



Orthopaedic Institute of Ohio Demographic Information

Date: _____

Patient Name	Age	Date of Birth	Marital Status	Sex
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Mailing Address (include PO Box and Apt #)	Social Security Number	
City, State, & Zip	Home Phone	Cell Phone

Employer's Name	Employer's Address	Employer's Phone
Referring Doctor	Family Doctor	
Phone	Phone	
Pharmacy	Location	Phone

CONTACT PERSON – Not Living at the Same Location

Name	Relationship	Phone
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SPOUSE/PARENT/GUARDIAN INFORMATION (Please Circle which one)

Name	Social Security Number	
Address	Date of Birth	
City, State	Zip	Marital Status
Employer's Name	Relationship to Patient	
Employer's Address	Employer's Phone	

INSURANCE INFORMATION (Please present your insurance cards so that we may obtain a copy for our records).

Primary Insurance Company		Secondary Insurance Company	
Policy Holder's Name	Social Security Number	Policy Holder's Name	Social Security #
Date of Birth	Co-Pay	Date of Birth	Co-Pay
Relationship to Patient		Relationship to Patient	
Policy Holder's Address		Policy Holder's Address	
Policy Holder's Employer		Policy Holder's Employer	
If BWC: Date of Injury			



Orthopaedic Institute of Ohio
 801 Medical Drive Suite A Phone: (419) 222-6622
 Lima, OH 45804

Release of Medical Information

Federal and state law direct when the Practice may disclose a patient's Protected Health Information to persons involved in a patient's care. This form allows a patient to designate family members, friends or other individuals to whom the practice may release Protected Health Information.

Date: _____

I, _____ (print patient name) hereby agree that the following person (s) involved in my care may receive medical information about me (friends or family members, not physicians).

 (Name)

 (Relationship to patient)

 (Name)

 (Relationship to patient)

 (Name)

 (Relationship to patient)

This form is not intended as a full authorization to release all of your Protected Health Information. The individuals listed above will only receive Protected Health Information directly relevant to such individual's involvement in your care or payment related to your care.

You may cancel or alter this designation at any time by informing OIO in writing of such change/ alteration. Any cancellation or alteration can only apply to future disclosures or actions regarding your Protected Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

Contact Information

Our office may need to contact you by telephone to remind you of appointments and to give you test results or other information related to you medical care. Please indicate in the order of how you would like to be contacted. All telephone numbers must be listed (work, cell, family, etc.) in order for us to comply with this request.

Number

Location

1. _____

2. _____

3. _____

Signature: _____

Date: _____



Orthopaedic Institute of Ohio

801 Medical Drive Suite A
Lima, OH 45804

Phone: (419) 222-6622

PATIENT AUTHORIZATION

I hereby authorize Orthopaedic Institute of Ohio, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above named insurance company. I permit a copy of this authorization to be used in such instances.

By signing below, I agree to pay all charges for services rendered by OIO which are not covered by the above referenced insurance coverage. If it becomes necessary for OIO to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of OIO for such action.

REFERRALS

I understand that I am responsible for obtaining a valid referral from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that OIO will attempt to obtain a pre-certification as a courtesy for me. I understand that OIO is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with OIO that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize OIO to release my medical information as I have directed. I understand that OIO does not copy records and that such record copying services are performed by the independent records copying company. Therefore, such record copying may be subject to a copying charge. I also understand that since OIO does not copy records that records must be requested at least two weeks in advance of desired receipt date. If there is a charge for copying my records, I understand that I will be billed by the independent records copying company based upon allowable charges under current Ohio law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by an OIO physician, or workman's compensation issues or any other situations covered by Ohio law.

PHOTOGRAPHY CONSENT

I give OIO permission to photograph my child for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Orthopaedic Institute of Ohio is committed to patient privacy and confidentiality. In our Patient Bill of Rights, we state that our patients have a right to privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regards to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone?

