OIO | Orthopaedic Institute of Ohio
Get well. Get moving again.

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**

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

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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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. I also authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided or associated with my account.

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 understand that I may receive a copy of the Privacy Practices upon request.

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).

External Prescription History

I give OIO permission to review external prescription history.

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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Patient Information

Please darken bubbles completely and PLEASE PRINT CLEARLY

Nathan T Hensley, DPM
Podiatry
Foot & Ankle Surgery

Patient Name: _____ Appointment Date: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ BP: _____ Male ☐ Female ☐

Referring Doctor: _____ Family Doctor: _____

Occupation: _____

How would you characterize your job (choose one): ☐ Mostly sit down work ☐ Manual labor ☐ Combination of both

Does your job have specific shoe wear requirements? ☐ Yes ☐ No

Are you a Health Care worker? ☐ Yes ☐ No

What foot or ankle concerns would you like addressed by your doctor today? ☐ Left ☐ Right or ☐ Both

_____

What bothers you most about your foot or ankle? ☐ Pain ☐ Swelling ☐ Feels unstable ☐ Deformity ☐ Stiffness

When did your condition begin? _____ Was it related to an injury? ☐ Yes ☐ No

If so, describe the injury? _____

Did the problem develop suddenly or gradually (choose one)? ☐ Gradually ☐ Suddenly

What is the quality of your pain (choose all that apply)?

☐ Sharp ☐ Stabbing ☐ Aching ☐ Pins and Needles ☐ Burning

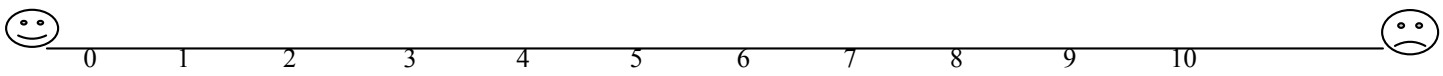
What qualities describe your pain (choose all that apply)?

☐ Shoots up or down the leg
☐ Wakes me up at night
☐ Is better with shoes on
☐ Is better without shoes
☐ No difference between wearing and not wearing shoes
☐ Worse with activity
☐ Hurts just as much in the morning as it does later in the day
☐ Gets worse as the day goes on
☐ You are always aware of the pain

Which activities make your symptoms worse?

☐ Standing ☐ Walking ☐ Walking on uneven ground ☐ Wearing certain types of shoes
☐ Running ☐ Going up stairs ☐ Going down stairs ☐ Getting up from a seated position

Mark the scale with a vertical line to indicate your *average* pain during the day due to your foot and ankle condition:



0 1 2 3 4 5 6 7 8 9 10

No Pain *Worst Pain Imaginable*

What things are you unable to do or are severely limited because of the pain/ problem (choose all that apply)?

☐ Sleep	☐ Take care of yourself	☐ Get around your home	☐ Enjoy life
☐ Run	☐ Walk even limited distances	☐ Exercise	☐ Play sports
☐ Enjoy life	☐ Engage in hobbies	☐ Work and perform at work	☐ Walk to exercise

Which of the following treatments have you tried?

☐ Anti-inflammatory medications (which kind and how long)?: _____

☐ Activity modifications	☐ Icing	☐ Compression wrapping	☐ Stretching exercises
☐ Physical Therapy	☐ Braces	☐ Chiropractic care	☐ Massage therapy
☐ Shoe inserts	☐ Heel lifts	☐ Prescription orthotics	☐ Over-the-counter orthotics
☐ Taping	☐ Cast	☐ Injections	☐ Shoe modifications
☐ Walker boot	☐ Night splint	☐ Shoe modifications	☐ Surgery

List any diagnostic studies (MRI, CT, Bone Scan, Vascular Studies, EMG) you've had for this condition along with a date and location of where the study was performed:

1. _____ 3. _____

2. _____ 4. _____

Allergies:

