ORTHOPEDICS TODAY

Today's Date: _____

Patient Name: _____
Last First Middle Initial

Date of Birth: _____ Age: _____ Social Security Number: _____ Gender: M F

Preferred Phone: _____ Secondary Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Employer: _____ Job Title: _____

Primary Care Physician: _____ Referring Physician: _____

Financial Responsible Party (if different than patient or if patient is a minor): _____

Social Security Number: _____ Date of Birth: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Ethnicity (Please Select One)**:**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Race (Please Select One)**:**

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Decline

Date of Injury (if applicable): _____ **Will this injury be filed with Worker's Compensation?** ☐ Yes ☐ No

Personal Insurance Information

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____

Secondary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: X_____ Date: _____

ORTHOPEDICS TODAY

Was this injury work-related? ☐ Yes ☐ No **Was this injury due to an auto accident?** ☐ Yes ☐ No

Please be advised that OSMI does not treat injuries acquired by an accident where a third-party entity is held liable for the incident (i.e. auto insurance). OSMI only files claims on personal health insurance or worker's compensation, and accepts self-pay patients. Any appointment under other circumstances may be cancelled.

Chief Complaint

Reason for your visit today **(Please specify Left and/or Right Side):**

_____

Date of Injury or when symptoms started: _____

Where did injury occur: _____

Describe how the injury or problem occurred: _____

_____

_____

_____

Symptoms (Check all that apply): ☐ Sharp Pain ☐ Dull Pain ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Burning Sensation

Additional Symptoms Not Listed:

_____

_____

What treatments have you already tried:

☐ Physical/Occupational Therapy

☐ NSAID (Tylenol, Advil, Aleve, etc.)

☐ Steroid Injection

☐ Other _____

☐ Home Exercises

☐ Ice/Heat

☐ Rest/Activity Modification

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: X_____ Date: _____

ORTHOPEDICS TODAY

Acknowledgement and Acceptance of Privacy Notice and Practices (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in the above paragraph:

- ☐ No restrictions: OSMI may release information, if requested, to anyone.
- ☐ Restrictions: Please list who we may release information to regarding your healthcare below

_____

_____

I wish to be contacted in the following manner (Check all that apply):

Home/Cell ph#: _____

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Work ph #: _____

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Office policies

Please be advised that our office houses physicians, physician's assistants, and a physical therapy center. After you sign in, our receptionists will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionists of any address, phone number or insurance change **before** you are seen. The office may verify insurance coverage prior to services being rendered, however, it is ultimately the patient's responsibility to be mindful of their own insurance benefits; including any required referrals or authorizations. All charges will be submitted to your insurance company. Any remaining balance is the responsibility of the patient or their financial responsible party.

Prescription Request

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill requests. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day.

Clinical Questions

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and may not be called away from patients to speak to you. Our receptionists will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Patient Forms

Please be aware that we charge $20.00 to complete the paperwork for any of the following: FMLA, long term or short term disability, third-party insurance (i.e., AFLAC, Unum, etc.). We require 4 business days to complete paperwork.

No Show Policy

Please be aware there will be a $25.00 charge for any appointments that are missed or not cancelled 24 hours prior.

I have read and fully understand the above information.

Patient or Guardian Signature: X_____ Date: _____

Medical Disorders: If you have had any of the following, place a mark inside box

- ☐ **No Medical History**
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Blood Clot Leg
- ☐ Blood Clot Lung
- ☐ Other Disease (list below)
- ☐ Stroke
- ☐ Cancer Breast
- ☐ Cancer Colon
- ☐ Cancer Lung
- ☐ Cancer Prostate
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Blood Thinners (Coumadin, Plavix, Aspirin, etc)
- ☐ Sleep Apnea
- ☐ Gout
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Seizures
- ☐ Ulcers, Bleeding

