

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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<b>Race:</b>	<b>Ethnicity:</b>	<b>Language:</b>
<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

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

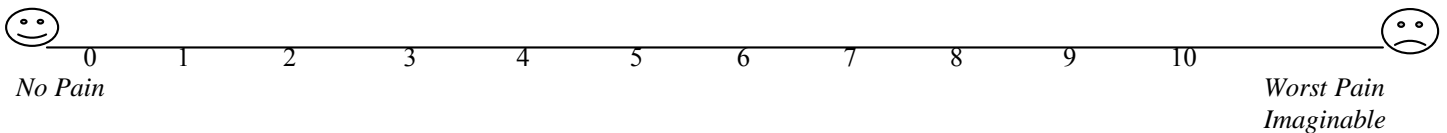
What qualities describe your pain (choose all that apply)?

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?  Yes  No      Do you have any dental problems (broken, chipped or loose teeth, abscess, gum 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:** Circle/Mark areas of concern or pain. Please comment next to mark (x)

**Right**

**Left**

