

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:

☐ White/Caucasian ☐ Asian

☐ Black or African-American ☐ Hispanic or Latino

☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander

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 Name:				Appointment Date:			
DOB:		OFFICE USE ONLY: Height:		Weight:	BP:	Pulse:	
Referring Doctor:				Family Doctor:		Heart Doctor:	

- I. Have you seen another doctor in this practice within the last 3 years? ☐ Yes ☐ No
 If yes, which doctor? _____
- II. Which side is affected? ☐ Right ☐ Left ☐ Bilateral(both sides) ☐ N/A
- III. Joint or part(s) that you are being seen for today:
☐ Neck ☐ Back ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist/Hand
☐ Hip ☐ Leg ☐ Knee(s) ☐ Ankle ☐ Foot/Toes
- IV. Date of Injury: _____ Or Start of Pain/Cause of pain? _____
 How did the pain occur? ☐ Injury ☐ Chronic ☐ Spontaneous
- VI. Pain Description (Choose all that apply):
 Quality of your pain? ☐ Mild ☐ Moderate ☐ Severe
 Type of pain? ☐ Sharp ☐ Dull ☐ Other: _____
- VII. What helps the pain? _____
- VIII. What makes the pain worse? _____

Medical History: - Do you have or have you had?					
Clubfoot	☐ Yes ☐ No	Hip Dysplasia	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Cancer Type _____	☐ Yes ☐ No	Problems with Anesthesia	☐ Yes ☐ No	Malignant Hyperthermia	☐ Yes ☐ No
Respiratory Problems	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Diabetes Type I or II (circle type)	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	GI Problems	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Blood Clot	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Mental Illness	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
HIV	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Hypothyroidism	☐ Yes ☐ No
Asthma/COPD	☐ Yes ☐ No	Prematurity	☐ Yes ☐ No		
Latex Allergies	☐ Yes ☐ No	Drug Allergies	☐ Yes ☐ No		
ALLERGIES (metal, medications, food, seasonal etc.)			REACTIONS/SYMPTOMS OF ALLERGIES		
Birth History		Pregnancy Complications	☐ Yes ☐ No	NICU Hospitalization	☐ Yes ☐ No
Was pregnancy full term?		☐ Yes ☐ No	If No, Weeks Premature _____		
Was Birth Type		☐ Vaginal ☐ C-Section	Breech Presentation		☐ Yes ☐ No

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Social History		
Does anyone in household smoke?	O Yes O No	If yes: O Inside O Outside
Do you play sports?	O Yes O No	Who is the primary caregiver at home? _____

Family History								
Hip Dysplasia	O	Father	O	Mother	O	Siblings	O	Grandparents
Club Foot	O	Father	O	Mother	O	Siblings	O	Grandparents
Scoliosis	O	Father	O	Mother	O	Siblings	O	Grandparents
Arthritis	O	Father	O	Mother	O	Siblings	O	Grandparents
Cancer	O	Father	O	Mother	O	Siblings	O	Grandparents
Diabetes	O	Father	O	Mother	O	Siblings	O	Grandparents
Stroke	O	Father	O	Mother	O	Siblings	O	Grandparents
Heart trouble	O	Father	O	Mother	O	Siblings	O	Grandparents
Lung Disease	O	Father	O	Mother	O	Siblings	O	Grandparents
Malignant Hyperthermia	O	Father	O	Mother	O	Siblings	O	Grandparents

Review of Systems						
Constitutional	Fatigue	O Yes O No	Fever	O Yes O No		
Gastrointestinal	Nausea/ Vomiting	O Yes O No	Stomach Ulcer/ Reflux	O Yes O No	Blood in Stool	O Yes O No
Cardiovascular	Chest pain	O Yes O No	Leg/Ankle Swelling	O Yes O No		
Neurological	Numbness/ Tingling	O Yes O No	Weakness/ Paralysis	O Yes O No		
Musculoskeletal	Joint pain	O Yes O No	Joint stiffness	O Yes O No	Joint Swelling	O Yes O No
Hematologic	Anemia	O Yes O No	Easy bruising	O Yes O No	Bleeding problem	O Yes O No

Current Medications:	Please PRINT CLEARLY	

Surgeries/Hospitalizations:	Please PRINT CLEARLY	
Procedure	Date	

Print Patient Name: _____ DOB: _____
 Patient/Guardian Signature: _____ Date: _____