Surgical History: If you have had any of the following, place a mark inside box

- ☐ **No Surgical History Reported**
- ☐ Carpal Tunnel Left Wrist
- ☐ Arthroscopy Left Elbow
- ☐ Arthroscopy Left Shoulder
- ☐ Arthroscopy Left Ankle
- ☐ Arthroscopy Left Knee
- ☐ Arthroscopy Left Hip
- ☐ Left Hip Replacement
- ☐ Left Knee Replacement
- ☐ Spinal Fusion
- ☐ Other Surgery (list below)
- ☐ Cardiac (Heart)
- ☐ Carpal Tunnel Right Wrist
- ☐ Arthroscopy Right Elbow
- ☐ Arthroscopy Right Shoulder
- ☐ Arthroscopy Right Ankle
- ☐ Arthroscopy Right Knee
- ☐ Arthroscopy Right Hip
- ☐ Right Hip Replacement
- ☐ Right Knee Replacement
- ☐ Laminectomy
- ☐ Fracture Surgery

Family History: If any family member below has any of the following history, place a mark inside the box

FATHER

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

MOTHER

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

SIBLING(S)

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Gout
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Muscle Disease
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis

Social History: Please respond to the following by placing a mark inside the box

Substance Use:

Tobacco	☐ Yes ☐ No ☐ Former
Alcohol	☐ Yes ☐ No
Caffeine	☐ Yes ☐ No
Illicit Drugs	☐ Yes ☐ No
	☐ I do not use any of the above

Hand Dominance: ☐ Right Handed
☐ Left Handed

Females Only: Could you be pregnant?
☐ Yes ☐ No

Allergies: Do you have allergies to any of the following medications or substances

☐ **No Known Drug Allergies**	☐ Depakene	☐ Septra	☐ Insulin
☐ Penicillin	☐ Aspirin	☐ Lamictal	☐ Lidocaine
☐ Codeines	☐ Amoxil	☐ Tegretol	☐ Latex
☐ Sulfa Drugs	☐ Keflex	☐ Bactrim	☐ IVP/X-Ray Dye
☐ Iodine/Shellfish	☐ Cefzil	☐ Pediazole	☐ Metal
☐ Ampicillin	☐ Ceftin	☐ Dilantin	☐ Egg/Avian (Bird)
☐ Vantin	☐ Suprax	☐ Novocaine	

Please list any other allergies:

Current Medications: Please list all medications you are currently taking.

Preferred Pharmacy: _____ Phone#: _____

Are you currently taking any medications? ☐ Yes ☐ No ☐ See list provided

Medication	Dose	Frequency

Anesthesia/Height/Weight

Have you had any past problems with anesthesia? ☐ Yes ☐ No If yes, please explain:

_____

Height: ____Ft____In Weight: _____

Review of Symptoms: If you have any of the following, place a mark inside circles

Constitutional
- ☐ Weight Loss/Gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Fever

Eyes
- ☐ Glasses or Contacts
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Excessive Tearing

Ear Nose Mouth Throat
- ☐ Ears Ringing
- ☐ Earaches
- ☐ Hearing Aid
- ☐ Frequent Colds
- ☐ Nasal Discharge
- ☐ Hay Fever
- ☐ Nosebleeds
- ☐ Dentures
- ☐ Bleeding Gums
- ☐ Frequent Sore Throats

Cardiovascular
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Rheumatic Fever
- ☐ Palpitations
- ☐ Has Pacemaker

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis

Gastrointestinal
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Abdominal Pain
- ☐ Gallbladder Trouble
- ☐ Hepatitis

Genitourinary
- ☐ Blood in Urine
- ☐ Urinary Infections
- ☐ Kidney Stones
- ☐ Burning Urination
- ☐ Sexual Disease

Musculoskeletal
- ☐ Joint Paint
- ☐ Arthritis
- ☐ Muscular Weakness
- ☐ Stiffness
- ☐ Muscular Pain

Skin
- ☐ Rashes
- ☐ Sores
- ☐ Lumps
- ☐ Dryness
- ☐ Itching

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures
- ☐ Abdominal Pain
- ☐ Gallbladder Trouble
- ☐ Hepatitis

Psychological
- ☐ Nervousness
- ☐ Depression
- ☐ Mood Changes

Endocrine
- ☐ Thyroid Trouble
- ☐ Excessive Sweating
- ☐ Excessive Thirst

Blood or Lymph
- ☐ Anemia
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Swollen Glands

Immunologic
- ☐ Reactions to Drugs
- ☐ Skin Rashes
- ☐ Reactions to Foods