



# Orthopaedic Institute of Ohio

## Demographic Information

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

Patient Name		Home Phone		Cell Phone	Employer Phone
Mailing Address (include PO Box and Apt. #)			Family Doctor Name and Phone Number		
City, State, Zip			Referring Doctor Name and Phone Number		
Age	Date of Birth	Sex	Marital Status	Social Security Number	
Employer's Name			Employer's Address		

### SPOUSE/PARENT/GUARDIAN INFORMATION (Please circle which one)

Name	Social Security #	Date of Birth	Relationship to patient	Marital Status
Mailing Address				

### EMERGENCY CONTACT

Name	Relationship	Phone
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### 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 Number
Date of Birth	Co-Pay	Relationship to patient	Date of Birth	Co-Pay	Relationship to patient
Policy Holder's Address			Policy Holder's Address		
Policy Holder's Employer			Policy Holder's Employer		
If BWC: Date of Injury	Pharmacy Card (company name)		ID Number	Phone	

E-mail Address	I authorize OIO to leave a message at (please initial all that apply) _____ Home _____ Work _____ Cell
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#### Race:

- White/Caucasian
- Black or African-American
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Asian
- Hispanic or Latino

#### Ethnicity:

- Latino or Hispanic
- Not Latino or Hispanic

#### Language:

- English
- Spanish
- Indian
- Other

Pharmacy Name	Location	Pharmacy Phone Number
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# Orthopaedic Institute of Ohio

## 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?

## Release of Medical Information Agreement

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.

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	Phone
_____	_____	_____
Name	Relationship to patient	Phone
_____	_____	_____
Name	Relationship to patient	Phone

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.

_____	_____	_____
Date	Patient/ Parent or Guardian Signature	Date of Birth



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### Dr. Dasari Patient History Form

Name: \_\_\_\_\_ Sex: \_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

Have you seen Dr. Dasari within the last three years?  Yes  No BP \_\_\_\_\_

1. Chief complaint (reason why you are here, eg: neck pain): \_\_\_\_\_

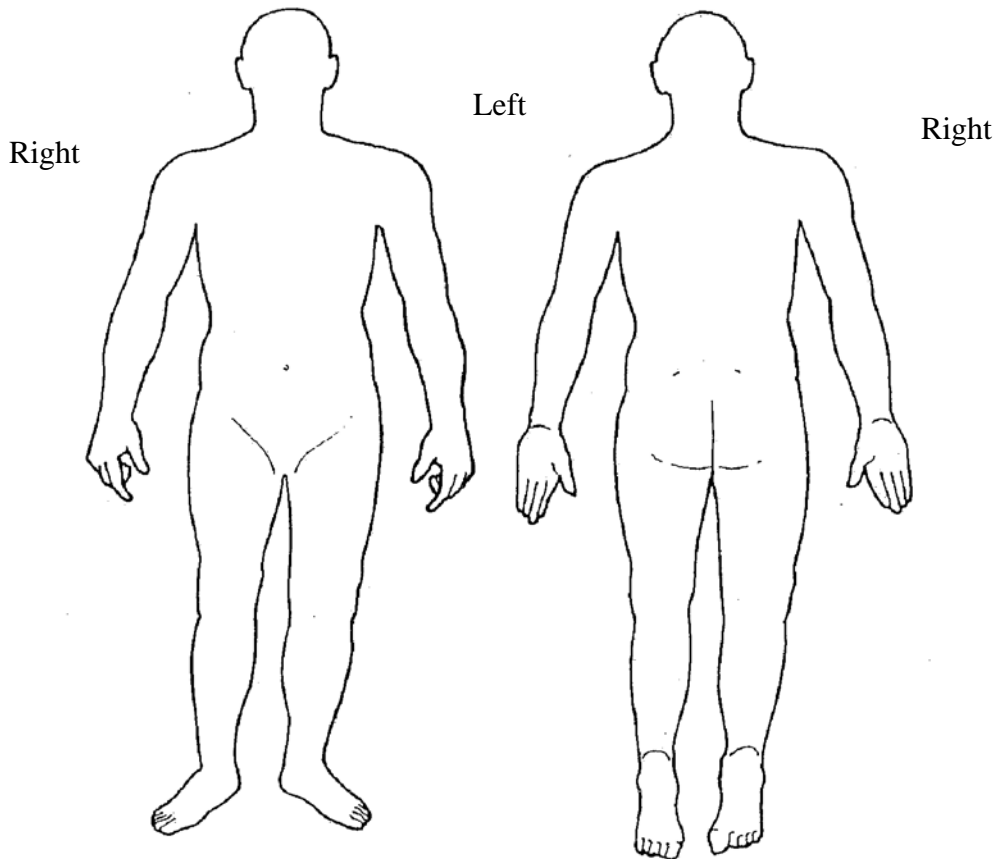
2. How long have you had the problem (eg: 2 months)? \_\_\_\_\_

