Orthopaedic Specialists

1

PATIENT NAME _____ **DOB** _____ **SSN** _____

MAILING ADDRESS _____ **CITY** _____ **ST** _____ **ZIP** _____

HOME # (____) _____ CELL # (____) _____ WORK # (____) _____

PLEASE LEAVE MESSAGES ON MY ☐ HOME ☐ CELL ☐ WORK

E-MAIL ADDRESS _____

SEX ☐ M ☐ F MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

EMPLOYER _____ **OCCUPATION** _____

***RACE**
☐ AMERICAN INDIAN OR ALASKA NATIVE
☐ ASIAN
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ BLACK OR AFRICAN AMERICAN
☐ WHITE
☐ HISPANIC
☐ OTHER RACE _____

***ETHNICITY**
☐ HISPANIC
☐ NON HISPANIC
☐ REFUSE TO REPORT

***LANGUAGE** _____

EMERGENCY CONTACT NAME _____ RELATION _____

PHONE # (____) _____ **LIVING WILL?** ☐ YES ☐ NO **POWER OF ATTORNEY?** ☐ YES ☐ NO

**Government requires this information to protect patients against discrimination*

PERSON RESPONSIBLE FOR BILL (If different from patient)

RELATION _____ **NAME** _____ **DOB** _____ **SSN** _____

ADDRESS (If not same as above) _____

HOME # (____) _____ CELL # (____) _____ WORK # # (____) _____

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PRIMARY INSURANCE COMPANY _____

POLICY HOLDER _____ DOB _____

SECONDARY INSURANCE COMPANY

POLICY HOLDER _____ DOB _____

PRIMARY CARE PHYSICIAN _____ **OFFICE #** _____

REFERRING PHYSICIAN _____ **OFFICE #** _____

NEW PATIENT MEDICAL HISTORY FORM

PATIENT NAME _____ PRIMARY CARE PHYSICIAN _____

DATE OF BIRTH _____ GENDER / AGE _____ /_____

3 PAIN HISTORY BACKGROUND

What is your main reason for visit?

Which side is your pain located on?
Right **Left** **Both**

How long has this pain been present? _____ **Days** _____ **Weeks** _____ **Months** _____ **Years**

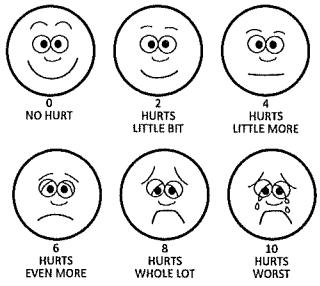
How often is the pain present? *(please circle)*
Frequent **(several times/hour)** ***Constant***
Occasional **(several times/week)** ***Sporadic*** **(several times/day)** ***Rare*** **(several times/month)**

What words best describe how the pain feels? *(please circle)*
Sharp Burning Shooting Stabbing Deep Aching Dull Tingling Throbbing Pressure
Other:

What makes your pain *better*? *(please circle)*
Heat Cold Medication Exercise

What makes your pain *worse*? *(please circle)*
Heat Cold Walking Sitting Standing Lying Stress Bending/Twisting
Coughing/Sneezing Standing from Sitting

Rank your Pain on scale of 1 to 10 (worst pain) _____



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Have you tried physical therapy?	Yes	No	Helpful?	Yes	No	Where?
Have you tried chiropractic treatments?	Yes	No	Helpful?	Yes	No	
Have you tried a brace or support?	Yes	No	Helpful?	Yes	No	
Are you taking prednisone or cortisone pills?	Yes	No	Helpful?	Yes	No	
Have you had a cortisone injection?	Yes	No	Helpful?	Yes	No	

5

Work related injury	Date: _____	How did your main pain complaint begin? *(please give details)*
Motor vehicle accident	Date: _____	_____
Fall or other trauma	Date: _____	_____
Following surgery	Date: _____	_____
Following illness	Date: _____	_____
Unknown reason	Date: _____	_____
Other _____		_____

TREATMENT HISTORY

Have you had a **RADIOLOGIC IMAGING** for your current pain complaint? **Yes** **No** *(please bring images to initial appointment)*

6

Study Type	Body part imaged	Date of Study	Where study was performed
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Have you had an Electromyography or EMG test to evaluate nerve function? **Yes** **No**

Are you currently being treated by a pain management physician or clinic? **Yes** **No**

