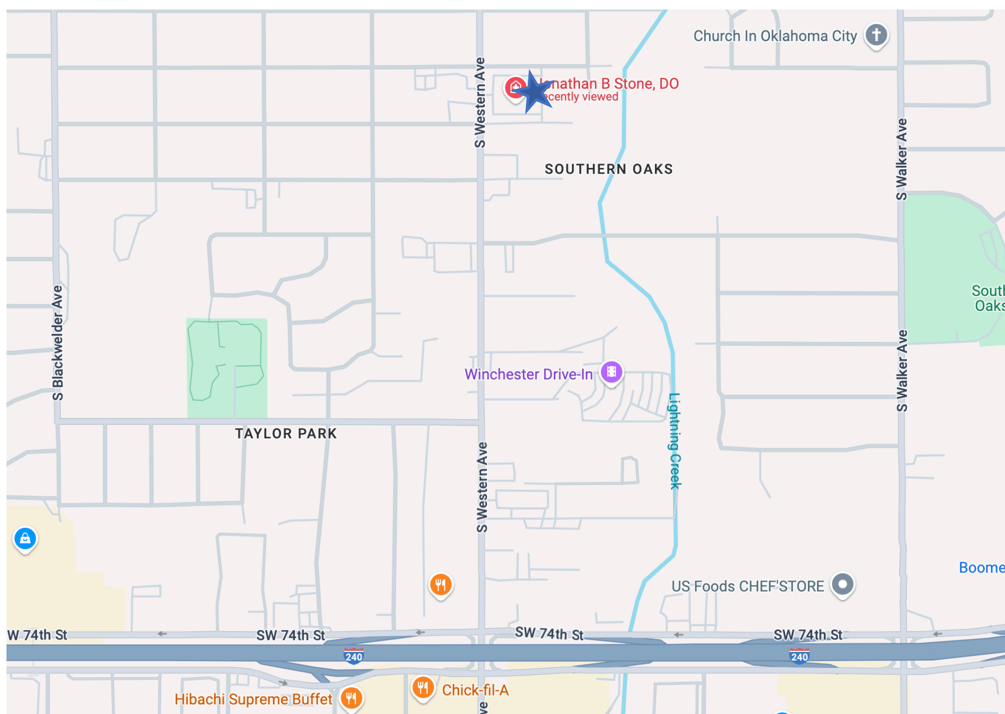
Oklahoma Spine and Musculoskeletal Medicine

Jonathan Stone, DO
6510 S. Western Ave, Suite 102
Oklahoma City, OK 73139
Phone: 405-601-5899   Fax: 405-601-5903
www.oksmm.com

You have been referred by ____.

Jonathan B. Stone is board certified in Physical Medicine & Rehabilitation and Pain Medicine. As a physiatrist, he specializes in non-operative musculoskeletal and spine problems with conservative use of medications, physical therapy, home exercise programs, osteopathic manual medicine, spinal injections, joint injections, and EMG (electro-diagnostic nerve tests).

Our office space is located at 6510 S. Western Ave at Western Medical Park in **Building 100**. The **Suite 102** entrance is at the northeast corner of the building. There is ample parking in the lot near the entrance.



If you have had a MRI, BRING YOUR MRI DISC. If you do not currently have it, please get it from the facility where it was done.

Our office is pleased to provide you with online access to your health information through our secure Patient Portal. Please visit **[www.oksmm.com]** to create your account.

OKLAHOMA SPINE ANE MUSCULOSKELETAL MEDICINE 6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

NEW PATIENT INFORMATION

Today's date: Primary Care Provider:

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Social Security no.: | Home phone no.: ( ) Check Preferred ☐

P.O. box: | City,State,Zip: | Cell Phone no.: ( ) ☐

Occupation: | Employer: | Employer phone no.: ( ) | May we send you text messages? Yes ☐ No ☐

Email address:

Language other than English: Race: Ethnicity:

Chose clinic because/Referred to clinic by (please check one box): Text ❑ Dr. ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Preferred Pharmacy:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

THIRD PARTY BILLING

Is your injury work related? ❑ Yes ❑ No Is this injury due to an accident? ❑ Yes ❑ No If your injury is MVA related, have you obtained an accident report? ❑ Yes ❑ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the physician or insurance company to release any information required to process my claims. I acknowledge and agree that I have received a copy of the OSMM Privacy Notice.

