OIO | Orthopaedic Institute of Ohio

801 Medical Dr, Ste A, Lima, OH 45804 ● 419-222-6622 ● Fax: 419-224-0015 ● www.orthoohio.com

Welcome to the Orthopaedic Institute of Ohio

To facilitate your surgical consultation, we request the following information to be brought to your appointment:

- Test Reports (EMG, Radiology)
- Driver's license
- Insurance Card(s)
- Current list of medications
- Co-pay, if applicable
- Please complete enclosed paperwork

Your appointment is on: _____A.M./P.M. at the following office:

_____ Lima Office – 801 Medical Drive, Suite A, Lima, OH

_____ Findlay Office – 1501 Bright Road, Findlay, OH

_____ Coldwater Office – 830 West Main Street, Suite 4, Coldwater, OH

_____ Sidney Office – 915 West Michigan Street, Building B, Sidney, OH

_____ St. Mary's Office – 1275 East Greenville Road, St. Mary's, OH

_____ Van Wert Office – 1180 Professional Drive, Van Wert, OH

* You may also log onto OrthoOhio.com to pre-register through our patient portal.

Sincerely,

Frank E. Fumich, MD
Alec Curry, PA-C
James Carlier, PA-C
Selvon F. St. Clair, MD, Ph.D.
Steven Palte, PA-C
Alexis Diglio, PA-C
Austin J. Roebke, MD
Quentin Poling, PA-C

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

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

Are there any other physicians to whom you would like your medical records sent?
(Please include name, address and phone): _____

_____

_____

How were you referred to Orthopaedic Institute of Ohio (OIO):

O Physician O Patient / Friend O Health Connection O Workers Comp

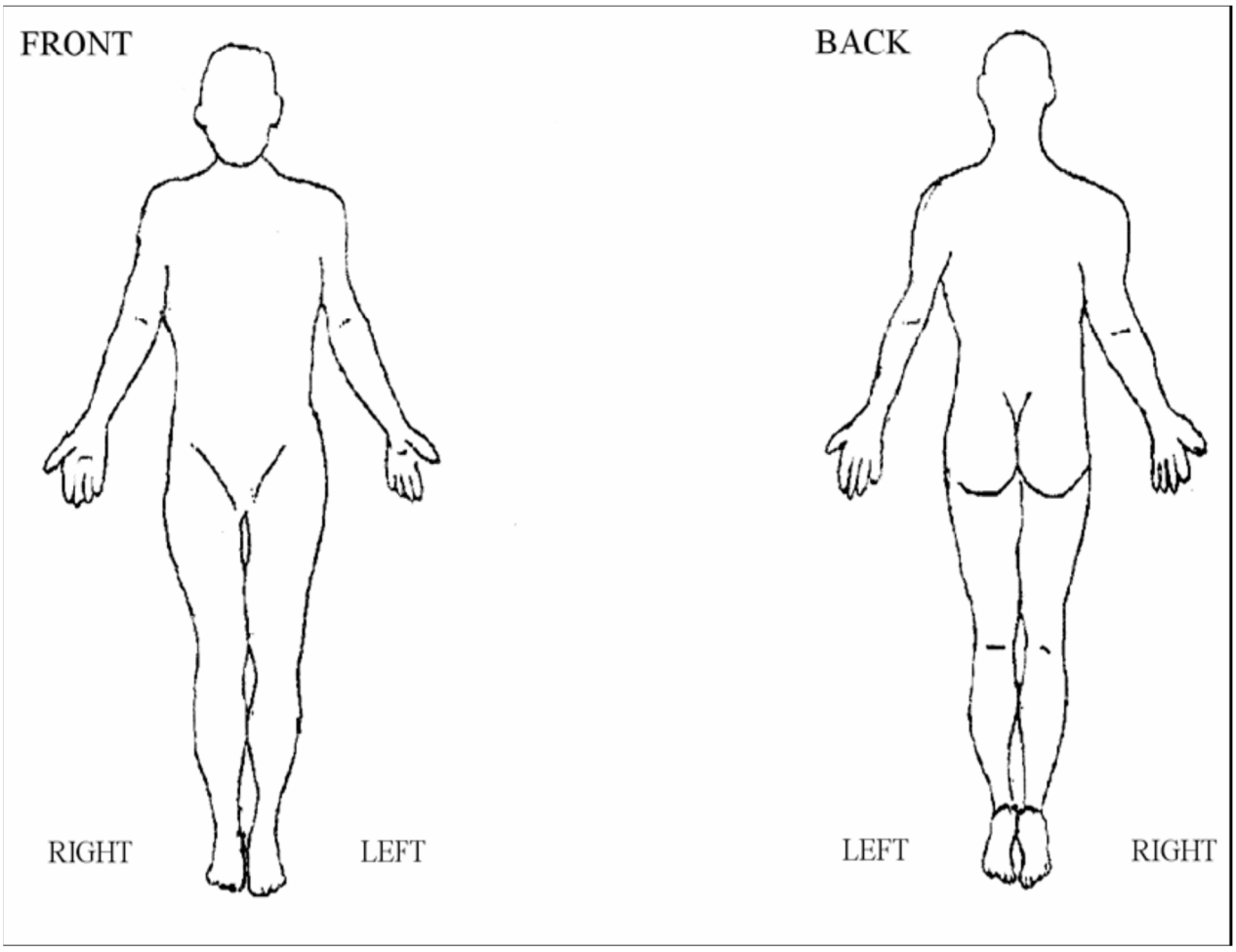
O OIO Reputation O Insurance O Radio / TV Advertisement O Other: _____

