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 (OIO) to submit claims, apply for benefits, authorize payment of insurance benefits directly to OIO for services provided, and release information reasonably necessary, including medical information, as permitted by applicable federal and state law, including HIPAA, to obtain payment for covered services rendered.
I certify that the information I have provided regarding my insurance coverage is accurate.
By signing below, I agree to pay amounts determined to be my financial responsibility under my health benefit plan and applicable law, including applicable copayments, deductibles, coinsurance, and non-covered services.

COMMUNICATION CONSENT

OIO may contact me via phone, text message, email, patient portal, or other electronic means regarding my treatment, appointments, billing, care coordination, and other healthcare operations as permitted by applicable law. I understand I may request restrictions on communication methods and may revoke this consent at any time by notifying OIO through any reasonable means. Standard message and data rates may apply. Communication preferences may be updated at any time by notifying OIO or through the patient portal, when available.

REFERRALS AND PRE-CERTIFICATION

I understand that some insurance plans require a referral from my primary care physician (PCP) and/or prior authorization before certain services are provided. It is my responsibility to obtain any required referral from my PCP and to notify OIO of any referral or authorization requirements under my health plan. I agree to provide complete and accurate insurance information and to cooperate with OIO in obtaining any required prior authorizations or other payer-required approvals. Nothing in this agreement limits any rights or protections afforded to patients under applicable federal or state law or applicable payer contracts. I understand that insurance verification, referrals, and prior authorizations are not guarantees of payment. Final payment is subject to the terms, conditions, limitations, and eligibility requirements of my health benefit plan.

POLICY CONCERNING PAYMENT

I agree to promptly pay all amounts for which I am responsible. As a parent or legal guardian, I accept financial responsibility for services provided to the patient.

MEDICAL RECORDS

Medical record copies may be subject to fees in accordance with applicable state and federal law. Copies of medical records may be provided by an authorized third-party records vendor. Once information is disclosed to an authorized recipient, OIO cannot control or be responsible for any further disclosure by that recipient except as required by applicable law.

PHOTOGRAPHY CONSENT

I authorize OIO to photograph me or, if I am signing as the patient's parent or legal guardian, the patient, for security, patient identification, and patient safety purposes during treatment at OIO. I understand the photograph will be retained in the medical record and used for identification purposes only.

PRIVACY

OIO maintains confidentiality in accordance with HIPAA and applies the minimum necessary standard when using or disclosing information.

TECHNOLOGY USE

OIO may utilize technology, including artificial intelligence, to support treatment, documentation, care coordination, quality improvement, and operational functions in accordance with applicable law.

EXTERNAL PRESCRIPTION HISTORY

I authorize OIO to access and review my external prescription history from available electronic sources for treatment, medication reconciliation, and care coordination purposes.

HIE NOTICE

OIO participates in a Health Information Exchange (HIE), which allows healthcare providers to securely share medical information for treatment, payment, and healthcare operations. Participation is voluntary where permitted by law. You may opt out at any time by contacting Clinisync.

RELEASE OF MEDICAL INFORMATION DESIGNATION

I authorize OIO to disclose limited health information to designated individuals directly involved in my care or payment for my care, consistent with the minimum necessary standard. This authorization may be revoked at any time by notifying OIO and will apply prospectively to future disclosures.
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

I acknowledge that I have been offered a copy of OIO's Notice of Privacy Practices. I acknowledge receipt of this Patient Authorization and Financial Responsibility Agreement and have had the opportunity to ask questions before signing.

_____	_____	_____
Date	Patient/ Parent or Guardian Signature	Date of Birth

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Patient Information

Please darken bubbles completely and PLEASE PRINT CLEARLY

Nathan T Hensley, DPM
Podiatry
Foot & Ankle Surgery

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

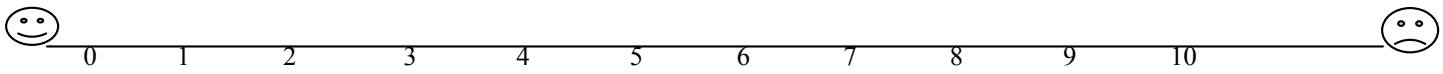
What qualities describe your pain (choose all that apply)?

☐ 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:



0 1 2 3 4 5 6 7 8 9 10

No Pain

Worst Pain Imaginable

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

☐ Sleep	☐ Take care of yourself	☐ Get around your home	☐ Enjoy life
☐ Run	☐ Walk even limited distances	☐ Exercise	☐ Play sports
☐ Enjoy life	☐ Engage in hobbies	☐ Work and perform at work	☐ Walk to exercise

Which of the following treatments have you tried?

☐ Anti-inflammatory medications (which kind and how long)?: _____

☐ Activity modifications	☐ Icing	☐ Compression wrapping	☐ Stretching exercises
☐ Physical Therapy	☐ Braces	☐ Chiropractic care	☐ Massage therapy
☐ Shoe inserts	☐ Heel lifts	☐ Prescription orthotics	☐ Over-the-counter orthotics
☐ Taping	☐ Cast	☐ Injections	☐ Shoe modifications
☐ Walker boot	☐ Night splint	☐ Shoe modifications	☐ 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:	☐ Yes	☐ No
Allergies to latex:	☐ Yes	☐ No
Allergies to foods:	☐ Yes	☐ No
Allergies to medications:	☐ Yes	☐ 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):

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

If any apply, please explain: _____

Have you been seen by a Dentist in the last year? ☐ es ☐ 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**