

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

HOME # (\_\_\_\_\_) \_\_\_\_\_ CELL # (\_\_\_\_\_) \_\_\_\_\_ WORK # (\_\_\_\_\_) \_\_\_\_\_

PLEASE LEAVE MESSAGES ON MY :  HOME  CELL  WORK

E-MAIL ADDRESS \_\_\_\_\_

SEX:  M  F MARITAL STATUS:  Married  Single  Divorced  Widowed

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

\* RACE  AMERICAN INDIAN OR ALASKA NATIVE  WHITE  
 ASIAN  HISPANIC  
 NATIVE HAWAIIAN OR OTHER PACIFIC  OTHER RACE: \_\_\_\_\_  
 BLACK OR AFRICAN AMERICAN

EMERGENCY CONTACT NAME (NOT LIVING WITH YOU): \_\_\_\_\_ RELATION \_\_\_\_\_

PHONE #: \_\_\_\_\_ LIVING WILL?  YES  NO POWER OF ATTORNEY?  YES  NO

*\* Government requires this information to protect patients against discrimination*

**Person Responsible for Bill (if different from Patient)**

RELATION: \_\_\_\_\_ NAME \_\_\_\_\_ DOB: \_\_\_\_\_ SSN \_\_\_\_\_

ADDRESS (if not same as above) \_\_\_\_\_

HOME # (\_\_\_\_\_) \_\_\_\_\_ CELL # (\_\_\_\_\_) \_\_\_\_\_ WORK # (\_\_\_\_\_) \_\_\_\_\_

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DOB \_\_\_\_\_

RELATIONSHIP OF POLICY HOLDER TO PATIENT \_\_\_\_\_

ADDRESS (if not same as above) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ID/ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

POLICY HOLDER \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DOB \_\_\_\_\_

RELATIONSHIP OF POLICY HOLDER TO PATIENT \_\_\_\_\_

ADDRESS (if not same as above) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ID/ POLICY # \_\_\_\_\_ GROUP # \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ OFFICE # \_\_\_\_\_







REFERRING PHYSICIAN \_\_\_\_\_ OFFICE # \_\_\_\_\_

**NEW PATIENT MEDICAL HISTORY FORM**

Patient Name: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender/Age \_\_\_\_\_ / \_\_\_\_\_

**PAIN HISTORY BACKGROUND**

What is your main complaint?	Which side is your pain located on? <b>Right                  Left                  Both</b>
How long has this pain been present? <b>Days _____ Weeks _____ Months _____ Years _____</b>	How often is the pain present? <i>(please circle)</i> <b>Constant</b> <b>Frequent</b> (several times/hour) <b>Sporadic</b> (several times/day) <b>Occasional</b> (several times/week) <b>Rare</b> (several times/month)
What makes your pain <b>better</b> ? <i>(please circle)</i> Heat   Cold   Medication   Exercise	What words best describe how the pain feels? <i>(please circle)</i> Sharp   Burning   Shooting   Stabbing   Deep   Aching   Dull Tingling   Throbbing   Pressure   Other: _____
What makes your pain <b>worse</b> ? <i>(please circle)</i> Heat   Cold   Walking   Sitting   Standing   Lying   Stress Bending/Twisting   Coughing/Sneezing   Standing from Sitting	Rank your Pain on scale of 1       to 10 (worst pain) _____ <small>0 NO HURT    2 HURTS LITTLE BIT    4 HURTS LITTLE MORE    6 HURTS EVEN MORE    8 HURTS WHOLE LOT    10 HURTS WORST</small>

Have you tried physical therapy?	Yes	No	Helpful?	Yes	No	Where?
Have you tried chiropractic treatments?	Yes	No	Helpful?	Yes	No	
Have you tried a brace or support?	Yes	No	Helpful?	Yes	No	
Are you taking prednisone or cortisone pills?	Yes	No	Helpful?	Yes	No	
Have you had a cortisone injection?	Yes	No	Helpful?	Yes	No	

Work related injury	Date: _____	How did your main pain complaint begin? <i>(please give details)</i> _____ _____ _____ _____ _____
Motor vehicle accident	Date: _____	
Fall or other trauma	Date: _____	
Following surgery	Date: _____	
Following illness	Date: _____	
Unknown reason	Date: _____	
Other		

**TREATMENT HISTORY**

Have you had a **RADIOLOGIC IMAGING** for your current pain complaint?    **Yes**    **No**    *(please bring images to initial appointment)*

Study Type	Body part imaged	Date of Study	Where study was performed
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Have you had an Electromyography or EMG test to evaluate nerve function?    **Yes**    **No**

Are you currently being treated by a pain management physician or clinic?    **Yes**    **No**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ DATE \_\_\_\_\_

**PAST MEDICAL HISTORY**

Abnormal heart beat	Depression	Heart attack	Rheumatoid arthritis
Stomach ulcer or GI bleed	Anxiety	Emphysema/COPD	Osteoarthritis
Heartburn/Acid reflux (GERD)	Insomnia	Cancer	Peripheral neuropathy
Diabetes	Seizures	Stroke	Multiple Sclerosis (MS)
Liver disease	Fibromyalgia	Asthma	Irritable bowel
Kidney disease	Migraine headaches	Hypothyroid/Hyperthyroid	HIV/Aids
Bleeding disorder	Psychiatric Conditions	High blood pressure/ High cholesterol	Vascular disease
Sleep apnea	Alcoholism	Hepatitis	Broken Bones

**PAST SURGICAL HISTORY**

Please list any surgical procedures you have had in the past.

