

**DRISKO, FEE & PARKINS, P.C.**  
**Orthopaedic Surgery**

**2790 Clay Edwards Drive Ste 600  
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**Alexandra J. Strong, M.D.  
Paul F. Nassab, M.D.  
Christopher L. Wise, M.D.  
Matthew M. Thompson, M.D.**

We want to welcome you to our office.

For your convenience, we have enclosed our patient information and history forms which you should complete prior to your appointment. To expedite your check-in, bring the completed forms with you at the time of your office visit, as well as your insurance card(s). If your insurance plan requires a co-payment and/or a referral form from your primary care physician, this should be presented at the time of your visit.

It is very important for our doctors to have copies of all recent tests and diagnostic studies pertaining to your problem at the time of your visit. Please contact your primary care physician or referring doctor to obtain copies of these records. These records include: chart notes, x-ray film and reports, MRI film and reports, CT film and reports, arthrogram reports, as well as operative reports from any previous surgery on the affected part of your body. If you have had any x-rays or MRIs, bring in the actual films as well as the report(s). These may be obtained from the radiology department in which the study was performed. *PLEASE DO NOT MAIL XRAYS OR MRIs.*

If you arrive without the requested medical history documents and films, you may be asked to reschedule your appointment at a future date. If you are on any medications, please bring a list of your medications and dosage.

Call our office with any questions.

Thank you for choosing our physicians.

# Welcome To Our Office!

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last

Nick Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact by: Phone, Letter, E-Mail Sex: Male or Female SSN: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

*We are required by federal standards to collect information on race and ethnicity.*

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White, Other \_\_\_\_\_

Ethnicity: Hispanic or Latino, Non-Hispanic or Latino, Other \_\_\_\_\_

Preferred Language: \_\_\_\_\_

Preferred Pharmacy (name, address, phone) \_\_\_\_\_

Occupation: \_\_\_\_\_ Status: Full-time or Part-time

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

***Complete this section only if someone other than the patient is financially responsible.***

Responsible Party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: Male or Female

Occupation: \_\_\_\_\_ Status: Full-time Part-time

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home#: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_ Cell#: ( ) \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Family, Friend, ER \_\_\_\_\_ Ad \_\_\_\_\_ Other \_\_\_\_\_

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**Insurance Information!**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last

**[Primary Insurance]**

Name of Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male or Female  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Status: Full-time or Part-time  
Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**[Secondary Insurance]**

Name of Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male or Female  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Cell #: ( ) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Status: Full-time or Part-time  
Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_ **Location of Accident:** Home, Work or Other: \_\_\_\_\_  
Description of accident: \_\_\_\_\_  
Did you report the accident to your employer? Yes No  
Did your injury happen as a result of an Auto Accident? Yes No  
If auto accident please list the liability insurance information \_\_\_\_\_

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. See our complete financial policy for details.

Please initial and sign below. Initials

I authorize the release of any medical information necessary to process my claim. \_\_\_\_\_

I authorize payment of medical and surgical benefits to Drisko, Fee & Parkins, P.C. \_\_\_\_\_

Signature of Patient of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

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