Patient/Guardian signature *Date*

OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE, PLLC
Jonathan B. Stone, D.O. - Physical Medicine & Rehabilitation
6510 S Western Ave., Suite 102, Oklahoma City, OK 73139
Phone: (405) 601-5899 Fax: (405) 601-5903

Authorization to Release Medical Information

Patient Name: ______________________________ Date of Birth: ______________________

Social Security # ______________________________ Telephone #: ______________________

I am the _____ Patient, _____ Guardian, _____Parent of Minor Child, _____ Personal Representative and hereby authorize

______________________ personnel to disclose medical information on the above named patient to:

Jonathan B. Stone, D.O.
6510 S Western Ave., Suite 102
Oklahoma City, OK 73139
Fax: (405) 601-5903

Purpose of Request: _____Patient Request _____ Referral _____Other: ______________________

Dates of treatment: ____

Information Requested: (Copies will be provided at $1.00 for first page and $0.50 per additional page)

☐ Radiology Reports	☐ Physicians Orders	☐ Complete Medical Record
☐ Radiology Films	☐ Progress Notes	☐ Other ______________
☐ Laboratory Reports	☐ Dictated Reports	______________

I understand:

- I may revoke this Authorization at any time by sending a written request to the address at the top of this form. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be 12 months from the date of my signature.
- If I do not sign this form, my health care and the payment for my healthcare will not be affected unless stated otherwise.
- **The information authorized for release my include records that may indicate the presence of a communicable disease or noncommunicable disease.**
- The information authorized for release may include drug/alcohol abuse treatment records protected under the Code of Federal Regulations and psychiatric records. Re-disclosure of alcohol and drug abuse records by the recipient is prohibited without specific authorization. If the records are psychiatric in nature, the attending physician must consent to the release of medical records.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

______________________________________ ______________________

Signature of Patient, Parent, Personal Representative Date

____

Relationship to Patient

____

Witness

OKLAHOMA SPINE ANE MUSCULOSKELETAL MEDICINE
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

AUTHORIZATION FOR TREATMENT

I hereby authorize Dr. Jonathan B. Stone, D.O. to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to Dr. Jonathan B. Stone, D.O. of the medical insurance benefits otherwise payable to me for services rendered during my visit at OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE. I understand I am financially responsible for charges not covered by this assignment.

MEDICAL INFORMATION RELEASE

I authorize the physician to release any medical information required to process this claim.

CONSENT TO CALL

I authorize my provider's office to contact my by telephone to remind me of my appointments.

MEDICATION HISTORY

I authorize my provider's office to access and download my medication history from pharmacy benefit managers.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Oklahoma Spine & Musculoskeletal Medicine Notice of Privacy Practices.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE and its physicians from any claim for responsibility or damages in the event of loss of my property, including, but not limited to, money, cell phone, or jewelry.

I understand a photocopy of this document is as valid as the original.

SIGNED: ____ **Date:** ______________
(Patient)

OR ____ Witness to Signature: ___________________
(Nearest relative or responsible party)

__________________________________ Policyholder's Signature: _________________________
(Relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court, or to the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is release, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Department of Health, or by law.

OKLAHOMA SPINE ANE MUSCULOSKELETAL MEDICINE
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

OFFICE FINANCIAL POLICY

We would like to thank you for choosing Dr. Jonathan Stone as your doctor. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

PAYMENT

Payment is expected at the time of service. This is an insurance company rule. This includes co-payments or coinsurance for participating insurance companies. OKLAHOMA SPINE & MUSCULOSKELETAL MEDICINE, accepts cash, personal checks, and most credit cards. There is a service charge of $25 for returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

INSURANCE

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit.

CANCELED APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office 24 hours before your appointment to reschedule. This will allow time to provide that time slot to another patient. We reserve the right to charge $100 for appointments that are not canceled at least 24 hours in advance.

PAST DUE ACCOUNTS

If we have to turn your account over to collection, you may be charged 5% interest on the outstanding balance from the date your bill was due, and you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys' fees.