Name _____ DOB _____

7 PAST MEDICAL HISTORY ☐ N/A (not applicable)

Abnormal heart beat	Depression	Heart attack	Rheumatoid arthritis
Stomach ulcer or GI bleed	Anxiety	Emphysema/COPD	Osteoarthritis
Heartburn/Acid reflux (GERD)	Insomnia	Cancer	Pacemaker, Stent
	Seizures	Stroke	Multiple Sclerosis (MS)
Diabetes	Fibromyalgia	Asthma	Irritable bowel
Liver disease	Migraine headaches	Hypothyroid/Hyperthyroid	HIV/Aids
Kidney disease	Psychiatric Conditions	High blood pressure	Vascular disease
Bleeding disorder	Alcoholism	High cholesterol	Broken Bones
Sleep apnea		Hepatitis	

PAST SURGICAL HISTORY

8 Please list any surgical procedures you have had in the past. ☐ N/A (not applicable)

SURGERY	DATE (MONTH/YEAR)	SURGEON

CURRENT MEDICATIONS

9 PREFERRED PHARMACY: _____ Location: _____ Phone: _____

ALLERGIES

Do you have any known drug allergies?	Yes	No	Are you allergic to IV contrast dye?	Yes	No
If yes, please list your allergies:			Are you allergic to local anesthetics?	Yes	No
			Are you allergic to latex?	Yes	No

10 HEIGHT AND WEIGHT

Height	Weight

11 FAMILY MEDICAL HISTORY

Father	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer	High Blood Pressure
Mother	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer	High Blood Pressure
Brother	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer	High Blood Pressure
Sister	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer	High Blood Pressure

☐ Please check here if you are adopted

12 SOCIAL HISTORY

What is your marital status?	Single	Married	Divorced	Widowed	
Occupation?	Full-time	Part-time	Retired	Student	Disabled
Do you use tobacco?	Current Smoker	Cigarettes/Cigars _____ packs/day	Former Smoker Date: _____	Non-Smoker	Other: _____
Do you use alcohol?	Never	Rarely	Socially	Regularly, _____ drinks/day	

Financial Agreement/Responsibility

I acknowledge financial responsibility for services provided by Orthopaedic Specialists. I understand that the clinic will file my insurance as a courtesy and that I am responsible for any amounts including but not limited to: co-payments, co-insurance, deductibles, FMLA/ Disability paperwork, copies of x-rays and/or medical records. I understand that co-pays and prior balances are due at time of service. Deductibles and co-insurance carries made on my behalf will be directed to Orthopaedic Specialists for services provided.

Signed _____ Date _____

Consent of Treatment/Payment/HIPAA Consent

I authorize Orthopaedic Specialists physician and staff to provide medical treatment as needed. I authorize the order and use of x-rays, injections, casting and/or diagnostic tests to diagnose and treat my illness or injuries. I hereby consent to Orthopaedic Specialists to use or disclose, for the purpose of carrying out treatment, payment, and/or healthcare operations at any time by giving a written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information.

Signed _____ Date _____

Consent of Communication Method

I acknowledge and agree that Orthopaedic Specialists and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided and any other telephone number associated with my account, including wireless and/or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as ATDS (Automated Telephone Dialing System) or pre-recorded message. I also agree that I will notify Orthopaedic Specialists if I have given up ownership or control of any such telephone numbers.

Signed _____ Date _____

ePrescribing

A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription to a pharmacy from the point of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program. These include:

- *Formulary and benefit transactions* - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- *Medication history transactions* - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form, you are agreeing that Orthopaedic Specialists can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signed _____ Date _____

I have received a copy of the Notice of Privacy Practices of Orthopaedic Specialists.

Signed _____ Date _____

***PLEASE COMPLETE ALL SECTIONS!**

Full Name _____ Date of Birth _____

Address _____

Telephone _____ Email _____ Social Security _____

I hereby authorize _____ and its physicians, employees, and/or agents

to release or disclose the following protected health information to: _____

Telephone _____ Fax _____

Address _____

THE REQUEST AND AUTHORIZATION APPLIES TO:

_____ Medical Records

_____ Specific records listed below, including dates, body part, time frame, etc. (example: physician office notes, lab and test results, operative report _____

_____

_____ Itemized account/billing information

This authorization will expire one year from date of signature.

If you do not want certain portions of your medical records released, initial in the space(s) below for the information you do ***not*** want released.

_____ Substance abuse _____ Mental health _____ HIV/AIDS/sexually transmitted diseases _____ Other/Specified: _____

- I understand I may revoke this authorization at any time by sending a written request to the attention of the Privacy Officer for Orthopaedic Specialists. However, the revocation will not have any effect on any uses or disclosures that Orthopaedic Specialists may have made before receiving the revocation.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and may not be protected by federal confidentiality rules.
- I understand that I am not required to sign the authorization as a condition of treatment or payment, or for enrollment or eligibility for benefits.

I give my authorization to use or disclose my protected health information as described:

Patient or Authorized Representative's Signature: _____ Date: _____

Relationship to the patient if not signed by the patient: _____

You have a right to a copy of this form after you sign it