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

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? O Yes O No

If yes, which doctor?_____

II. Which side is affected? O Right O Left O Bilateral(both sides)

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: _____ V: Start of Pain/Cause of pain?_____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this a Worker's Comp Claim? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

Is there a Third Party responsible for payment? O Yes O No

If accident, where did the accident occur?_____

VI. Pain Description (Choose all that apply):

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: _____

VII. Have you been seen by a Dentist in the last year? O Yes O No

VII. Do you have any dental problems (Broken, chipped or loose teeth, abscess, gum disease) O Yes O No

If yes, please explain:_____

Medical History: - Do you have or have you had?					
Asthma/COPD	O Yes O No	Respiratory Problems	O Yes O No	Lung Disease	O Yes O No
Cancer Type_____	O Yes O No	Problems with Anesthesia	O Yes O No	Malignant Hyperthermia	O Yes O No
Heart Attack	O Yes O No	Heart Problems	O Yes O No	Hypothyroidism	O Yes O No
Seizures	O Yes O No	Diabetes Type I or II (circle type)	O Yes O No	GI Problems	O Yes O No
Stroke	O Yes O No	Blood Clot	O Yes O No	High Blood Pressure	O Yes O No
Depression	O Yes O No	Mental Illness	O Yes O No	Anxiety	O Yes O No
Kidney Trouble	O Yes O No	If Yes Please Explain	_____		
HIV	O Yes O No	Hepatitis	O Yes O No	Sleep Apnea	O Yes O No
CPAP Machine	O Yes O No	Do you use the CPAP Machine?			O Yes O No
Do you have a pacemaker or AICD (automatic internal cardiac defibrillator)?					O Yes O No
Latex Allergies	O Yes O No	Drug Allergies	O Yes O No	Bariatric Surgery Type _____	O Yes O No

ALLERGIES (metal, medications, food, seasonal etc.)	**REACTIONS/SYMPTOMS OF ALLERGIES**

Medical History (continued)	Have you been in close contact with someone who has had MRSA within the last year?	O Yes O No
Have you ever had or presently have MRSA?	O Yes O No	Are you a Health Care Worker?	O Yes O No

Social History							
				Do you consume alcohol?	O Yes O No		
Do you smoke?	O Yes O No	Chew Tobacco?	O Yes O No	Do you exercise?	O Yes O No		
What is your place of residence	O Home	O Nursing Home	O Assisted Living	O Other:_____			

Family History							
Arthritis	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Cancer	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Diabetes	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Stroke	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Heart trouble	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Lung Disease	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Malignant Hyperthermia	☐ Father	☐ Mother	☐ Siblings	☐ 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: _____