ORTHO PAIN CHART

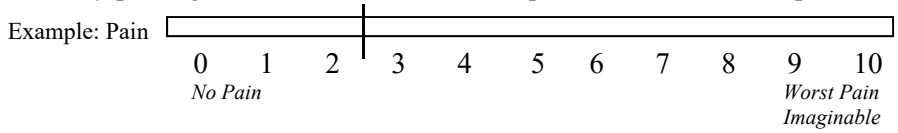
Mark the areas of your body where you feel the pain and/or sensations below, using the appropriate SYMBOL.

Mark the areas where your pain radiates, include all affected areas.

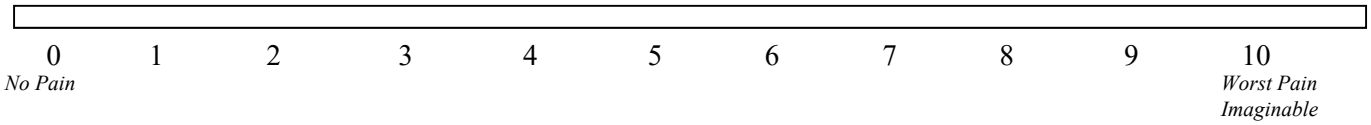
Numbness	Pin & Needles	Burning/Aching	Stabbing
= = = = = =	0 0 0 0 0	XXXXX	/ / / / / /



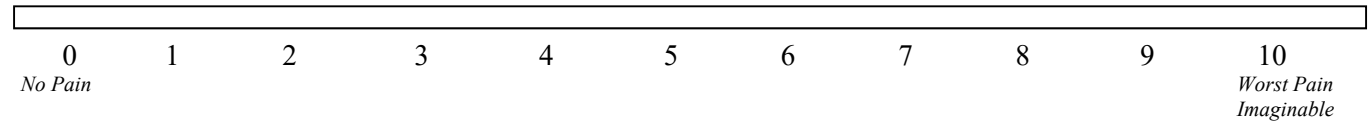
Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.



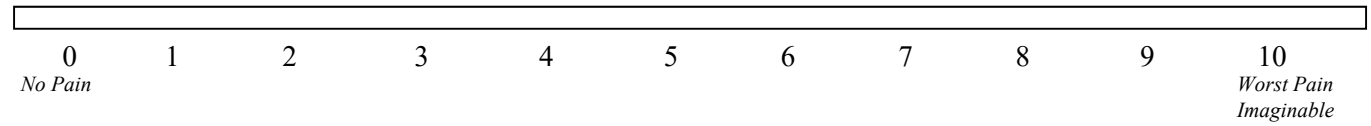
Pain at its worst:



Pain at its best (lying down, resting):



Pain on average:



HISTORY OF PRESENT COMPLAINT

1. Age: ____ O Male O Female Pain is on which side? O Right O Left

2. Where is your problem located? O Neck O Upper Back O Arm O Lower Back O Hip O Leg

3. How long have you had this problem? _____ Since? _____/_____/_____ (Month/Day/Year)

4. Briefly, please give the details of how this problem originally started: _____

_____

_____

5. Was this from a work-related injury? O Yes O No Is it under workers compensation O Yes O No

Have you missed any work because of this problem? O Yes O No How much? _____

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

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

8. Please describe your present pain/problem now (what you feel, where, when, etc.): _____

_____

_____

9. Have you had spinal surgery in the past: (Check one) O Yes O No How many times? _____

What type of surgery(s) was/were performed? O Discectomy O Laminectomy O Fusion

O IDET O Unknown O Other _____

What spinal level? _____

What was the date of your most recent spine surgery? _____

Did you improve from your spine surgery procedure(s)? O Yes O No

10. Which of the following best describes your ratio for neck & arm or back & leg discomfort (if appropriate):

A. 100% back pain and 0% leg pain	A. 100% neck pain and 0% arm pain
B. 90% back pain and 10% leg pain	B. 90% neck pain and 10% arm pain
C. 75% back pain and 25% leg pain	C. 75% neck pain and 25% arm pain
D. 50% back pain and 50% leg pain	D. 50% neck pain and 50% arm pain
E. 25% back pain and 75% leg pain	E. 25% neck pain and 75% arm pain
F. 10% back pain and 90% leg pain	F. 10% neck pain and 90% arm pain
G. 0% back pain and 100% leg pain	G. 0% neck pain and 100% arm pain

11. For any pain/numbness in your arm(s) or leg(s), which side is worse? (Choose one if appropriate):

Leg Symptoms	**Arm Symptoms**
A. 100% left leg and 0% right leg	A. 100% left arm and 0% right arm
B. 75% left leg and 25% right leg	B. 75% left arm and 25% right arm
C. 50% left leg and 50% right leg	C. 50% left arm and 50% right arm
D. 25% left leg and 75% right leg	D. 25% left arm and 75% right arm
E. 0% left leg and 100% right leg	E. 0% left arm and 100% right arm

CURRENT PAIN PROFILE

12. Please choose letters A – F (in first column) to answer the questions in column two.

A. Unable to tolerate
B. About 15 minutes only
C. About 30 minutes only
D. About 45 minutes
E. About 1 hour
F. Indefinitely

How long can you sit? _____

How long can you stand? _____

How long can you walk? _____

13. Which of the following activities change the nature of your pain?

	Aggravates Pain	**Relieves Pain**	**Neither**
Sitting	O	O	O
Standing	O	O	O
Walking	O	O	O
Leaning forward (brushing teeth)	O	O	O
Bending forward	O	O	O
Lying in your side	O	O	O
Lying on your back	O	O	O
Lying on your stomach	O	O	O
Rising from sitting	O	O	O
Changing positions	O	O	O
Coughing / Sneezing	O	O	O
Driving	O	O	O

Now go back and CIRCLE the box to indicate **the most aggravating activity** and the **most relieving activity.**

14. If the symptoms of your present pain have changed, please indicate the most appropriate statement: (Circle one)

A. My symptoms have remained the same since the time of onset.

B. My symptoms are more severe since the time of onset

C. My symptoms are less severe since the time of onset.

15. How have the symptoms of your present pain changed: (Circle one)

A. No change in symptoms

B. Increased aggravation in one arm or leg

C. Increased aggravation in both arms or legs

D. Increased aggravation in the back or neck

E. Increased aggravation in both arms/legs and back/neck

PAST BACK HISTORY

16. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Which type	Check which one applies:			Facility Name	Date
		Helpful	Not Helpful	Not Used		
Anti-inflammatory						
Muscle Relaxants						
Narcotic Pain Medications						
Hot Packs						
Ice						
Ultrasound						
TENS Unit / Muscle Stim (Circle)						
Physical Therapy Treatment						
Back/Neck Exercises						
Chiropractor						
Injections						
Acupuncture / Massage						
Traction / VAX-D (Circle)						
Other						

17. Please indicate whether you have had any of the following studies and write when/where the most recent was:

	YES	NO	When/Where		YES	NO	When/Where
Regular X-ray of Spine				Myelogram			
CT Scan of spine				Discogram			
EMG				MRI of spine			
Nuclear Bone Scan				Bone Density			

18.Have you had any past episodes of similar pain or injury? O Yes O No (please describe)