MOTOR VEHICLE ACCIDENT

If your injury was due to a Motor Vehicle Accident you will be set up on a self-pay account for any charges incurred up to $500.00. If charges exceed $500.00, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician.

ADDITIONAL PAPERWORK

There is a $25.00 charge for any FMLA, disability or accidental form completed. This charge is applicable per form completed and is payable prior to completion by cash or money order.

MORE INFORMATION

Please call 405-601-5899 if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made.

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

Sincerely,
Jonathan B. Stone, D.O. & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: ____ Date: ______________________________
(signature of person financially responsible for payment)

Relationship if other than patient : ____

OKLAHOMA SPINE AND MUSCULOSKELETAL MEDICINE

Jonathan B. Stone, DO
6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

REQUEST TO RESTRICT THE MANNER AND METHOD OF CONFIDENTIAL COMMUNICATION

PATIENT INFORMATION	
Name:	
Address:	Birth Date:
City, State, Zip	Telephone

I hereby request to receive confidential communications from OSMM regarding my health condition, care, treatement, appointments, and/or payments in the following manner and method (please check all that apply):

- ☐ At a telephone number other than my home number.
  Alternate number is: ______________________________
- ☐ At a mailing address other than my home address.
  Alternate address is: ______________________________
  ____
- ☐ Via email.
  email address: ______________________________
- ☐ The following individuals may pick up my prescriptions, samples, appointment information and records. ______________________________
  ____
- ☐ Messages may be left concerning my care on the answering machine, voicemail, or with the following individuals: ______________________________
  ____

I understand that if OSMM agrees to provide me with confidential communications regading my healthcare via the above identified alternate manner and method, OSMM may condition agreement upon the following:

1. The receipt of information from me as to how payment for OSMM services will be handled.
2. The specification of an alternate address or other method of contact.

______________________________ ______________
Patient Signature Date

OKLAHOMA SPINE AND MUSCULOSKELETAL MEDICINE

Jonathan B. Stone, DO

6510 S. WESTERN AVE, SUITE 102, OKLAHOMA CITY, OK 73139

NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION			
Name		Age	Date
Employer:		Job Title:	
Referred by:		Family Physician:	
Is this a work related injury? □ Yes □ No	Date of injury:	Who is your attorney? OR □ Attorney not involved	

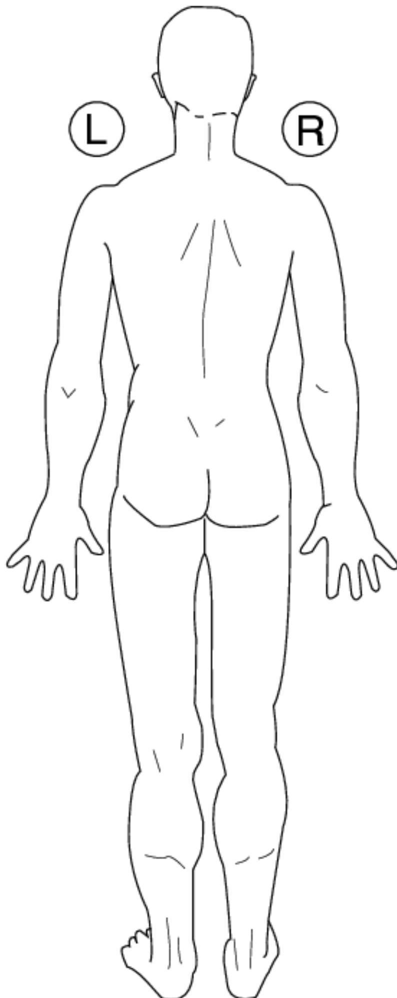
What is the reason for your visit? ______________________________

