

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

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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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

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

Dr. Dasari New Patient History Form

Name: _____ Sex: ____ DOB: _____ Height: _____ Weight: _____

Referring Doctor: _____ Family Doctor: _____

Have you seen Dr. Dasari within the last three years? Yes No BP _____

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

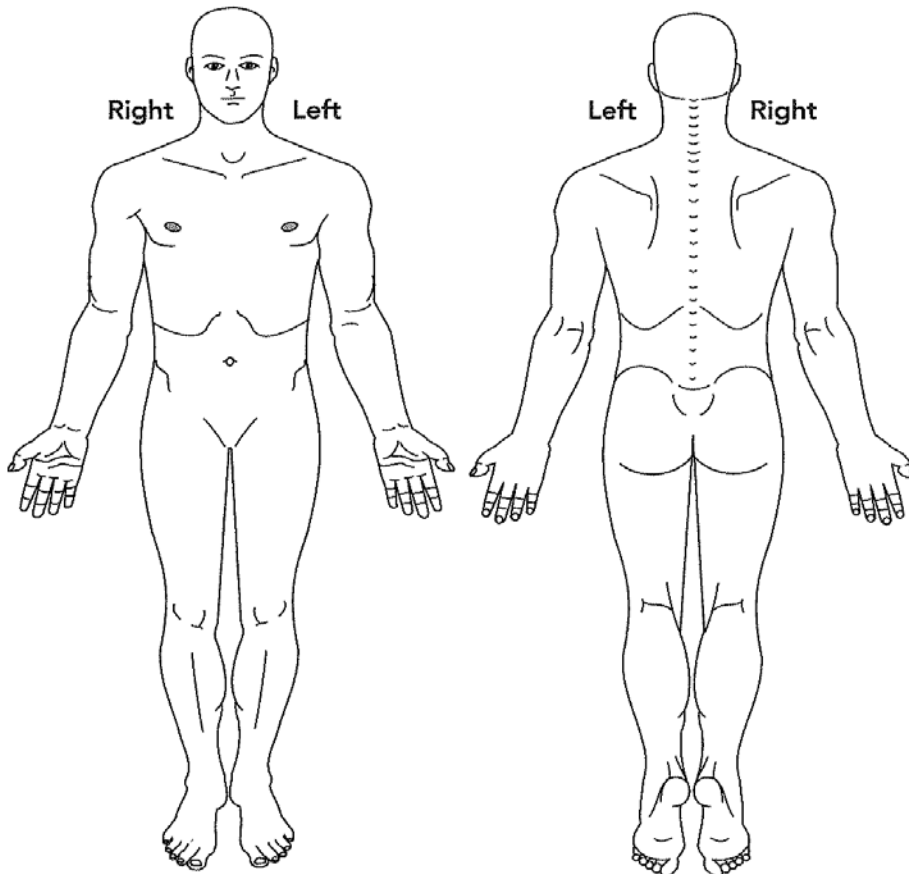
2. How long have you had the problem (eg: 2 months)? _____

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.



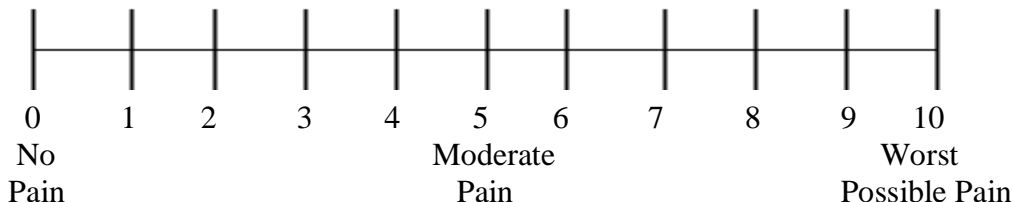
7. Is your pain: (check one)

- Constant (24/7) Comes and goes Occasional (once in awhile)

8. Describe the quality of pain: (check one)

- dull ache sharp stabbing shooting throbbing

9. Please rate the intensity of your pain on this scale from 0 to 10. A rating of 0 means “no pain at all”. A rating of 10 means “the worst possible pain you could imagine”. (circle **ONE** number)



10. What makes the pain worse? (Check all that apply)

- walking bending lifting standing home chores other _____

11. What makes the pain better? (check all that apply):

- resting sitting heat stretching medications other _____

12. Do you have trouble sleeping due to pain? Yes No

13. Do you wake up at night to take pain medication? Yes No

14. Which doctor(s) have you seen for this problem? (please list the names) _____

15. What treatments have you had for this problem?

- physical therapy home exercises surgery epidural steroid injections
 TENS chiropractic medications none
 other _____

16. Which treatment helped? _____

17. Past medical history: (check all that apply)

- diabetes high blood pressure heart disease/heart attack
 Asthma/COPD cancer stroke
 fibromyalgia hepatitis anxiety
 depression bipolar disorder pacemaker
 cardiac defibrillator other _____

18. Please describe any past surgeries: _____

19. Do you have any drug allergies? Yes No If yes, please list and describe reaction _____

20. Medications you are taking, prescription, over-the-counter, herbal, vitamins/mineral/dietary(nutritional) supplements:

Medication name	Dosage	How often do you take it?	How do you take it? (Oral, topical)

21. For women only:

Are you pregnant now? Yes No Are you breast feeding? Yes No

Have your periods ceased? Yes No

22. FAMILY HISTORY: Please check any of the following medical problems anyone in your immediate family (mother, father, sibling, grandparents) has had. Please check all applicable boxes.

- Arthritis Cancer Diabetes Heart disease Sleep Apnea
 Lung disease Anxiety Depression Bipolar disorder

23. SOCIAL HISTORY:

Marital status (circle): Single Married Divorced Widowed

Number of children? _____ Ages: _____

With whom do you live? _____ Do you drive? Yes No

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 _____

24. 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:

Circle if you are experiencing any of the following.

Please explain.

1. Constitutional:	fever	weight loss	_____
2. Eyes:	eye pain	double vision	_____
3. Ears:	ringing/buzzing	difficulty hearing	_____
4. Gastrointestinal:	nausea/vomiting	constipation/diarrhea	_____
5. Skin:	skin rashes	itching/burning	_____
6. Musculoskeletal:	joint pain	low back/neck pain	_____
7. Respiratory:	shortness of breath	wheezing	_____
8. Cardiovascular:	chest pain	leg/ankle swelling	_____
9. Genitourinary:	painful urination	frequent urination	_____
10. Neurological:	tingling/numbness	seizure/epilepsy	_____
11. Psychiatric:	anxiety/depression	drug/alcohol abuse	_____

Patient Signature: _____ Date: _____

Opioid Risk Tool (office use only)

Mark each box that applies:	Female	Male
1. Family history of substance abuse		
Alcohol	1 <input type="checkbox"/>	3 <input type="checkbox"/>
Illegal Drugs	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Prescription Drugs	4 <input type="checkbox"/>	4 <input type="checkbox"/>
2. Personal history of substance abuse		
Alcohol	3 <input type="checkbox"/>	3 <input type="checkbox"/>
Illegal drugs	4 <input type="checkbox"/>	4 <input type="checkbox"/>
Prescription Drugs	5 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Age (mark box if between 16-45 years)	1 <input type="checkbox"/>	1 <input type="checkbox"/>
4. History of preadolescent sexual abuse	3 <input type="checkbox"/>	0 <input type="checkbox"/>
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	2 <input type="checkbox"/>	2 <input type="checkbox"/>
Depression	1 <input type="checkbox"/>	1 <input type="checkbox"/>
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%)

Physician Signature: _____ Date: _____