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

Ethnicity:
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ 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
_____	_____	_____

Rev:10/2014

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Dr. Dasari & Dr. Stretanski 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):_____

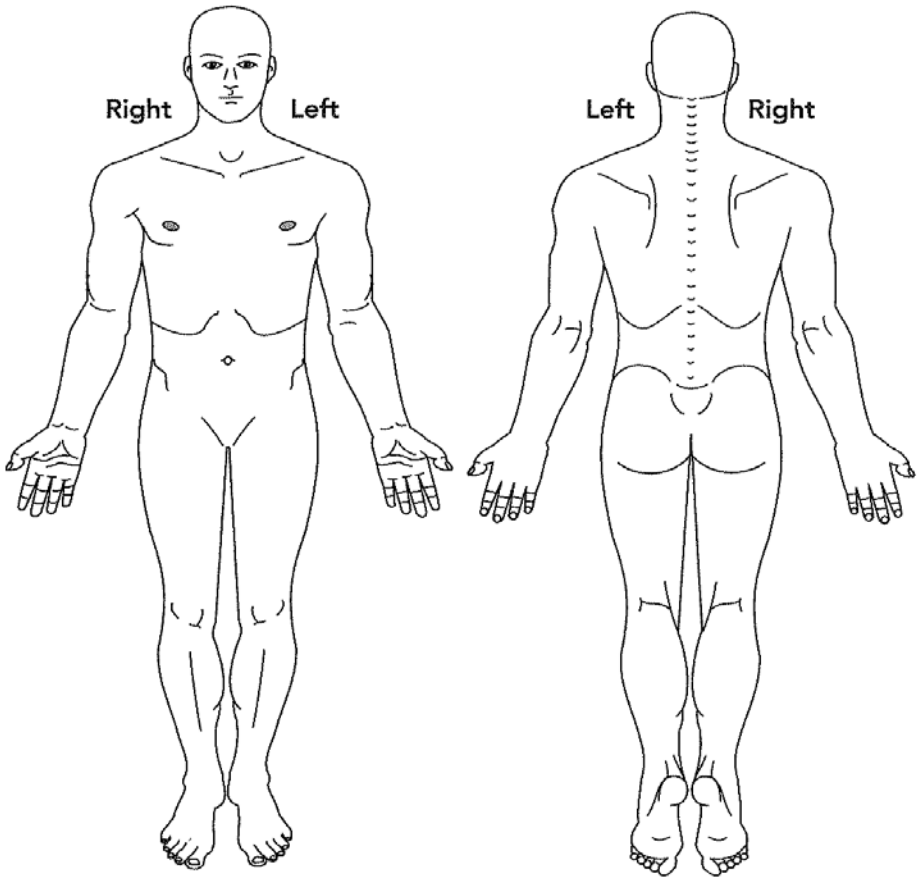
2. How long have you had the problem (eg: 2 months)? _____

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.



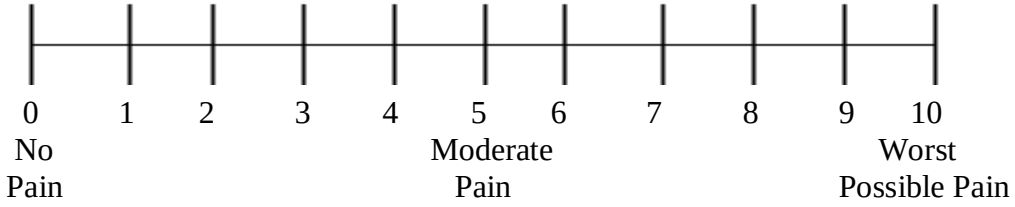
7. Is your pain: (**check one**)

◯ 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 <u>ONE</u> 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)
			Select one
			Select one
			Select one
			Select one
			Select one
			Select one
			Select one
			Select one
			Select one
			Select one

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:
☐Heroine ☐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 ☐	3 ☐
Illegal Drugs	2 ☐	3 ☐
Prescription Drugs	4 ☐	4 ☐
2. Personal history of substance abuse		
Alcohol	3 ☐	3 ☐
Illegal drugs	4 ☐	4 ☐
Prescription Drugs	5 ☐	5 ☐
3. Age (mark box if between 16-45 years)	1 ☐	1 ☐
4. History of preadolescent sexual abuse	3 ☐	0 ☐
5. Psychological disease		
ADO, OCD, bipolar, schizophrenia	2 ☐	2 ☐
Depression	1 ☐	1 ☐
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: _____