



# 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  
Lima, OH 45804

Phone: (419) 222-6622

## 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: \_\_\_\_\_



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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?

## 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.**



<b>Office Use only:</b> BP ____/____ Pulse ____ Temp ____ Resp ____
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**SPINE HISTORY FORM**

Primary Care Doctor: \_\_\_\_\_

Who referred you here? \_\_\_\_\_

Have you ever seen a doctor at this practice before? Y N

If yes, which doctor \_\_\_\_\_

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

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

1. Chief Complaint (reason why you are here): \_\_\_\_\_

2. History of present problem: \_\_\_\_\_

Date problem began: \_\_\_\_\_

Is this a work-related or auto injury? \_\_\_\_\_

Is there a Third Party responsible for payment? Y N

Did problems begin following? A fall \_\_\_\_\_ lifting \_\_\_\_\_ work Injury \_\_\_\_\_

recreational injury \_\_\_\_\_ automobile accident \_\_\_\_\_ no apparent cause \_\_\_\_\_

If accident, where did the accident occur? \_\_\_\_\_

Where is the pain located? \_\_\_\_\_

Is the pain better \_\_\_\_\_ same \_\_\_\_\_ worse \_\_\_\_\_ than when it started?

Describe the quality of pain (e.g., burning, stabbing, throbbing)  
\_\_\_\_\_  
\_\_\_\_\_

Is the pain? (Circle) Constant, Constant but worse with activity, Intermittent (comes and goes), Intermittent but worse with activity

What makes the pain worse? (e.g., walking, bending, sneezing, coughing, sitting, standing):

---

What makes the pain better?

---

Is there a time of day when it is worse?

Morning \_\_\_\_\_ Evening \_\_\_\_\_ Night \_\_\_\_\_

Does the pain wake you up at night? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have? Fevers/Chills/ or unexplained weight loss? (Circle, if applicable)

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Do you have "pins and needles" in your feet/hands (circle)?

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Do you have numbness in your feet/hands (circle)? Y N

Do you have weakness in your arms or legs (circle)? Y N

Do you have full control of your bowel and bladder? Y N

(Explain if NO):

---

Are you able to perform your usual activities of daily living? Y N

Have you had surgery for this problem? Y N

If so, describe date, surgeon & procedure: \_\_\_\_\_

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Did surgery help? \_\_\_\_\_

**CHECK ANY STUDIES YOU HAVE HAD FOR CURRENT PROBLEM:**

Diagnostic X-rays \_\_\_\_\_ MRI (magnetic resonance imaging) \_\_\_\_\_

CT (computed tomography) \_\_\_\_\_ Myelogram (x-ray w/spinal inj.) \_\_\_\_\_

Discogram \_\_\_\_\_ Electromyogram (EMG) \_\_\_\_\_

Arthrogram/sonogram \_\_\_\_\_

**CHECK ANY TREATMENTS YOU HAVE HAD FOR CURRENT PROBLEM:**

<u>Treatment Type</u>	<u>Check All That Apply</u>	<u>How long did you have treatment?</u>
Physical Therapy		
Home strengthening/ Stretching		
Home Exercises		
Acupuncture		
Chiropractic		
Epidural spine injections		
Massage		
Medication		
Other (Please Explain)		

Have any treatments ever made the pain better? \_\_\_\_\_ If yes, which treatment helped?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug Allergies/ symptoms

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to latex? Y N

Do you have a pacemaker or AICD (automatic internal cardiac defibrillator?) Y N

Past Medical Problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle any or all at that apply: Diabetes, Heart disease, Heart attack Blood disorders, cancer, Hypertension (High Blood Pressure), Asthma/ COPD, Hepatitis, Lung Disease, Seizures, Stroke, Blood Clots, problems with anesthesia

Medications:

\_\_\_\_\_

\_\_\_\_\_

Prior surgeries:

\_\_\_\_\_

\_\_\_\_\_

Tobacco use: Y / N If yes how much per day or week? \_\_\_\_\_

Alcohol use: Y / N If yes how much per day or week? \_\_\_\_\_

Exercise: Y / N If yes how much per day or week? \_\_\_\_\_

### Family History

Check any or all that apply:

Arthritis	Father	Mother	Siblings	Grandparents
Cancer	Father	Mother	Siblings	Grandparents
Diabetes	Father	Mother	Siblings	Grandparents
Stroke	Father	Mother	Siblings	Grandparents
Heart Trouble	Father	Mother	Siblings	Grandparents
Lung Disease	Father	Mother	Siblings	Grandparents

### Review of Systems

Check yes or no: If yes then please explain.