SURGERY	DATE (MONTH/YEAR)	SURGEON

**CURRENT MEDICATIONS**

**PREFERRED PHARMACY:** \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_


**ALLERGIES**

Do you have any known drug allergies?    Yes    No	Are you allergic to IV contrast dye?    Yes    No
If yes please list your allergies:	Are you allergic to local anesthetics?    Yes    No
	Are you allergic to latex?    Yes    No

**HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Father	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer
Mother	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer
Sibling(s)	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer

Please check here if you are adopted

**SOCIAL HISTORY**

What is your marital status?	Single	Married	Divorced	Widowed	
Occupation?	Fulltime	Part-time	Retired	Student	Disabled
Do you use tobacco?	Current Smoker	Former Smoker	Non-Smoker	Other: _____	Cigarettes/Cigars, _____ packs/day
Do you use alcohol?	Never	Rarely	Socially	Regularly, ___ drinks/day	

### **Financial Agreement / Responsibility**

I acknowledge financial responsibility for services provided by Orthopaedic Specialists, I understand that the clinic will file my insurance as a courtesy and that I am responsible for any amounts including but not limited to: co-payments, co-insurance, deductibles, FMLA/Disability paperwork, copies of x-rays and/or medical records. I understand that co-pays and prior balances are due at time of service. Deductibles and co-insurance carries made on my behalf will be directed to Orthopaedic Specialists for services provided.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### **Consent of Treatment/Payment/HIPAA Consent**

I authorize Orthopaedic Specialists physician and staff to provide medical treatment as needed. I authorize the order and use of x-rays, injections, casting and/or diagnostic tests to diagnose and treat my illness or injuries. I hereby consent to Orthopaedic Specialists to use or disclose, for the purpose of carrying out treatment, payment, and/or healthcare operations at any time by giving a written notice. I also understand that I will not be able to revoke this consent in cases where my provider has referred to it for purposes of disclosing my health information.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### **Consent of Communication Method**

I acknowledge and agree that Orthopaedic Specialists and any affiliates or vendor thereof, including collection or billing companies, may contact me by telephone or text message to any telephonic number I have provided and any other telephone number associated with my account, including wireless and/or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as and ATDS (Automated Telephone Dialing System) or pre-recorded message. I also agree that I will notify Orthopaedic Specialists if I have given up ownership or control of any such telephone numbers.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### **ePrescribing**

A patient portal is a secure online website that give patients convenient 24-hour access to personal health information from anywhere with an internet connection. ePrescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription to a pharmacy from the point of care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program. These include:

- *Formulary and benefit transactions* - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- *Medication history transactions* - provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events

By signing this consent form, you are agreeing that Orthopaedic Specialists can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Signed \_\_\_\_\_ Date \_\_\_\_\_

***I have received a copy of the notice of Privacy Practices of Orthopaedic Specialists.***

Signed \_\_\_\_\_ Date \_\_\_\_\_

**\* PLEASE COMPLETE ALL SECTIONS!**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_ Social Security \_\_\_\_\_

I hereby authorize \_\_\_\_\_ and its physicians, employees, and/or agents to release or disclose the following protected health information to: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Address \_\_\_\_\_

**THE REQUEST AND AUTHORIZATION APPLIES TO:**

\_\_\_\_ Medical Records

\_\_\_\_ Specific records listed below, including dates, body part, time frame, ect. (example: physician office notes, lab

and test results, operative report \_\_\_\_\_

\_\_\_\_ itemized account/billing information

This authorization will expire one year of signature.

If you do not want certain portions of your medical records released, initial in the space(s) below for the information you do **not** want released.

\_\_\_ Substance abuse \_\_\_ Mental health \_\_\_ HIV/AIDS/ sexually transmitted diseases \_\_\_ Other/Specified: \_\_\_\_\_

- I Understand I may revoke this authorization at any time by sending a written request to the attention of the Privacy Officer for Orthopaedic Specialists. However, the revocation will not have any effect on any uses or disclosures that Orthopaedic Specialists may have made before receiving the revocation.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and may not be protected by federal confidentiality rules.
- I understand that I am not required to sign the authorization as a condition of treatment or payment, or for enrollment or eligibility for benefits.

**I give my authorization to use or disclose my protected health information as described.**

Patient or Authorized Representative's Signature: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the patient if not signed by the patient: \_\_\_\_\_

*You have a right to a copy of this form after you sign it*