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**

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. 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
_____	_____	_____

Rev:10/2014

Lloyd C. Briggs, Jr., M.D., M.S.
Board Certified, American Board of Orthopaedic Surgery
Fellowship Trained in Foot and Ankle Surgery
Fellow American Academy of Orthopaedic Surgery
Member American Orthopaedic Foot and Ankle Society

Greetings,

In the near future, you are scheduled to meet with Dr. Briggs at the Orthopaedic Institute of Ohio. Dr. Briggs is a foot and ankle fellowship trained orthopaedic surgeon who specializes in foot and ankle surgery. He and our staff are dedicated to try to help people with both major and minor foot and ankle problems. In preparation for your visit, we have three recommendations.

First, in order to make your visit as productive as possible, we ask that you take the time to fill out the enclosed questionnaire which asks you to describe your medical problem and give a detailed past medical history. The foot and ankle is an integral part of your body and it is affected by other medical problems you may have. It is important that we have as much information as possible concerning your medical health in order to properly diagnose your problem and provide a treatment plan that is best suited for you. Your own description of your injury or problem is often times the most important factor in making a proper diagnosis, as well as, understanding how this problem affects your life. We realize no one likes to fill out paperwork, but please take the time to fill out the form in its entirety before your visit. This will help us be as thorough as possible and will ultimately benefit you.

Second, written reports of x-rays, MRIs, CT scans, and bone scans can be inaccurate. In order to be as thorough as possible, we like to review the original films of any x-rays, CT scans, MRI scans, or bone scans you might have undergone. Sometimes the reports are helpful and sometimes they are not. Reading the actual films gives us far more information than the reports typically do. From past experience, if you call your doctor's office or the hospital, and ask them to send films or medical records, 75% of the time we do not end up getting them in time for your visit. To ensure that these records or films are present for your visit, please pick up the records and film yourself to be sure we have them for your visit. Do not rely on the mail or courier service to get the films to the office in time for the appointment.

Third, for the physical exam, we usually like to examine the foot, the ankle and legs up to, and above the knees so please bring a pair of shorts or wear a pair of pants which can be easily rolled up above the knees. In addition, for your initial visit, please bring the shoes you wear most often as well as any braces, orthoses, or shoe inserts you use or have used.

Finally, thanks for your time and cooperation. We look forward to trying to help you with your problem. If you have any problems please feel free to call and speak with Michelle at 419-222-6622 (ext. 3391) and she will try to help you. REMEMBER TO BRING YOUR COMPLETED FORM WITH YOU TO YOUR VISIT. If you forget, we can give you another one at the time of your visit, but you will have to fill it out before you can be seen.

Thanks again,

Lloyd C. Briggs, Jr., M.D., M.S. and the staff at the Orthopaedic Institute of Ohio

Orthopaedic Institute of Ohio
801 Medical Drive, Suite A
Lima, Ohio 45804
(419)222-6622
www.orthoohio.com

Dear New Patient,

Recently, you have been scheduled for a surgical consultation with Dr. Briggs at the Orthopaedic Institute of Ohio. We would like to welcome you to our practice and assure you that we will do everything we can to help you with your current foot or ankle problem. In order to make your visit as productive for you as possible we would like to make you aware of Dr. Briggs' office policies.

Dr. Briggs is a Board Certified Orthopaedic surgeon who completed a Foot and Ankle fellowship in New York City before coming to Lima. While we certainly help many people with therapy or bracing, the primary emphasis of his practice is on the surgical treatment of foot and ankle problems. Often times our ability to help you will depend on whether or not your problem can be treated with surgery. If for some reason you cannot have surgery or your problem cannot be fixed with surgery, we may not be able to help you very much with your problem.

We also need to let you know that because his practice is primarily surgical, Dr. Briggs does not prescribe narcotics for the treatment of pain, with the exception of the first couple weeks after surgery or the first couple of weeks after a fracture. Treatment of pain with medications for longer than a few weeks is referred to as "chronic pain management". This is not something Dr. Briggs does. If you are on narcotics or other types of pain medications now, you should continue to get them from the physician who prescribed them to you because Dr. Briggs will not write for, or continue those medications. If you think that pain medications should be part of your long term treatment, Dr. Briggs recommends that you seek a health care provider who provide "chronic pain management", (long term, medication-oriented pain management) so you can be safely monitored long-term with these medications.