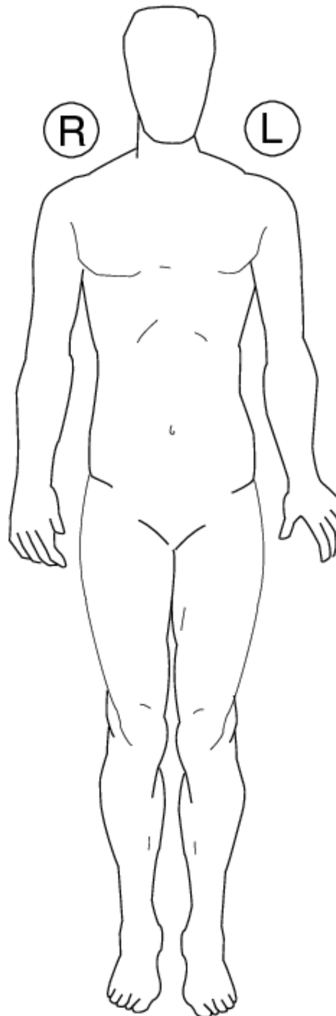
Describe where you hurt: ______________________________

____

____

Draw your pain on the diagrams below. Use the corresponding symbols to show the type of pain you feel





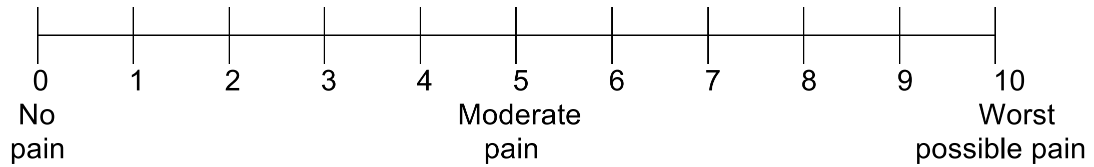
Stabbing Pain
////

Burning Pain
0000

Aching Pain
xxxx

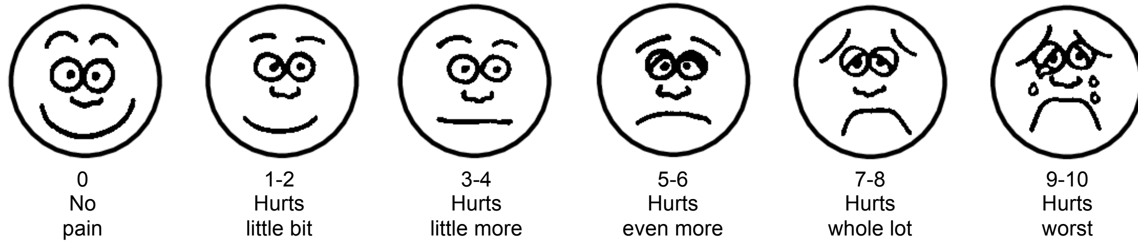
Numbness
====

Rate your pain TODAY.



On your worst day?__________

Choose the face that best describes how you feel TODAY.



When did your pain start? ____

How did the pain begin? Mark all that apply.

□ Injured at work	□ Suddenly	□ Fall	□ Pulling
□ Auto accident	□ Gradually	□ Bending	□ Lifting
□ Sports injury	□ No apparent cause	□ Twisting	□ Other

Do you have a history of this type of problem in the past? If so, when? ______________________

____

How long have you had this pain? _____ years _____ months _____ days

What activities make your pain better?

□ Nothing	□ Sitting	□ Resting	□ Bending Backward
□ Heat	□ Standing	□ Lying down	□ Bending Forward
□ Ice/Cool	□ Stretching	□ Chiropractic Care	□ Walking
□ Medication	□ Position Change	□ Exercise	□ Massage

Other: ____

What activities make your pain worse? (Check all that apply)

□ Twisting	□ Sitting	□ Coughing	□ Exercise
□ Lifting	□ Standing	□ Sneezing	□ Bending forward
□ Getting out of bed	□ Walking	□ Twisting	□ Bending backward
□ Going from sit to stand	□ Lying Down	□ Driving	□ None

Other: ____

Do you have any weakness or numbness in an arm or leg? □ Yes □ No Describe: ____________

____

Do you have problems controlling your bowel or bladder? □ Yes □ No

Do you have pain that radiates into the arm or leg? □ Yes □ No Describe: ____________________

____

Have you had any fever? □ Yes □ No

Have you have any recent weight gain/loss? □ Yes □ No

Does your pain awaken you from a deep sleep? □ Yes □ No

Have you had any diagnostic tests for you pain? (Check all that apply)

Test	**Date(s)**	**Test**	**Date(s)**
□ MRI		□ EMG	
□ CT Scan		□ Discogram	
□ Myelogram		□ Bone Scan	

Have you had any treatment for your pain? (Check all that apply)

□ Medication □ Neck Brace □ Chiropractor

□ Back Brace □ OMT □ No Treatment

□ Physical Therapy When? _________ How Long? _____________ □ Epidural injections

□ Other ____

Are you allergic to any medications?

