an interest in any cause of action I may be arising out of injuries directly or indirectly resulting in this period of treatment.

NOTICE OF PRIVACY PRACTICES

I acknowledge that the Notice of Privacy Practices of *Orthopaedic Associates, LLP/OSTC/Yogish Kamath M.D.* was made available for me to read.

KELL WEST HOSPITAL (PHYSICIAN PATIENT'S ONLY)

I acknowledge that Kell West Hospital is a physician-owned hospital and that the physicians of *Orthopaedic Associates, LLP* are minor shareholders.

Patient Name(PRINT)_____Signature_____Date_____

Responsible Party
Name (PRINT)_____Signature_____

Orthopaedic Sports Medicine
Arthroscopic Surgery of
Knee and Shoulder
Joint Replacement Surgery

PRIVACY PRACTICE

I have reviewed the Privacy Practices of this office which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Orthopaedic Associates, LLP / OSTC / Yogish Kamath M.D. may release information to the following people:

Name:_____DOB:_____Relation:_____

Name:_____DOB:_____Relation:_____

Name:_____DOB:_____Relation:_____

Patient Name (PRINT):_____

Signature of Patient or Responsible Party:_____

Date:_____

#1 West Medical Court, Wichita Falls, TX 76310 ■ Phone: (940) 689-9664 Fax: (940) 689-9662

Orthopaedic Associates, L.L.P.

Orthopaedic Sports Medicine
Arthroscopic Surgery of
Knee and Shoulder
Joint Replacement Surgery
Spine Surgery/Brain Surgery
Nerve Surgery/Neck & Back Pain
Huang, M.D.
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Stephen D. Ruyle, M.D.
Steven J. Wilson, M.D.
Brandon A. Perez, M.D.
Michael A. Hames, M.D.
David S.

We are excited to announce we have implemented new technology for automated appointment reminders. It is important for you to reply to the reminders to let us know if you intend to keep your appointment, since we have patients on a waitlist who can fill open appointment slots. In addition, after your appointment with your doctor, you may receive a short email or text message survey. We value your feedback and would appreciate you taking time to complete the survey so we can continue to provide the best care and experience for all of our patients.

Please update your contact information:

Name _____
Email _____
Home Phone _____
Cell _____
English/Spanish _____

Please check which reminder type(s) you prefer, if you have a preference.

- ❑ Voice Call
- ❑ Text Message
- ❑ Email

I give permission to the staff at Orthopaedic and Sports Therapy Center to communicate personal health information electronically.

- ❑ Yes
- ❑ No