

**Patient Information**

Please fill out this form as accurately as possible. The physician will use this information to determine how best to treat you.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
 Gender: M \_\_\_ F \_\_\_ Current Age: \_\_\_\_\_ Referred by: \_\_\_\_\_ Family Doctor: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ x \_\_\_\_\_ Cell: \_\_\_\_\_  
 E-Mail \_\_\_\_\_ I allow Kansas City Sports Medicine to send documents to me via email. Y N  
 Emergency Contact: \_\_\_\_\_ Relation to patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
 \*\*I allow Kansas City Sports Medicine to share my medical information with my emergency contact. Y N  
 Employer: \_\_\_\_\_ Employer City/State: \_\_\_\_\_ Job Title: \_\_\_\_\_  
 Type of Employment: \_\_\_ Sitting \_\_\_ Standing \_\_\_ Walk a lot \_\_\_ Labor \_\_\_ Lifting \_\_\_ Climbing \_\_\_ Squatting

**Current Injury**

What body part are you here for today? \_\_\_\_\_ Was there an incident? \_\_\_ If yes, what date? \_\_\_\_\_  
 If no, how long has it been bothering you? \_\_\_\_\_ Have you had x-rays? \_\_\_ MRI? \_\_\_ Where? \_\_\_\_\_

**Insurance Information**

Primary Ins Company: _____ 2 <sup>nd</sup> : _____ <small>(must provide copy of insurance cards)</small> Subscriber Name: (if not patient) _____ DOB: _____ Relation: _____ SS# if Ins uses for ID#: _____	Work Comp Insurance: _____ Claim #: _____ Date of Injury: _____ Case Manager: _____ Phone: _____ Employer at time of injury: _____
--	---

**Medical History**

If additional space is needed, please use the back of this form.

**Do you have, or have you had, any of the following? Check all that apply.**

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Excessive Bleeding    | <input type="checkbox"/> Hepatitis A, B, or C    | <input type="checkbox"/> Psychiatric Care    |
| <input type="checkbox"/> Allergy to Latex       | <input type="checkbox"/> Claustrophobic       | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Spina Bifida        |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Drug Dependence      | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Irregular Heartbeat     | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Swelling of Limbs   |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Tuberculosis        |

Do you currently have a pacemaker, aneurysm clip, or any metal in the body? \_\_\_\_\_

Do you have, or ever had, any serious illness not listed above? \_\_\_\_\_

**Current Medications:** (If you have a list, we will copy that)

Medication	Dosage

**Previous Surgeries:**

Surgery	Year

**Medication Allergies:**

Medication	Reaction

**Family History:**

Condition	Relation	Condition	Relation
Heart Disease		Hypertension	
Diabetes		Cancer	

**Social History:**

Marital Status: \_\_\_\_\_ Number of Children \_\_\_\_\_ Do you use tobacco? Y N If yes, how much? \_\_\_\_\_  
 Do you drink alcoholic beverages? Y N If yes, how much? \_\_\_\_\_ Do you exercise regularly? Y N If yes, how much? \_\_\_\_\_  
 How would you describe your diet? Poor Average Well-Balanced

**This information is true and accurate to the best of my knowledge.**

Signed: \_\_\_\_\_  
Parent or guardian sign if patient under the age of 18.

Date: \_\_\_\_\_



# **KANSAS CITY SPORTS MEDICINE**

## **OFFICE POLICIES & PROCEDURES**

Welcome to KCSM. Dr. Parmar has a special interest in arthroscopic surgery of the shoulder and knee, as well as hip, elbow, and ankle. We have locations all around the KC Metro area including Lenexa, Lansing, KCK, and KCMO. Please take a moment to read our policies and procedures so you may better understand how our practice operates.

You must bring insurance cards/work comp information. We do not obtain this from your doctor's office or employer. Thanks.

### **FINANCIAL POLICY**

**KCSM participates with most insurance companies however, it is the patient responsibility to contact your insurance provider to confirm we are in-network with your plan. We do not contact your insurance company prior to your visit.**

- We will obtain precertification for procedures done by Dr. Parmar. If you are referred for an MRI, Physical Therapy, Pain Management, etc., those departments will obtain the precertification for their procedures.
- Our office will file a claim with your insurance company for services received. After your insurance company processes the claim, you will receive a statement from our office showing the "**Patient Responsibility**" amount. Your portion is due within 15 days of your statement. For large balances, you may contact our billing department to make payment arrangements.
- Individual coverage varies dramatically and **your coverage is an agreement between you and your insurance company. It remains your responsibility to verify that the care you receive is covered by your insurance.** This is separate from a precertification for procedures.
- KCSM is not responsible for the expense of treatment not paid by your insurance.
- We will not require you to present your insurance card after the first visit. If your insurance changes, you must let our office know and present all insurance cards at your next visit.

### **MEDICATION REFILLS**

When you are needing a medication refill, please call your pharmacy. Your pharmacy will contact our office with all the information and we will respond to their request. Do not wait until you are out of medications as your request may not be authorized the same day. The doctor may require a visit with you before authorizing the refill. Our fax number for requests to be sent to is 913-351-3009. No refills after hours or weekends. Please note: Our office does not routinely order narcotic pain medication, nor do we treat chronic pain.

### **DIAGNOSTIC TESTING/RESULTS**

Your test may require precertification with your insurance company. The imaging center will do this for you and it may take 2-3 days. Once your test is complete, please make sure you have an appointment made to see Dr. Parmar. He will go over your results and treatment options with you in the office.

### **MEDICAL RECORDS**

If you need copies of your medical records, please email our office with detail of what you are requesting and we will send you a pdf file of your doctor's notes. If you need your notes sent to another doctor's office, you must also email a written request with the doctor's office information you want them sent to.

### **FMLA/DISABILITY/PHYSICIAN STATEMENTS**

Dr. Parmar will write a note on his own form if he is taking you off work. If your employer or insurance requires their forms be completed, there is a \$20 fee per set of forms. Payment is due when you drop off the forms, then allow 7-10 days for completion. They cannot be filled out while you wait. Forms are not accepted via fax/email as payment must be made at the time the forms are left with our office.

### **CONTACTING OUR OFFICE**

Our office runs out of a different location each day of the week and we do not have phone lines at each office. If you have a question for the medical staff, you must leave a message and we will return your call once we have answers to your questions. You must leave any questions, phone/fax numbers, email addresses and other information in your message, and only leave one message. 913-351-3005 is our only phone number. You can reach scheduling, medical, and billing from this number. You can also reach us at the email below. **\*If you have call block on your phone, we will be unable to return your call. Our phone lines show as 'Private' or 'Restricted' on caller I.D.**