



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 (phone number cannot be the same as patient's home or cell number)

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		SS#	Policy Holder's Name		SS#
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: | Ethnicity: | Language: |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Asian | <input type="checkbox"/> English |
| <input type="checkbox"/> Black or African-American | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Not Latino or Hispanic | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | <input type="checkbox"/> 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



Orthopaedic Institute of Ohio

801 Medical Drive, Suite A

Lima, Ohio 45804

(419)222-6622 or (800) 225-3921

Fax: (419)238-3941

Please make sure when completing the attached form to darken the circles completely.

LIKE THIS



Thank you for your cooperation.

The staff at the Orthopaedic Institute of Ohio.

Social History								
Do you smoke?	<input type="radio"/> Yes	<input type="radio"/> No	Do you consume alcohol?	<input type="radio"/> Yes	<input type="radio"/> No	Do you exercise?	<input type="radio"/> Yes	<input type="radio"/> No
Family History								
Arthritis	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Cancer	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Diabetes	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Stroke	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Heart trouble	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Lung Disease	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents
Malignant Hyperthermia	<input type="radio"/>	Father	<input type="radio"/>	Mother	<input type="radio"/>	Siblings	<input type="radio"/>	Grandparents

Review of Systems									
Constitutional	Fatigue	<input type="radio"/> Yes	<input type="radio"/> No	Fever	<input type="radio"/> Yes	<input type="radio"/> No	X		
Gastrointestinal	Nausea/ Vomiting	<input type="radio"/> Yes	<input type="radio"/> No	Stomach Ulcer/ Reflux	<input type="radio"/> Yes	<input type="radio"/> No	Blood in Stool	<input type="radio"/> Yes	<input type="radio"/> No
Cardiovascular	Chest pain	<input type="radio"/> Yes	<input type="radio"/> No	Leg/Ankle Swelling	<input type="radio"/> Yes	<input type="radio"/> No	X		
Neurological	Numbness/ Tingling	<input type="radio"/> Yes	<input type="radio"/> No	Weakness/ Paralysis	<input type="radio"/> Yes	<input type="radio"/> No	X		
Musculoskeletal	Joint pain	<input type="radio"/> Yes	<input type="radio"/> No	Joint stiffness	<input type="radio"/> Yes	<input type="radio"/> No	Joint Swelling	<input type="radio"/> Yes	<input type="radio"/> No
Hematologic	Anemia	<input type="radio"/> Yes	<input type="radio"/> No	Easy bruising	<input type="radio"/> Yes	<input type="radio"/> No	Bleeding problem	<input type="radio"/> Yes	<input type="radio"/> No

Current Medications:			Please PRINT CLEARLY		

Surgeries/Hospitalizations:		Please PRINT CLEARLY	
Procedure		Date	

OIO-WS-101 rev: 08/2011

Print Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____