Allergies to metals:	☐ Yes	☐ No
Allergies to latex:	☐ Yes	☐ No
Allergies to foods:	☐ Yes	☐ No
Allergies to medications:	☐ Yes	☐ No

Please list (medication and reaction): _____

List all your current medications:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Personal Medical History (Please circle all that apply):

☐ Anemia	☐ Gout	☐ Osteoporosis	☐ High Blood Pressure	☐ Cancer
☐ Mental Illness	☐ Seizures	☐ Phlebitis	☐ Chronic Back Pain	☐ Sciatica
☐ Alcoholism	☐ AIDS	☐ Fibromyalgia	☐ Irregular Heart Beat	☐ Leg Stents
☐ Depression	☐ Diabetes	☐ Stroke	☐ Bleeding/Bruising tendency	☐ Heart Stents
☐ Heart Condition	☐ Heart Attack	☐ Blood Clots	☐ Kidney Transplant or Dialysis	
☐ Stomach Ulcers	☐ "Osteo Arthritis"	☐ Pulmonary Embolism (blood clot in lung)		☐ Cochlear Implants
☐ Rheumatoid Arthritis	☐ Pacemaker	☐ Asthma/Emphysema/Wheezing		☐ Defibrillator
☐ Malignant Hypothermia				

Do you have Sleep Apnea? ☐No ☐Yes

If yes, do you have a CPAP Machine? ☐No ☐Yes Do you use the CPAP Machine? ☐No ☐Yes

List any surgical procedures by year, starting with the most recent:

1. _____ 3. _____

2. _____ 4. _____

5. _____ 6. _____

Review of Systems (Please circle all that apply, recent or current only):

Fever	☐No ☐Yes	Fatigue	☐No ☐Yes	Weight Loss	☐No ☐Yes
Headache	☐No ☐Yes	Loss of Appetite	☐No ☐Yes	Trouble Swallowing	☐No ☐Yes
Nausea/Vomiting	☐No ☐Yes	Constipation	☐No ☐Yes	Diarrhea	☐No ☐Yes
Muscle Cramps	☐No ☐Yes	Joint Stiffness	☐No ☐Yes	Joint Swelling	☐No ☐Yes
Joint Weakness	☐No ☐Yes	Muscle Weakness	☐No ☐Yes	Swelling of Feet	☐No ☐Yes
Memory Loss	☐No ☐Yes	Balance Problems	☐No ☐Yes	Coordination Problems	☐No ☐Yes
Tremors	☐No ☐Yes	Dizziness	☐No ☐Yes	Fainting	☐No ☐Yes
Cold Hands or Feet	☐No ☐Yes				

If any apply, please explain: _____

Have you been seen by a Dentist in the last year? ☐ es ☐ No

Do you have any dental problems (broken, chipped or loose teeth, abscess, gum disease)? No ☐ Yes ☐

If yes, please explain: _____

Social History

Do you participate in any Sports or regular exercise activity: ☐ No ☐ Yes If yes, what type? _____

What activities do you enjoy during your free time? _____

Do you smoke? ☐ No ☐ Yes How much? _____

Do you drink alcohol? ☐ No ☐ Occasional ☐ Several times a week ☐ Daily

Where do you reside? ☐ Home ☐ Nursing Home ☐ Assisted Living ☐ Other: _____

Do you currently see anyone for Pain Management? ☐ No ☐ Yes Provider: _____

In the past, have you seen anyone for Pain Management? ☐ No ☐ Yes Provider: _____

Family History

Please circle any relevant medical conditions that run in your family (Mother, Father, Siblings, Grandparents):

Osteo (old age) arthritis: M F S G

Rheumatoid arthritis: M F S G

Gout: M F S G

Lupus: M F S G

History of problems with anesthesia: M F S G

Malignant Hypothermia: M F S G

Diabetes: M F S G

Other, relevant conditions (please specify): _____

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Foot/Ankle Pain Diagram

Instructions: Circle/Mark areas of concern or pain. Please comment next to mark (x)

Right **Left**