Name	Reaction

Current Medications

Name	Dose	Name	Dose

Family Health History

Parent's Health Problems: ____

____

Brother's/Sisters Health Problems: ____

____

Grandparent's Health Problems: ____

____

Describe any spine related problems in your family: ______________________________

____

Have you ever had any health problems?

□ Yes □ No	Heart Attack	□ Yes □ No	Seizures
□ Yes □ No	Diabetes	□ Yes □ No	Blood Clots in Legs
□ Yes □ No	High Blood Pressure	□ Yes □ No	Stomach Ulcers
□ Yes □ No	Bleeding Problems	□ Yes □ No	Asthma/Lung Problems
□ Yes □ No	Cancer (Where?_____________)	□ Yes □ No	Other: _____________________

Have you had back/neck surgery? □ Yes □ No If yes, provide Type/Date/Surgeon

Type	Date	Surgeon

Have you had any surgery not listed above? □ Yes □ No If yes, provide Type/Date/Surgeon

Type	Date	Surgeon

Have you been hospitalized for any other reason?

Do you smoke? □ Yes □ No Do you chew tobacco? □ Yes □ No

Do you drink alcohol? □ Often □ On Occasion □ Rarely □ Never

Marital Status: □ Married □ Divorced □ Single □ Widowed Number of Children: _______

Education: Highest grade completed ____________

Vocational Training ____________________________ Degrees ___________________________

Are you Currently working? □ Yes □ No □ Retired

If unable to work, please give last date you worked: _____________________________________

What are your job duties? ____

____

How long have you been at this job? ____

General Medical Review

Please circle any medical problems you have experienced involving the following categories:

Constitutional	Unexpected weight loss, weight gain, fever, chills
Eyes	Corrective lens, blurred/double vision, pain, redness, watering
Ear/Nose/Throat	Headache, swallowing difficulty, nose bleed, ear ache, ringing
Cardiovascular	Chest pain, palpitations, fainting, murmur, irregular rhythm
Respiratory	Short of breath, wheezing, cough, tightness, pain during inspiration
Gastrointestinal	Heartburn, nausea, vomiting constipation, diarrhea, bloody stool
Genitourinary	Frequency urgency, difficult/painful urination, flank pain bloody urine
Musculoskeletal	Joint pain, swelling, instability, stiffness, redness, heat, pain
Skin	Poor healing, rash, itch, redness, skin ulcers
Neurologic	Numbness, tingling, unsteady gait, dizziness, tremors, seizures, headaches
Psychiatric	Nervousness, anxiety, depression, hallucinations, bipolar disorder
Hematologic	Easy bruising, anemia
Endocrine	Excessive thirst or urination, heat/cold intolerance, diabetes, thyroid disease
Allergic	Reaction to food or environment, latex allergy
Immune	Open wounds, active infection, HIV/AIDS, hepatitis

Your height_______________ Your current weight ________________

Patient Signature ____ Date_______________

Reviewed by ____________________________________ Completed by_____________________________

Physical Function – Short Form 10a

Please respond to each question or statement by marking one box per row.

		Not at all	Very little	Somewhat	Quite a lot	Cannot do
PFA1	Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC36r1	Does your health now limit you in walking more than a mile (1.6 km)?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC37	Does your health now limit you in climbing one flight of stairs?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA5	Does your health now limit you in lifting or carrying groceries?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA3	Does your health now limit you in bending, kneeling, or stooping?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Without any difficulty	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Unable to do**
PFA11	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA16r1	Are you able to dress yourself, including tying shoelaces and buttoning your clothes?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB26	Are you able to shampoo your hair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA55	Are you able to wash and dry your body?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFC45r1	Are you able to sit on and get up from the toilet?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

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Date: ________________________________

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Presciption Drugs	[ ]	5	5
3. Age (Mark box if age 16-45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention DeficitDisorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		