Finally, we need to let you know that Dr. Briggs does not perform permanent disability evaluations. The emphasis of our practice is to return people to work as soon as possible. Unfortunately, there are some people whose injury or injuries are so severe that they cannot return to work and they are best off seeking permanent disability. Unfortunately, our practice does not provide that service at this time. So if the purpose of your visit is to seek permanent disability, you should make other arrangements.

If you have any questions concerning these policies or other questions about the practice please feel free to call Michelle, my assistant, at 419-222-6622, ext. 3391.
Sincerely,

Dr. Briggs' Staff at the Orthopaedic Institute of Ohio.

Orthopaedic institute of ohio

Lloyd C. Briggs, Jr., M.D., M.S.
Orthopaedic Surgery
Foot & Ankle Surgery

Patient Information

Please darken bubbles completely and PLEASE PRINT CLEARLY

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

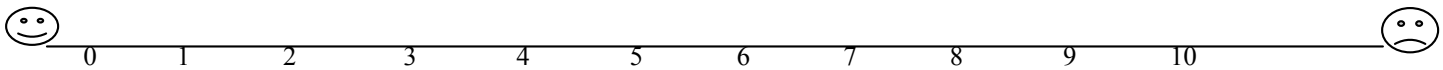
What qualities describe your pain (choose all that apply)?

☐ 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? ☐ Yes ☐ 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): _____

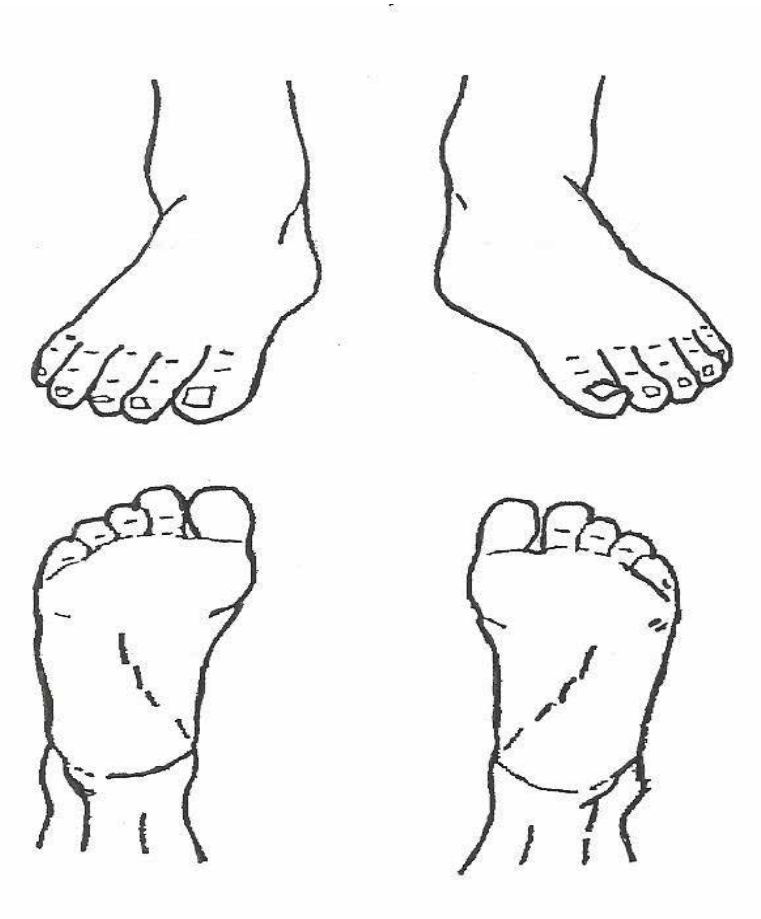
Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

Foot/Ankle Pain Diagram

Instructions:

Please place an “X” on the diagram where your pain is the most severe. Place a “2” where the pain is the second most severe and a “3” where the pain is next most severe.



Right Left