

| | | | | | |
|---|---------------|------------|--|------------------------|----------------|
| 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: | | Ethnicity: | | Language: | |
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Asian | <input type="checkbox"/> Latino or Hispanic | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> Indian |
| <input type="checkbox"/> Black or African-American | <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Not Latino or Hispanic | <input type="checkbox"/> Other | | |
| <input type="checkbox"/> American Indian or Alaska Native | | | | | |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | | | | | |

| | | |
|---------------|----------|-----------------------|
| Pharmacy Name | Location | Pharmacy Phone Number |
|---------------|----------|-----------------------|

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

Dr. Dasari Patient History Form

Name: _____ Sex: ___ DOB: _____ Height: _____ Weight: _____

Referring Doctor: _____ Family Doctor: _____

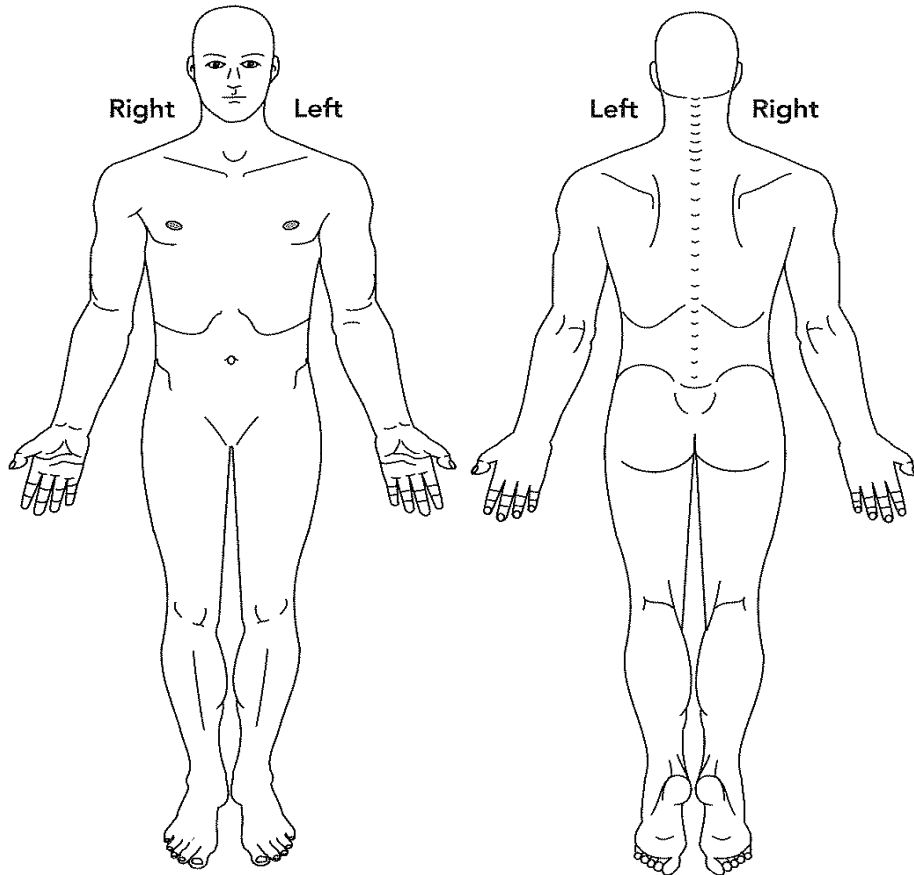
Have you seen Dr. Dasari within the last three years? Yes No BP _____

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 Fall Cause Unknown
Date it happened: _____

4. Mark the areas on your body where you feel pain.



5. Is your pain: **(check one)**
 Constant (24/7) Comes and goes Occasional (once in awhile)

6. Describe the quality of pain: **(check one)**
 dull ache sharp stabbing shooting throbbing

7. What makes the pain worse? (Check all that apply)
 walking bending lifting standing home chores other _____

8. What makes the pain better? (check all that apply):
 resting sitting heat stretching medications other _____

9. PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain

Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

No interference

As bad as you can imagine

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

No interference

As bad as you can imagine

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

11. What treatments have you had for this problem?

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

12. Which treatment helped? _____

13. 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 _____

14. Please describe any past surgeries: _____

REVIEW OF SYSTEMS:

Check 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: _____

Rev: 7/2020