

# 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:  Single  Married  Divorced  Widowed Sex:  Male  Female  
Race:  White  African American  Asian  American Indian  Native Hawaiian  Other: \_\_\_\_\_  Refuse to report  
Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Refuse to report Pharmacy: \_\_\_\_\_  
Preferred Language:  English  Spanish  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:  Self  Spouse  Child  Parent  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:  Self  Spouse  Child  Parent  Other: \_\_\_\_\_  
Secondary Insurance Name: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_  
Name of Subscriber: \_\_\_\_\_ SS#: \_\_\_\_\_  
Relationship to Patient:  Self  Spouse  Child  Parent  Other: \_\_\_\_\_

**EMERGENCY CONTACT:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Have you ever had an interaction with a staff member of OSTC that made you want to choose OSTC?  Yes  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)**

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

<b><u>Surgeries / Hospitalization</u></b>	<b><u>Complications</u></b>	<b><u>Year</u></b>

<b><u>Drug Allergies</u></b>	<b><u>Reaction</u></b>	<b><u>Drug Allergies</u></b>	<b><u>Reaction</u></b>

**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**

<b><u>Member</u></b>	<b><u>Alive/Dead</u></b>	<b><u>Diseases</u></b>
Grandma (Mom's) .....	A / D	
Grandpa (Mom's) .....	A / D	
Grandma (Dad's) .....	A / D	
Grandpa (Dad'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:**

**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
- diabetes type II

**HEMATOLOGIC/LYMPHATIC**

- abnormal bleeding and bruising
- anemia

**ALLERGY/IMMUNOLOGY**

- anaphylactic reaction
- food allergy

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**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.

M.D.

*Stephen D. Ruyle, M.D.*

*Steven J. Wilson,*

*Brandon A. Perez,*

*Michael A. Hames, M.D.*

*David S. Huang, M.D.  
Yogish Kamath, M.D.*

**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).

<b><u>MEDICATION</u></b>	<b><u>DOSAGE</u></b>	<b><u>FREQUENCY</u></b>	<b><u>ADMINISTERED</u></b> <b>(ORAL, INJECTION, OTHER)</b>
_____	_____	_____	_____
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**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 services 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  
Associates, LLP.*

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: \_\_\_\_\_



*Orthopaedic  
Associates, L.L.P.*

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Arthroscopic Surgery of  
Knee and Shoulder  
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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

