



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

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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?

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



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(419) 222-6622 • (800) 225-3921 Fax: (419) 222-0015
www.orthoohio.com

Dr. Dasari Patient History Form

Name: _____ Age: _____ Sex: _____ DOB: _____

Referring Doctor: _____ Height: _____

Family Doctor: _____ Weight: _____

Have you seen any doctor in this practice within the last three years? Yes No

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

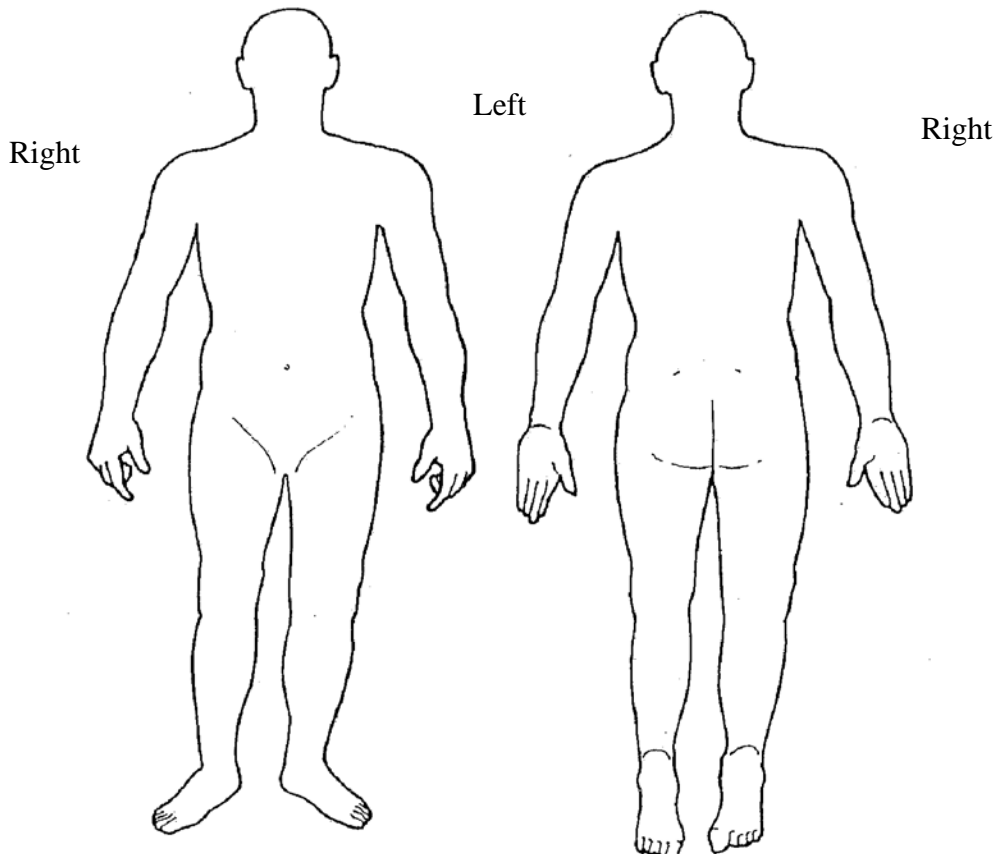
2. How long have you had the problem (eg: 2 months)? _____

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.



Do you drive? Yes No

Do you need help with feeding, bathing, toileting, and dressing? Yes No

If yes, give the name/relationship of your caregiver: _____

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 _____

27. 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:

Are you experiencing any of the following in the past week? (circle all that apply)

- | | | | |
|----------------------|---------------------|---------------------|--------------------|
| 1. Constitutional: | chills/fever | night sweats | weight loss |
| 2. Eyes: | cataracts | eye pain | double vision |
| 3. Ears: | hearing aid | ringing/buzzing | difficulty hearing |
| 4. Gastrointestinal: | nausea/vomiting | constipation | diarrhea |
| 5. Musculoskeletal: | joint pain | low back pain | neck pain |
| 6. Respiratory: | shortness of breath | wheezing | chronic coughing |
| 7. Cardiovascular: | chest pain | irregular heartbeat | leg/ankle swelling |
| 8. Genitourinary: | kidney stones | painful urination | frequent urination |
| 9. Neurological: | tingling/numbness | memory loss | seizure/epilepsy |
| 10. Psychiatric: | bipolar | anxiety/depression | drug/alcohol abuse |

Opioid Risk Tool (office use only)

Mark each box that applies:

Female

Male

1. Family history of substance abuse

Alcohol

1

3

Illegal Drugs

2

3

Prescription Drugs

4

4

2. Personal history of substance abuse

Alcohol

3

3

Illegal drugs

4

4

Prescription Drugs

5

5

3. Age (mark box if between 16-45 years)

1

1

4. History of preadolescent sexual abuse

3

0

5. Psychological disease

ADO, OCD, bipolar, schizophrenia

2

2

Depression

1

1

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%)