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

| | | | | | |
|---|---|---|---|---|---|
| **Patient Name:** | | | | **Appointment Date:** | |
| **DOB:** | | **OFFICE USE ONLY: Height:** | **Weight:** | BP: | Pulse: |
| **Referring Doctor:** | | **Family Doctor:** | | **Heart Doctor:** | |

I. Have you seen another doctor in this practice within the last 3 years? ◯ Yes ◯ No

If yes, which doctor?_____

II. Which side is affected? ◯ Right ◯ Left ◯ Bilateral(both sides)

III. Joint or part(s) that you are being seen for today:

◯ Neck ◯ Back ◯ Shoulder ◯ Arm ◯ Elbow ◯ Wrist/Hand
◯ Hip ◯ Leg ◯ Knee(s) ◯ Ankle ◯ Foot/Toes

IV. Date of Injury: _____ V: Start of Pain/Cause of pain?_____

How did the pain occur? ◯ Injury ◯ Chronic ◯ Spontaneous

Is this a Worker's Comp Claim? ◯ Yes ◯ No

Is this the result of a motor vehicle accident? ◯ Yes ◯ No

Is there a Third Party responsible for payment? ◯ Yes ◯ No

If accident, where did the accident occur?_____

VI. Pain Description (Choose all that apply):

Quality of your pain? ◯ Mild ◯ Moderate ◯ Severe

Type of pain? ◯ Sharp ◯ Dull ◯ Other: _____

VII. Have you been seen by a Dentist in the last year? ◯ Yes ◯ No

VII. Do you have any dental problems (Broken, chipped or loose teeth, abscess, gum disease) ◯ Yes ◯ No

If yes, please explain:_____

| **Medical History:** - Do you have or have you had? | | | | | |
|---|---|---|---|---|---|
| Asthma/COPD | ◯ Yes ◯ No | Respiratory Problems | ◯ Yes ◯ No | Lung Disease | ◯ Yes ◯ No |
| Cancer Type_____ | ◯ Yes ◯ No | Problems with Anesthesia | ◯ Yes ◯ No | Malignant Hyperthermia | ◯ Yes ◯ No |
| Heart Attack | ◯ Yes ◯ No | Heart Problems | ◯ Yes ◯ No | Hypothyroidism | ◯ Yes ◯ No |
| Seizures | ◯ Yes ◯ No | Diabetes | ◯ Yes ◯ No | GI Problems | ◯ Yes ◯ No |
| Stroke | ◯ Yes ◯ No | Blood Clot | ◯ Yes ◯ No | High Blood Pressure | ◯ Yes ◯ No |
| Depression | ◯ Yes ◯ No | Mental Illness | ◯ Yes ◯ No | Anxiety | ◯ Yes ◯ No |
| HIV | ◯ Yes ◯ No | Hepatitis | ◯ Yes ◯ No | Sleep Apnea | ◯ Yes ◯ No |
| CPAP Machine | ◯ Yes ◯ No | Do you use the CPAP Machine? | | | ◯ Yes ◯ No |
| Do you have a pacemaker or AICD (automatic internal cardiac defibrillator)? | | | | | ◯ Yes ◯ No |
| Latex Allergies | ◯ Yes ◯ No | Drug Allergies | ◯ Yes ◯ No | Bariatric Surgery Type _____ | ◯ Yes ◯ No |

| **ALLERGIES** (metal, medications, food, seasonal etc.) | **REACTIONS/SYMPTOMS OF ALLERGIES** |
|---|---|
| | |
| | |
| | |

| **Medical History** (continued) | Have you been in close contact with someone who has had MRSA within the last year? | ◯ Yes ◯ No |
|---|---|---|
| Have you ever had or presently have MRSA? ◯ Yes ◯ No | Are you a Health Care Worker? | ◯ Yes ◯ No |

| **Social History** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Do you smoke? | ◯ Yes ◯ No | Do you consume alcohol? | ◯ Yes ◯ No | Do you exercise? | ◯ Yes ◯ No | | |
| What is your place of residence | ◯ Home | ◯ Nursing Home | ◯ Assisted Living | ◯ Other:_____ | | | |

| **Family History** | | | | |
|---|---|---|---|---|
| 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 |
| Malignant Hyperthermia | ☐ Father | ☐ Mother | ☐ Siblings | ☐ Grandparents |

| **Review of Systems** | | | | | | |
|---|---|---|---|---|---|---|
| **Constitutional** | Fatigue | ◯ Yes ◯ No | Fever | ◯ Yes ◯ No | | |
| **Gastrointestinal** | Nausea/ Vomiting | ◯ Yes ◯ No | Stomach Ulcer/ Reflux | ◯ Yes ◯ No | Blood in Stool | ◯ Yes ◯ No |
| **Cardiovascular** | Chest pain | ◯ Yes ◯ No | Leg/Ankle Swelling | ◯ Yes ◯ No | | |
| **Neurological** | Numbness/ Tingling | ◯ Yes ◯ No | Weakness/ Paralysis | ◯ Yes ◯ No | | |
| **Musculoskeletal** | Joint pain | ◯ Yes ◯ No | Joint stiffness | ◯ Yes ◯ No | Joint Swelling | ◯ Yes ◯ No |
| **Hematologic** | Anemia | ◯ Yes ◯ No | Easy bruising | ◯ Yes ◯ No | Bleeding problem | ◯ Yes ◯ No |

| **Current Medications:** | **Please PRINT CLEARLY** | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Surgeries/Hospitalizations:** **Please PRINT CLEARLY**

| **Procedure** | **Date** |
|---|---|
| | |
| | |
| | |

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

**Patient/GaurdianSignature: _____ Date:**