3. Is your problem:  work related  Motor Vehicle Accident  Other Date it happened: \_\_\_\_\_

4. Did the problem begin without apparent cause?  Yes  No

5. Where is the pain located? (eg: right side of neck) \_\_\_\_\_

6. Mark the areas on your body where you feel pain.



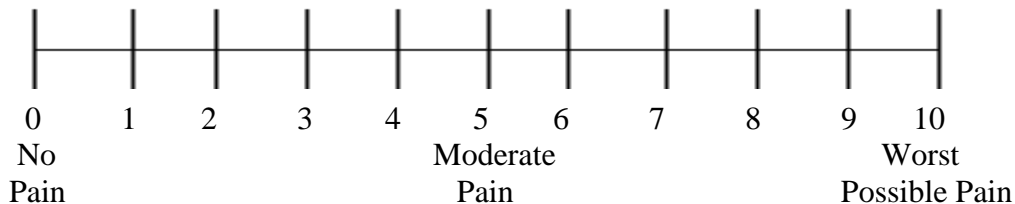
7. Is your pain: **(check one)**

- Constant (24/7)     Comes and goes     Occasional (once in awhile)

8. Describe the quality of pain: **(check one)**

- dull ache     sharp     stabbing     shooting     throbbing

9. Please rate the intensity of your pain on this scale from 0 to 10. A rating of 0 means “no pain at all”. A rating of 10 means “the worst possible pain you could imagine”. **(circle ONE number)**



10. What makes the pain worse? (Check all that apply)

- walking     bending     lifting     standing     home chores     other \_\_\_\_\_

11. What makes the pain better? (check all that apply):

- resting     sitting     heat     stretching     medications     other \_\_\_\_\_

12. Do you have trouble sleeping due to pain?  Yes     No

13. Do you wake up at night to take pain medication?  Yes     No

14. Which doctor(s) have you seen for this problem? (please list the names) \_\_\_\_\_  
\_\_\_\_\_

15. What treatments have you had for this problem?

- physical therapy     home exercises     surgery     epidural steroid injections  
 TENS     chiropractic     medications     none  
 other \_\_\_\_\_

16. Which treatment helped? \_\_\_\_\_

17. Past medical history: (check all that apply)

- diabetes     high blood pressure     heart disease/heart attack  
 Asthma/COPD     cancer     stroke  
 fibromyalgia     hepatitis     anxiety  
 depression     bipolar disorder     pacemaker  
 cardiac defibrillator     other \_\_\_\_\_

18. Please describe any past surgeries: \_\_\_\_\_

19. Do you have any drug allergies?  Yes  No If yes, please list and describe reaction \_\_\_\_\_

20. Please list the medications you are taking, prescription and over-the-counter:

Medication name	Dose (example 10 mg)	How often do you take it?

21. For women only:

Are you pregnant now?  Yes  No      Are you breast feeding?  Yes  No  
Have your periods ceased?  Yes  No

22. 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.

Arthritis                       Cancer                       Diabetes                       Heart disease  
 Lung disease                       Anxiety                       Depression                       Bipolar disorder

23. SOCIAL HISTORY:

Marital status (circle):    Single                      Married                      Divorced                      Widowed

Number of children? \_\_\_\_\_ Ages: \_\_\_\_\_

With whom do you live? \_\_\_\_\_ Do you drive?  Yes  No

Do you smoke?  Yes  No If yes, how many packs per day \_\_\_\_\_ for \_\_\_\_\_ years.

Do you drink alcohol?  Yes  No If yes, how many drinks per day \_\_\_\_\_ for \_\_\_\_\_ years.

Do you use recreational drugs?  Yes  No If yes, please check:

Heroin     Cocaine     Marijuana     Amphetamines     Barbiturates     Other \_\_\_\_\_

24. Are you:    working                       retired                       on disability

If working, what do you do? \_\_\_\_\_

Present Employer: \_\_\_\_\_ How long have you worked at the present employer? \_\_\_\_\_

If not working, how long have been off work? \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Circle if you are experiencing any of the following.

Please explain.

1. Constitutional:	fever	weight loss	_____
2. Eyes:	eye pain	double vision	_____
3. Ears:	ringing/buzzing	difficulty hearing	_____
4. Gastrointestinal:	nausea/vomiting	constipation/diarrhea	_____
5. Skin:	skin rashes	itching/burning	_____
6. Musculoskeletal:	joint pain	low back/neck pain	_____
7. Respiratory:	shortness of breath	wheezing	_____
8. Cardiovascular:	chest pain	leg/ankle swelling	_____
9. Genitourinary:	painful urination	frequent urination	_____
10. Neurological:	tingling/numbness	seizure/epilepsy	_____
11. Psychiatric:	anxiety/depression	drug/alcohol abuse	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Opioid Risk Tool (office use only)**

Mark each box that applies:	Female	Male
1. Family history of substance abuse		
Alcohol	1 <input type="checkbox"/>	3 <input type="checkbox"/>
Illegal Drugs	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Prescription Drugs	4 <input type="checkbox"/>	4 <input type="checkbox"/>
2. Personal history of substance abuse		
Alcohol	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Illegal drugs	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Prescription Drugs	5 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Age (mark box if between 16-45 years)	1 <input type="checkbox"/>	1 <input type="checkbox"/>
4. History of preadolescent sexual abuse	3 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Depression	1 <input type="checkbox"/>	1 <input type="checkbox"/>
Scoring totals:	_____	_____

**Administration**

On initial visit  
Prior to Opioid therapy

ADO: attention-deficit disorder      OCD: obsessive-compulsive disorder

**Scoring**

0-3: low risk (6%)  
4-7: moderate risk (28%)  
≥ 8: high risk (>90%)

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_