<b>Constitutional:</b>	Fatigue	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
<b>Gastrointestinal:</b>	Nausea/ Vomiting	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Stomach Ulcer/ Reflux	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Blood in stool	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
<b>Musculoskeletal:</b>	Joint pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Joint stiffness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Joint swelling	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
<b>Hematologic:</b>	Anemia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Easy Bruising	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Bleeding problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
<b>Cardiovascular:</b>	Chest Pain	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Leg/ Ankle swelling	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
<b>Neurological:</b>	Numbness/ Tingling	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	
	Weakness/ Paralysis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	NO	

**PATIENT PAIN DRAWING**

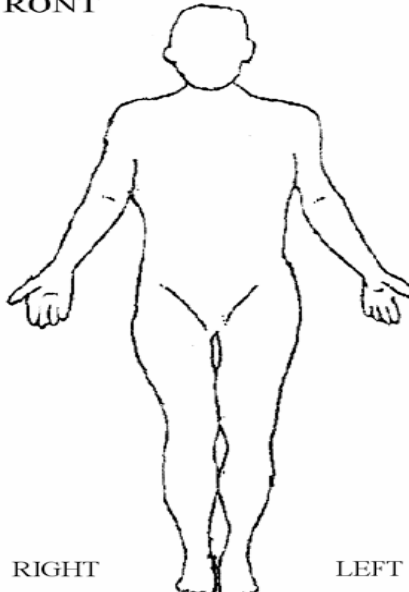
Mark the areas of your body where you feel the pain and/or sensations below, using the appropriate SYMBOL.

Mark the areas where your pain radiates, include all affected areas.

Aching/Pain	Numbness	Pins & Needles	Burning	Stabbing
^^^	===	OOO	XXX	///

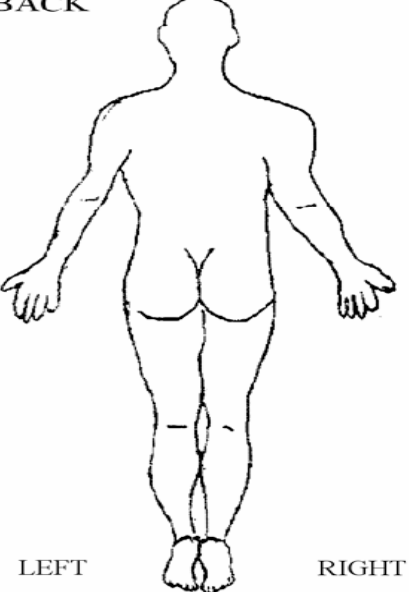
  

**FRONT**



RIGHT                      LEFT

**BACK**



LEFT                      RIGHT

**PAIN SCALE**

This is a pain scale from “0” (no pain) to “10” (torture pain). Please choose a number that best fits your pain complaints for your “AVERAGE” pain and your “WORST” pain in whatever area(s) hurt.

0	2	4	6	8	10							
NONE	MILD	DISCOMFORTING	DISTRESSING	HORRIBLE	EXCRUCIATING							
<b>Worst pain you've ever had</b>		1	2	3	4	5	6	7	8	9	10	
<b>Current Neck Pain</b>		<b>Average</b>	1	2	3	4	5	6	7	8	9	10
		<b>Worst</b>	1	2	3	4	5	6	7	8	9	10
<b>Current Arm Pain</b>		<b>Average</b>	1	2	3	4	5	6	7	8	9	10
		<b>Worst</b>	1	2	3	4	5	6	7	8	9	10
<b>Current Mid-Back Pain</b>		<b>Average</b>	1	2	3	4	5	6	7	8	9	10
		<b>Worst</b>	1	2	3	4	5	6	7	8	9	10
<b>Current Low-Back Pain</b>		<b>Average</b>	1	2	3	4	5	6	7	8	9	10
		<b>Worst</b>	1	2	3	4	5	6	7	8	9	10
<b>Current Leg Pain</b>		<b>Average</b>	1	2	3	4	5	6	7	8	9	10
		<b>Worst</b>	1	2	3	4	5	6	7	8	9	10

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

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