_____

_____

_____

19. List all other physicians with whom you have consulted in the past year for this problem.

_____

_____

_____

MEDICAL/SURGICAL HISTORY

Please choose all current and past medical conditions

High blood pressure	O Yes O No	Cancer - Where?_____	O Yes O No
Heart attack	O Yes O No	Kidney Failure	O Yes O No
Heart failure	O Yes O No	Kidney Stones	O Yes O No
Abnormal heart rhythm	O Yes O No	Osteoporosis	O Yes O No
Lung disease	O Yes O No	Osteoarthritis	O Yes O No
Tuberculosis	O Yes O No	Rheumatoid arthritis	O Yes O No
Asthma	O Yes O No	Bleeding disorders	O Yes O No
Bronchitis	O Yes O No	Anemia	O Yes O No
Emphysema	O Yes O No	Blood clots in legs/lung	O Yes O No
Liver disease	O Yes O No	Endometriosis	O Yes O No
Hepatitis	O Yes O No	Ovarian cysts	O Yes O No
Diabetes	O Yes O No	Anxiety	O Yes O No
Thyroid disease	O Yes O No	Depression	O Yes O No
Stomach ulcers	O Yes O No	Schizophrenia	O Yes O No
Gastric Reflux	O Yes O No	Anorexia/bulimia	O Yes O No
Irritable bowel	O Yes O No	Alcoholism	O Yes O No
Stroke	O Yes O No	Seen a psychiatrist	O Yes O No
Seizures	O Yes O No	HIV	O Yes O No
Malignant Hyperthermia	O Yes O No	Pacemaker or AICD	O Yes O No
Have you ever had or presently have MRSA?			O Yes O No
Have you been in close contact with someone who has had MRSA within the last year?			O Yes O No
Are you a healthcare worker	O Yes O No	Sleep Apnea	O Yes O No
Do you have a CPAP machine	O Yes O No	Do you use the CPAP machine	O Yes O No

20. Are you under a doctor's care for any other medical condition? O Yes O No If yes, please explain:

_____

_____

21. Have you been seen by a dentist in the last year? O Yes O No

22. Do you have any dental problems? (broken, chipped or loose teeth, abscess, gum disease) O Yes O No
If yes, please explain: _____

Surgeries/Hospitalizations: **Please PRINT CLEARLY**

Procedure	Date

Latex Allergy? O Yes O No **Drug Allergies: O Yes O No** **Metal Allergies: O Yes O No**
If yes, please list below:

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

Please list the medications you are CURRENTLY taking:

SOCIAL HISTORY

23.Current work status: **O** Working full-time, regular duty **O** Working part-time, regular duty **O** Not working

O Working restricted duty (Since_____) **O** Retired **O** Disabled (Since _____) **O** Student

O Homemaker **O** Unemployed

Company: _____ Occupation:_____ Title:_____

How long have you worked for this company?_____

24. Marital status: O Single O Married O Divorced O Widowed

25. Number of Children:_____

26. I live: O Alone O With:_____

27. I live in a: O House O Apartment O Assisted living O Nursing home

28. Are you a ? O Current smoker O Former smoker O Nonsmoker O Current every day smoker

O Current some day smoker O Current smoker, status unknown O Unknown if every smoked

How long have you smoked? O More than 5 years O Less than 5 years

How much do you smoke? O 5 or less O 6 to 10 O 11 to 20 O 21-30 O 31 or more

How soon after you wake do you smoke your first cigarette? ? O within 5 minutes O 6-30 min O after 60 min

If you quit smoking, how long ago did you quit?_____

How old were you when you started smoking? _____

29. Do you drink any alcoholic beverages? (Check one) O Yes O No

How many drinks per day? O 0-1 O 2-3 O 4-5 O more than 5 How many? _____

For how many years? O 1-2 years O 3-5 years O more than 5 years

30. Have you ever had a problem with drug dependence? O Yes O No Alcoholic in past? O Yes O No

31. Do you exercise? O Yes O No

How many times per week? O 1 time O 2 times O 3 times O daily

How long do you exercise? O 10 minutes O 15 minutes O 30 minutes O more than 30 minutes

32. Are there any lawsuits pending or contemplated related to your problem? O Yes O No

If yes, please give your attorney's name and phone number: _____

33. Please write any additional information that you feel is important for us to know.

_____

_____

FAMILY HISTORY

What illnesses run in your close family (other than yourself)?

