Orthopedic Associates of Dayton

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ Social Security Number: _____-_____-_____

Home Phone: _____ Cell Phone: _____

Patient Employer Name: _____ Employer Phone: _____

Email Address: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced

Gender: ☐ Male ☐ Female ☐ Separated ☐ Widowed

Race: ☐ African American/Black ☐ Caucasian/White

☐ American Indian/Alaska Native ☐ Multi-Racial Emergency Contact: _____

☐ Native Hawaiian/Pac Islander ☐ Other Relationship to Patient: _____

Ethnicity: ☐ Hispanic, Latino, or Spanish Origin Emergency Contact Phone: _____

☐ Not Hispanic, Latino, or Spanish Origin

Preferred Language: _____

Primary Care Physician: _____ Phone: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Subscriber: _____ Subscriber: _____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Relationship to Patient: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ Date of Birth: ____/____/____

Social Security Number: _____-_____-_____ Social Security Number: _____-_____-_____

Employer: _____ Employer: _____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? YES / NO

*For Office Use Only: Registered By: _____ Date: _____

SYSTEMS REVIEW and PAST MEDICAL HISTORY

Patient Name _____
Date Completed _____ Age: _____
Date of Birth _____ Sex M F
Height _____ Weight _____
RIGHT HANDED _____ **LEFT HANDED** _____

PAST MEDICAL HISTORY
Do you have any of these medical conditions?

1. Cardiac
- a. **Hypertension/High Blood Press** YES NO
- b. Heart Attack YES NO
- c. Stroke YES NO
- d. Blood Clots YES NO
- e. Arrhythmia YES NO
- f. High Cholesterol YES NO
- g. Other _____

2. Respiratory
- a. Asthma YES NO
- b. Sleep Apnea (diagnosed) YES NO
- c. Other _____

3. Gastrointestinal
- a. Ulcer Disease YES NO
- b. Other _____

4. Endocrine
- a. Thyroid Problem YES NO
- b. Diabetes YES NO
  - i. Insulin? YES NO
  - ii. Medication? YES NO
  - iii. Diet Controlled? YES NO

5. Cancer YES NO
- a. Type _____
- b. Treatment _____

6. Liver Disease YES NO
- a. _____

7. Neurological Disease YES NO
- a. Seizure Disorder YES NO
- b. Parkinson's Disease YES NO
- c. Multiple Sclerosis YES NO
- d. Other _____

8. Kidney Disease YES NO
- a. _____

9. Malignant Hypertension YES NO
(Surgery Complication)

10. HIV/AIDS YES NO

11. Other (list)
- a. _____
- b. _____
- c. _____

PAST SURGICAL HISTORY
List all operations that you have had
1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY - If "Yes" please circle family member(s)
1. Heart YES NO
   Father / Mother / Brother / Sister
2. Lung YES NO
   Father / Mother / Brother / Sister
3. Cancer YES NO
   Father / Mother / Brother / Sister
4. Diabetes YES NO
   Father / Mother / Brother / Sister
5. Hypertension YES NO
   Father / Mother / Brother / Sister
6. Other _____
   Father / Mother / Brother / Sister

SOCIAL HISTORY
1. Tobacco YES NO
   a. Packs per day _____
2. Alcohol YES NO
   a. Frequency _____
3. Caffeine YES NO
   a. Cups per day _____
4. Do you or have you had a problem with chemical dependency? YES NO
5. Are you or could you be pregnant? YES NO

OCCUPATION
1. Employer _____
2. Job Description _____
3. Years Employed _____

ALLERGIES
1. General
   - a. Latex YES NO
   - b. Metal YES NO
   - c. Chicken Products YES NO
   - d. Other (test dyes, shellfish) _____

*** PATIENT NAME _____

REVIEW OF SYMPTOMS

Do you have any of the following problems?

1. Constitutional		
a. Recent Weight Loss	YES	NO
b. Fevers	YES	NO
c. Chills	YES	NO
d. Night Sweats	YES	NO
2. Eyes		
a. Blurred Vision	YES	NO
b. Glasses	YES	NO
3. ENT - Ear(s)	YES	NO
Nose	YES	NO
Throat	YES	NO
4. Respiratory		
a. Shortness of Breath	YES	NO
b. Wheezing	YES	NO
c. Persistent Cough	YES	NO
5. Cardiovascular		
a. Chest Pain	YES	NO
b. Irregular Heartbeat	YES	NO
6. Gastrointestinal		
a. Stomach Pain	YES	NO
b. Blood in Stool	YES	NO
c. Frequent Diarrhea	YES	NO
d. Constipation	YES	NO
7. Genitourinary		
a. Blood in Urine	YES	NO
b. Painful Urination	YES	NO
c. Difficulty	YES	NO
d. Frequent Urinary Infections	YES	NO
8. Neurologic		
a. Paralysis	YES	NO
b. Frequent Headaches	YES	NO
9. Skin		
a. Rash	YES	NO
10. Psychiatric		
a. Depressed Mood	YES	NO
11. Blood		
a. Easy Bruising/Bleeding	YES	NO

TESTS PERFORMED	DATE	BODY PART/SIDE
1.		
2.		
3.		
4.		
5.		