DURABLE MEDICAL EQUIPMENT (DME)

I authorize OIO to submit a claim for the products(s) on my behalf and I assign the benefits payable by my insurer for such product(s) to the Orthopaedic Institute of Ohio. I authorize my Health Care Provider to release any medical information required for my insurer to process the claim. I understand that I am responsible for, and I agree to pay, any portion of the amount due for such product not paid by my insurer, whether resulting from deductibles, co-pays, or otherwise.

I authorize/ request OIO to (please initial your choice)

Leave a message at work _____ Yes _____ No

Leave a message at home _____ Yes _____ No

Date

Patient/ Parent or Guardian Signature

Red Flag:
Identity Theft
Prevention



**DO YOU KNOW
ABOUT THE
“RED FLAG”
RULES TO FIGHT
IDENTITY THEFT?**

Identity Theft is a national and global issue, and each of us must protect our identity. The Federal Trade Commission adopted new rules for every creditor – including this facility – to implement by December 21, 2010. They are called the “Red Flag” Rules, and we are protecting YOUR identity by watching for the Red Flags of Identity Theft.

EFFECTIVE December 21, 2010, EVERY ADULT PATIENT REGISTERING FOR SERVICES MUST SHOW A PHOTO I.D. AND PROOF OF ADDRESS, UNLESS PAYING IN CASH, IN FULL, IN ADVANCE. IF THE PATIENT IS A MINOR, THE ADULT GUARANTOR’S IDENTIFICATION WILL BE CHECKED.

ACCEPTABLE PHOTO I.D. INCLUDES:

- PHOTO DRIVERS LICENSE OR STATE PHOTO I.D.
- PASSPORT, COLLEGE I.D. OR EMPLOYER I.D.
- VALID IMMIGRANT VISA or “GREEN CARD”

*IF THE ADDRESS ON YOUR DRIVER’S LICENSE IS NOT ACCURATE – PLEASE BRING IN A UTILITY BILL, PAYCHECK STUB OR GOVERNMENTAL CORRESPONDENCE SHOWING CURRENT RESIDENCE.

**PLEASE REMEMBER THE DAY OF SURGERY TO BRING
YOUR INSURANCE CARD, PHOTO ID
AND PROOF OF ADDRESS.**



Lloyd C. Briggs, Jr., M.D., M.S.
Board Certified, American Board of Orthopaedic Surgery
Fellowship Trained in Foot and Ankle Surgery
Fellow American Academy of Orthopaedic Surgery
Member American Orthopaedic Foot and Ankle Society



Greetings,

In the near future, you are scheduled to meet with Dr. Briggs at the Orthopaedic Institute of Ohio. Dr. Briggs is a foot and ankle fellowship trained orthopaedic surgeon who specializes in foot and ankle surgery. He and our staff are dedicated to try to help people with both major and minor foot and ankle problems. In preparation for your visit, we have three recommendations.

First, in order to make your visit as productive as possible, we ask that you take the time to fill out the enclosed questionnaire which asks you to describe your medical problem and give a detailed past medical history. The foot and ankle is an integral part of your body and it is affected by other medical problems you may have. It is important that we have as much information as possible concerning your medical health in order to properly diagnose your problem and provide a treatment plan that is best suited for you. Your own description of your injury or problem is often times the most important factor in making a proper diagnosis, as well as, understanding how this problem affects your life. We realize no one likes to fill out paperwork, but please take the time to fill out the form in its entirety before your visit. This will help us be as thorough as possible and will ultimately benefit you.

Second, written reports of x-rays, MRIs, CT scans, and bone scans can be inaccurate. In order to be as thorough as possible, we like to review the original films of any x-rays, CT scans, MRI scans, or bone scans you might have undergone. Sometimes the reports are helpful and sometimes they are not. Reading the actual films gives us far more information than the reports typically do. From past experience, if you call your doctor's office or the hospital, and ask them to send films or medical records, 75% of the time we do not end up getting them in time for your visit. To ensure that these records or films are present for your visit, please pick up the records and film yourself to be sure we have them for your visit. Do not rely on the mail or courier service to get the films to the office in time for the appointment.