Scoliosis	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Spine disease	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Arthritis	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Heart disease	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
High blood pressure	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Diabetes	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Cancer	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Bleeding disorder	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Mental Illness	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Alcoholism	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents

Kidney disease	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Malignant Hyperthermia	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents
Other:	**O** Father	**O** Mother	**O** Siblings	**O** Grandparents

REVIEW OF SYSTEMS

GENERAL					
Unexplained weight loss	O Yes O No	Appetite change	O Yes O No	Fever/Chills	O Yes O No
Night sweats	O Yes O No	Marked fatigue	O Yes O No	Difficulty sleeping	O Yes O No
EAR/NOSE THROAT					
Difficulty swallowing	O Yes O No	Hoarseness	O Yes O No	Loss of hearing	O Yes O No
Ear pain	O Yes O No	Nosebleeds	O Yes O No	Gum trouble	O Yes O No
EYES					
Glasses	O Yes O No	Change of vision	O Yes O No		
CARDIOVASCULAR					
Heart or chest pain	O Yes O No	Abnormal heartbeat	O Yes O No	Leg swelling	O Yes O No
Poor heart function	O Yes O No				
LUNG					
Morning cough	O Yes O No	Shortness of breath	O Yes O No	Productive cough/sputum	O Yes O No
DIGESTIVE					
Nausea/vomiting	O Yes O No	Stomach pain/ulcers	O Yes O No	Blood in stool	O Yes O No
Frequent diarrhea	O Yes O No	Frequent constipation	O Yes O No	Hemorrhoids	O Yes O No
Uncontrolled loss of stool	O Yes O No	Heartburn/Stomach acid	O Yes O No		
SKIN					
Frequent rashes	O Yes O No	Frequent itchiness	O Yes O No	Easy bruising	O Yes O No
Swollen ankles	O Yes O No				
NEUROLOGICAL					
Seizures	O Yes O No	Blackouts/fainting	O Yes O No	Tremor	O Yes O No
Headaches/migraines	O Yes O No				
MUSCULOSKELETAL					
Joint pain	O Yes O No	Joint swelling	O Yes O No	Back pain	O Yes O No
Neck pain	O Yes O No	Muscle pain	O Yes O No		
GENITOURINARY					
Burning on urination	O Yes O No	Incontinence	O Yes O No	Pelvic pain	O Yes O No
Difficulty starting to urinate	O Yes O No	Urinate at night more than once	O Yes O No	Unable to completely empty bladder	O Yes O No
PSYCHIATRIC					
Depression	O Yes O No	Nervous exhaustion	O Yes O No	Anxiety	O Yes O No
Paranoia	O Yes O No	Obsessive/compulsive behavior	O Yes O No		

Print Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

PLEASE ANSWER ALL QUESTIONS - USE A SEPARATE SHEET IF NECESSARY

Patient Name: _____DOB: _____

Thank you for choosing the Orthopaedic Institute of Ohio for your spine care. Please complete the following questions regarding the care and treatment that you have received in the past for your neck and/or back on another sheet of paper and bring this with you to your next appointment. This information will be used to help get approval through insurance if further testing or surgery is recommended. When answering the questions, please be specific and give as much detail as possible.

1. List all the over the counter medications that you have taken for your back/neck - What brand, how often taken and for how long?_____

2. List all prescription NSAIDS or steroids taken (prednisone, naproxen, lodine) - What brand, how often taken and for how long?_____

3. List all prescription pain medication taken (Vicodin, Tylenol 3, oxycontin) - What brand, how often taken and for how long?_____

4. Physical therapy - Where completed, when and for how long?_____

5. Home exercise program - Prescribed by whom, how long?_____ __

6. Chiropractic treatment - List treatment provided, when you started treatment and how often you went.

7. Epidural injections - How many have you had, dates of those procedures and where did you have the injections._____ _____

8. Pain management program – Where and when did you complete this program?_____

9. Weight loss- How much weight have you lost from your original weight? Are you involved in a weight loss program?_____

10. Acupuncture – How many visits have you had and when?_____ _____

11. Psychological Therapy – Where and when did you have therapy, what was your diagnosis and what medication did they prescribe for you?_____

12. Have you had a functional capacity evaluation? If yes, when and where did you have this evaluation?

_____

13. List any other medical treatment that you have had for your spine. Include activity modification, sleeping patterns and/or use of any supports while sleeping, ie pillow, etc. _____

14. Smoking - If you are a past smoker list the date you quit. If you presently smoke- how many cigarettes do you currently smoke per day and if you have tried or are currently trying to quit smoking what assistance have you used, if any? _____

If you have any questions, please don't hesitate to call our office. Thank you for your time and effort in completing these questions.