DOCTORS' NAMES	PHONE
1.	
2.	
3.	

PHYSICIAN'S SIGNATURE DATE

Reviewed

Date of Last Vaccine

Flu Vaccine: _____ Pneumonia: _____

Medication Reconciliation

Medicine name/strength	Purpose	Dosage/frequency/time	Doctor

Medicines allergic to:

Any other notes/comments

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physician and staff of OAD. I realize that if a medical procedure or surgery is required, I will be given additional information.

PAYMENT is expected at the time of your visit. We will accept cash, check or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. We do ask for a copy of an ID card due to many cases of identity theft in the news lately.

INSURANCE

We are participating providers with several insurance plans. We will file insurance for you. We make no claim to know what services your insurance covers. We will make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct or a guarantee of payment. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Be sure to check with your insurance regarding your benefits.

RETURNED CHECKS will incur a $35 service charge.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Orthopedic Associates of Dayton for charges not covered by insurance.

No Show Appointments: Please give us at least 24 hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. You will be charged **$25.00** for each no show appointments.

THIRD PARTY PAYER: Our office **does not** bill third party payers such as personal injury, motor vehicles accidents, or attorneys. Our policy is we bill your medical insurance and once you receive payment from your third party payer, you will reimburse your medical insurance.

RELEASE OF INFORMATION: I hereby authorize Orthopedic Associates of Dayton, Inc. to release to government agencies, insurance carrier, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I consent to OAD using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing.

I understand that OAD reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy.

I have a right to revoke this consent by notifying OAD in writing, except to the extent that OAD has taken action in reliance on my consent.

I acknowledge that I have received a copy of the Privacy Policies of OAD.

_____ _____

Patient Signature **Date**

_____ _____

Signature of Guarantor/Guardian if Minor (under 18) **Date**

CONSENT FOR CONTACT OF PROTECTED HEALTH INFORMATION

Name: _____D.O.B._____

Telephone: (Home) _____(Cell)_____

I give my written consent for Orthopedic Associates of Dayton, Inc. to share information regarding my protected health information and care to the following listed persons; I understand that these persons may be treated as personal representatives of myself.

Personal Representative that you may share my health information with:

Name: _____Relationship:_____

Phone #_____

Name: _____Relationship:_____

Phone #_____

Name: _____Relationship:_____

Phone #_____

You may leave a message: (please check all that apply)

_____At Home _____At Work _____On answering machine

Patient's Signature: _____Date: _____

DO NOT DISCUSS MY INFORMATION WITH ANYONE OTHER THAN MYSELF AT THIS TIME_____

Orthopedic Associates of Dayton

THIS NOTICE DESCRIBES HOW PERSONAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

Your Privacy is Important to Us- Orthopedic Associates of Dayton is committed to protecting the information you share with us and in turn respecting your privacy. This privacy statement will explain the type of information we collect, how we use that information and how we protect that information. Orthopedic Associates of Dayton reserves the right to change this Privacy Statement at any time and will notify you if any changes as required by law.

Who Will Follow This Policy- This notice describes information about privacy practices followed by our employees, staff and other personnel.

What Information we Collect- Orthopedic Associates of Dayton collect information on you from registration forms, medical history forms, authorizations, consents, and releases. This information can include, name, address and social security number, insurance ID number, past, present, family, social and medical history. We collect this information to 1) accurately identify you 2) protect and administer your account 3) understand your needs 4) provide you, a guardian, or responsible party with necessary information 5) provide for your treatment, receive payment, and for healthcare operations.

What Information We May Disclose-We may disclose information of a personal nature to your insurance company during the submission and processing of claims on your behalf, other medical providers such as laboratories, imaging facilities and other non- affiliated healthcare providers involved with your care. This information will be shared on a as-needed basis and only to the extent necessary for continuity of care or as required by law.

Protecting Your Personal Information- Orthopedic Associates of Dayton takes the security of your information very seriously and has established security standards and procedures to prevent unauthorized access to patient information. We maintain physical, electronic and procedural safe guards to protect your information. Only authorized personnel within our organization who need to service your account will see your information. These individuals are trained to properly handle personal information and must abide by the terms of a confidentiality agreement.

Patients Rights- Patient has the right to receive a copy of the Privacy Statement and Notice of Privacy Practices of Orthopedic Associates of Dayton and to request an amendment or correction be made to their medical records with the understanding that Orthopedic Associates of Dayton reserves the right to deny such requests as outlined in the Privacy Policy. We will adhere to the information policies and procedures described in the current privacy policy.