Third, for the physical exam, we usually like to examine the foot, the ankle and legs up to, and above the knees so please bring a pair of shorts or wear a pair of pants which can be easily rolled up above the knees. In addition, for your initial visit, please bring the shoes you wear most often as well as any braces, orthoses, or shoe inserts you use or have used.

Finally, thanks for your time and cooperation. We look forward to trying to help you with your problem. If you have any problems please feel free to call and speak with Michelle at 419-222-6622 (ext. 3391) and she will try to help you. REMEMBER TO BRING YOUR COMPLETED FORM WITH YOU TO YOUR VISIT. If you forget, we can give you another one at the time of your visit, but you will have to fill it out before you can be seen.

Thanks again,

Lloyd C. Briggs, Jr., M.D., M.S. and the staff at the Orthopaedic Institute of Ohio

Orthopaedic Institute of Ohio
801 Medical Drive, Suite A
Lima, Ohio 45804
(419)222-6622
www.orthoohio.com



Dear New Patient,

Recently, you have been scheduled for a surgical consultation with Dr. Briggs at the Orthopaedic Institute of Ohio. We would like to welcome you to our practice and assure you that we will do everything we can to help you with your current foot or ankle problem. In order to make your visit as productive for you as possible we would like to make you aware of Dr. Briggs' office policies.

Dr. Briggs is a Board Certified Orthopaedic surgeon who completed a Foot and Ankle fellowship in New York City before coming to Lima. While we certainly help many people with therapy or bracing, the primary emphasis of his practice is on the surgical treatment of foot and ankle problems. Often times our ability to help you will depend on whether or not your problem can be treated with surgery. If for some reason you cannot have surgery or your problem cannot be fixed with surgery, we may not be able to help you very much with your problem.

We also need to let you know that because his practice is primarily surgical, Dr. Briggs does not prescribe narcotics for the treatment of pain, with the exception of the first couple weeks after surgery or the first couple of weeks after a fracture. Treatment of pain with medications for longer than a few weeks is referred to as "chronic pain management". This is not something Dr. Briggs does. If you are on narcotics or other types of pain medications now, you should continue to get them from the physician who prescribed them to you because Dr. Briggs will not write for, or continue those medications. If you think that pain medications should be part of your long term treatment, Dr. Briggs recommends that you seek a health care provider who provide "chronic pain management", (long term, medication-oriented pain management) so you can be safely monitored long-term with these medications.

Finally, we need to let you know that Dr. Briggs does not perform permanent disability evaluations. The emphasis of our practice is to return people to work as soon as possible. Unfortunately, there are some people whose injury or injuries are so severe that they cannot return to work and they are best off seeking permanent disability. Unfortunately, our practice does not provide that service at this time. So if the purpose of your visit is to seek permanent disability, you should make other arrangements.

If you have any questions concerning these policies or other questions about the practice please feel free to call Michelle, my assistant, at 419-222-6622, ext. 3391.
Sincerely,

Dr. Briggs' Staff at the Orthopaedic Institute of Ohio.

PATIENT QUESTIONNAIRE

Lloyd C. Briggs, M.D.

Name: _____ Date of Birth: _____ Date: _____

Please describe what brings you here today: _____ Right

Where does it hurt? _____ Left

How long have you had the problem? _____

What makes it better? _____

What makes it worse? _____

Please describe the type of pain you have (check all that apply)

- Sharp Aching Stabbing
- Dull Cramping Throbbing
- Pins and Needles Constant Comes and goes
- Worse on uneven ground Worse with activity Worse with getting up from a seated position

If it is an injury, when did it happen (date)? _____

How did it happen? _____

On a scale of 1-10, how severe is the pain?
No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Where did it occur? Home School
 Work Auto Other

What bothers you the most about your foot/ankle?

Is there a third party responsible for payment?

