

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
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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 expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Orthopaedic Institute of Ohio, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Orthopaedic Institute of Ohio or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Orthopaedic Institute of Ohio, and/or their contractors, servicers, debt collection agencies, or agents.

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.

External Prescription History

I give OIO permission to review external prescription history.

HIE Notice

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Ben Broseke or Josh Baker.

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).

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



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



Get well. Get moving again.

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.

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

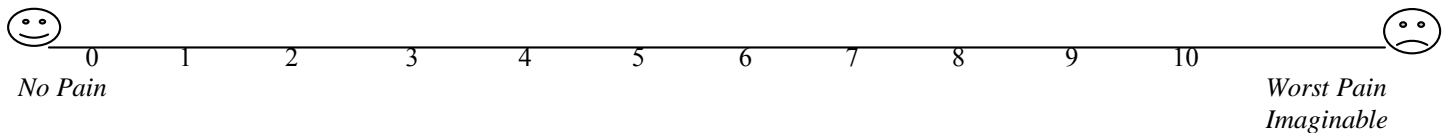
What qualities describe your pain (choose all that apply)?

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:



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

- | | | | |
|-------------------------------------|--|---|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Take care of yourself | <input type="checkbox"/> Get around your home | <input type="checkbox"/> Enjoy life |
| <input type="checkbox"/> Run | <input type="checkbox"/> Walk even limited distances | <input type="checkbox"/> Exercise | <input type="checkbox"/> Play sports |
| <input type="checkbox"/> Enjoy life | <input type="checkbox"/> Engage in hobbies | <input type="checkbox"/> Work and perform at work | <input type="checkbox"/> Walk to exercise |

Which of the following treatments have you tried?

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> Anti-inflammatory medications (which kind and how long)?: _____ | | | |
| <input type="checkbox"/> Activity modifications | <input type="checkbox"/> Icing | <input type="checkbox"/> Compression wrapping | <input type="checkbox"/> Stretching exercises |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Braces | <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Massage therapy |
| <input type="checkbox"/> Shoe inserts | <input type="checkbox"/> Heel lifts | <input type="checkbox"/> Prescription orthotics | <input type="checkbox"/> Over-the-counter orthotics |
| <input type="checkbox"/> Taping | <input type="checkbox"/> Cast | <input type="checkbox"/> Injections | <input type="checkbox"/> Shoe modifications |
| <input type="checkbox"/> Walker boot | <input type="checkbox"/> Night splint | <input type="checkbox"/> Shoe modifications | <input type="checkbox"/> 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: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to latex: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to foods: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to medications: | <input type="checkbox"/> Yes <input type="checkbox"/> 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):

- | | | | | |
|--|--|--|--|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> AIDS | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Leg Stents |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bleeding/Bruising tendency | <input type="checkbox"/> Heart Stents |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Kidney Transplant or Dialysis | |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> "Osteo Arthritis" | <input type="checkbox"/> Pulmonary Embolism (blood clot in lung) | <input type="checkbox"/> Cochlear Implants | |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Asthma/Emphysema/Wheezing | <input type="checkbox"/> Defibrillator | |
| <input type="checkbox"/> 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	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Weight Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes
Headache	<input type="checkbox"/> No <input type="checkbox"/> Yes	Loss of Appetite	<input type="checkbox"/> No <input type="checkbox"/> Yes	Trouble Swallowing	<input type="checkbox"/> No <input type="checkbox"/> Yes
Nausea/Vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
Muscle Cramps	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint Stiffness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Joint Swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes
Joint Weakness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle Weakness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Swelling of Feet	<input type="checkbox"/> No <input type="checkbox"/> Yes
Memory Loss	<input type="checkbox"/> No <input type="checkbox"/> Yes	Balance Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	Coordination Problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tremors	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dizziness	<input type="checkbox"/> No <input type="checkbox"/> Yes	Fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cold Hands or Feet	<input type="checkbox"/> No <input type="checkbox"/> Yes				

If any apply, please explain: _____

Have you been seen by a Dentist in the last year? Do you have any dental problems (broken, chipped or loose teeth, abscess, gum
 "I gu"" "P q".....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): _____

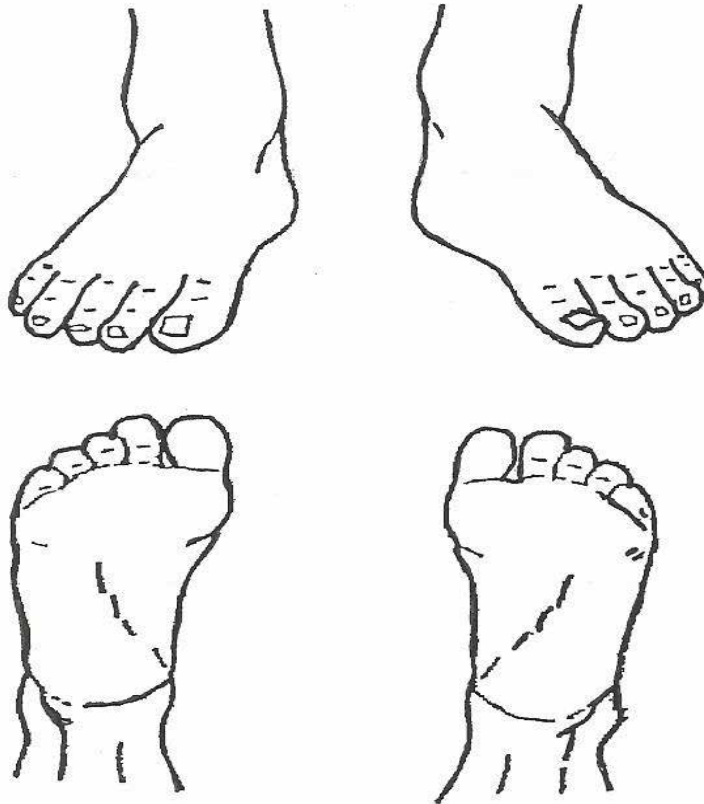
Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____

Foot/Ankle Pain Diagram

Instructions:

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