- Pain Swelling Feels unstable Deformity
- Yes No

What studies have you had for this problem? X-rays MRI CT Scan Arterial/ blood flow studies

EMG/NCV (needle nerve study) Blood work Bone scan Venous doppler study (looks for blood clots)

What treatments have you had for this problem? Physical therapy Orthosis/ shoe modifications

Injections Bracing Night splint Home stretching exercises Anti-inflammatory medications

Surgery

Who is your primary care physician? _____

Do you see any other specialists? _____

Which physician referred you here? _____

Have you seen Dr. Briggs before? Yes No Are you seeing him for: Same problem New problem

Have you seen another physician in this practice within the last three years?
 No Yes, which doctor? _____

Your height: _____ Your weight: _____ Your age: _____

Past Family History – Please check any of the following medical problems anyone in your immediate family (mother, father, sibling, grandparents) has had. Please check all applicable boxes and circle the appropriate relationship below.

- | | | | | | |
|------------------------------------|---------------------------------|-----------------------------------|---------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Lung disease |
| (M/F/S/G) | (M/F/S/G) | (M/F/S/G) | (M/F/S/G) | (M/F/S/G) | (M/F/S/G) |

Review of Systems – Please check any of the following you have had

- | | | | | |
|---|--|---|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Nausea/ vomiting | <input type="checkbox"/> Stomach ulcer/ reflux | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Anemia | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Bleeding problem | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Leg/ankle swelling | <input type="checkbox"/> Numbness/ tingling in the toes | <input type="checkbox"/> Weakness/ paralysis |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Back surgery | <input type="checkbox"/> Pain shooting down leg | | |

Past Medical History – Please check any of the following you have had

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Asthma/ COPD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Charcot-Marie Tooth disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Reynaud's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Reflex Sympathetic Dystrophy (RSD) | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Seizures | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Blood clots (phlebitis) | <input type="checkbox"/> Staph infection | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Charcot arthropathy |
| <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Gout | <input type="checkbox"/> Disc herniation (Back/neck) |

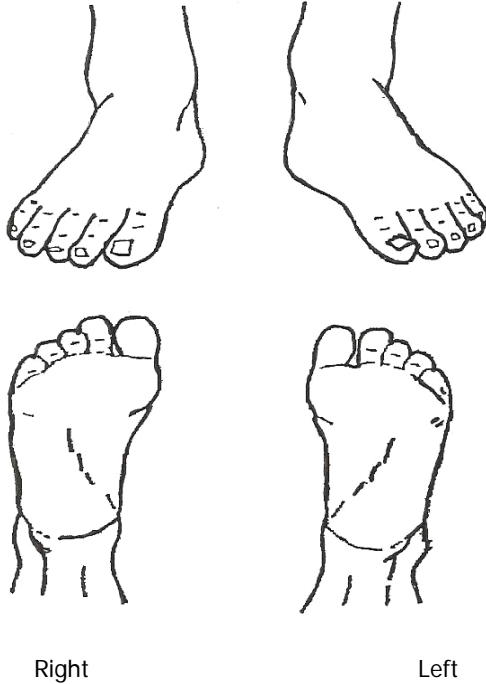
Please describe any of the problems you have checked from the above list

Please describe any past surgeries (and year)

Foot/Ankle Pain Diagram

Instructions:

Please place an "X" on the diagram where your pain is the most severe. Place a "2" where the pain is the second most severe and a "3" where the pain is next most severe.



Note: For each category please mark the statement which most closely resembles your current situation.

1) Pain level right now (circle one) [0 = no pain, 10 = the worst pain you ever had]:

0 1 2 3 4 5 6 7 8 9 10

2) Highest pain level during a typical day (circle one):

0 1 2 3 4 5 6 7 8 9 10

3) Has the pain gotten better, worse, or the same over the last month? Better Same Worse

4) Frequency of the Pain:

- Constant (24/7)
- Whenever awake
- Several times a day
- Once a day
- Once a week
- Once a month
- Less than once a month

6) The pain limits my activity level:

- Home activities (i.e. cooking)
- Outside activities (i.e. yard work or grocery shopping)
- Work
- Exercise
- No limitations

5) The pain interferes with my ability to:

- Sleep
- Sit
- Stand
- Walk
- None of the above

7) To walk, I need to use a:

- Cane
 - Walking boot
 - Orthosis/ Shoe insert
 - Specific type of shoe
 - No devices necessary