ORTHOPEDIC ASSOCIATES of DAYTON

Name: ___________________________ **Date of Birth:** ____________________________
Physician: ________________________ **Date:** ___________________________________
Weight: __________________________ **Height:** _________________________________

Pharmacy:
Pharmacy Name: ______________________ Pharmacy Phone Number: ______________

Pharmacy Address: ____

Medical History: Please check any of the medical conditions you have seen a doctor for.

☐ None	☐ Stomach Cancer	☐ Emphysema	☐ Hiatal Hernia
☐ Anemia	☐ Uterine Cancer	☐ Barret's Esophagus	☐ High Blood Pressure
☐ Anxiety Disorder	Other Cancer: _________________	☐ Fibromyalgia	☐ High Cholesterol
☐ Heart Valve Disease	☐ Congestive Heart Failure	☐ Ulcerative Colitis	☐ HIV / AIDS
☐ Osteoarthritis	☐ COPD	☐ Gallstones	☐ Irritable Bowel Syndrome
☐ Rheumatoid	☐ Coronary artery disease	☐ Glaucoma	☐ Kidney Stones
☐ Hemorrhoid's	☐ Crohn's Disease	☐ Headache/Migraine	☐ Pancreatitis
☐ Breast Cancer	☐ Hepatitis/ Type:_______________	☐ Thyroid Disease	☐ Parkinson's Disease
☐ Colon Cancer	☐ Liver Disease	☐ Atrial Fibrillation	☐ Reflux
☐ Esophageal Cancer	☐ Dementia	☐ Tachycardia	☐ Seizure Disorder
☐ Kidney Cancer	☐ Alzheimer's	☐ Bradycardia	☐ Sjogren's Disease
☐ Liver Cancer	☐ Depression	☐ SVT	☐ Sleep Apnea On CPAP
☐ Lung Cancer	☐ Diabetes	☐ Heart Attack	☐ Stroke
☐ Ovarian Cancer	☐ Diverticulitis/ Diverticulosis	☐ Prostate	☐ Other:
☐ Skin Cancer	☐ Ulcer		

Name: ___________________________________

Surgical History- Please check any surgeries you have had.

☐ None	☐ Gastric Sleeve	☐ Laparoscopy
☐ Appendix Removal	☐ Spinal Cord Stimulator	☐ Liver Biopsy
☐ Back/ Cervical Surgery	☐ Heart Stents	☐ Lung Surgery
☐ Bilateral Tubal Ligation	☐ Heart Surgery/ Bypass	☐ Mastectomy
☐ Blood Transfusions	☐ Heart Valve Replacement Aortic	☐ Pacemaker
☐ Carpal Tunnel Release	☐ Heart Valve Replacement Mitral	☐ Prostate
☐ Watch Man	☐ Hernia Repair	☐ Throat/ Mouth Surgery
☐ Colectomy	☐ Hiatal Hernia Surgery	☐ Tonsillectomy
☐ Colostomy	☐ Hysterectomy	☐ Adenoidectomy
☐ Ileostomy	☐ ICD (Internal Cardiac Defibrillation)	☐ Wisdom Teeth
☐ C-Section	☐ Joint Surgery	☐ Transplant
☐ Gallbladder Surgery	☐ Hip Replacement	☐ Thyroidectomy
☐ Gastric Bypass	☐ Knee Replacement	☐ Amputation
☐ Shoulder Replacement	☐ Other: Please List	

Family History:

Heart:
Father/ Mother/ Brother/ Sister

Lung:
Father/ Mother/ Brother/ Sister

Cancer:
Father/ Mother/ Brother/ Sister

Diabetes:
Father/ Mother/ Brother/ Sister

Hypertension:
Father/ Mother/ Brother/ Sister

Other:____
Father/ Mother/ Brother/ Sister

Name: ____

Social History
What is your occupation? ______________________________________
Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other________________________
Do you use tobacco? ☐No ☐Yes ☐Quit Age started______ Age Stopped________
Years Smoked ______
Do you currently use recreational drugs? ☐No ☐Yes
Type____________________
Frequency_____________________
Do you consume Alcoholic drinks? ☐No ☐Yes ☐Quit
Frequency/amount______________________
Dou you consume/drink caffeine? ☐No ☐Yes
Type_____________
Amount Per Day______________

Medications/Allergies (PLEASE PRINT)

Please list all medications you are taking, including vitamins and supplements.

Medication	Dosage	How Often

Please list all allergies or reactions you may have to medications or food.
____
____
____

Date of Last Vaccine:

Flu: _________________ **Pneumonia:** ______________________

Name: ____

Review of Symptoms:

Have you had any of the symptoms recently? Circle Yes or No

Symptom	Yes / No	Symptom	Yes / No
Weight Loss	Yes / No	Confusion	Yes / No
Fever	Yes / No	Memory Difficulty	Yes / No
Fatigue	Yes / No	Insomnia	Yes / No
Excessive thirst	Yes / No	Depression	Yes / No
Eye Symptoms	Yes / No	Nervousness	Yes / No
Blurred Vision	Yes / No	Excessive urination	Yes / No
Vision Loss	Yes / No	Easy Bleeding	Yes / No
Hearing Loss	Yes / No	Easy Bruising	Yes / No
Ringing in Ears	Yes / No	Anemia	Yes / No
Mouth Sores	Yes / No	Enlarged Glands	Yes / No
Taste Change	Yes / No	Itching	Yes / No
Sore Throat	Yes / No	Rash	Yes / No
Chronic Cough	Yes / No	Burning in urination	Yes / No
Spitting up blood	Yes / No	Irregular periods	Yes / No
Wheezing	Yes / No	Muscle Pain	Yes / No
Chest Pain	Yes / No	Back Pain	Yes / No
Shortness of Breath	Yes / No	Numbness	Yes / No
Swelling in Ankles	Yes / No	Weakness	Yes / No
Cold Intolerance	Yes / No	Headache	Yes / No
Heat Intolerance	Yes / No	Seizure	Yes / No
Joint Pain	Yes / No	Chest Pain	Yes / No

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. (Please do not be offended)

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. Remember approval for a service doesn't always mean a payment for the service so be aware of what your benefits are.

RETURNED CHECKS will incur a $35 service charge.

DISABILITY PAPERWORK: A $10.00 fee per set is required to complete the requested forms. We reserve the right to allow 7-10 business days to complete the forms.

ACCOUNTING PRINCIPALS Payment and credits are applied to the oldest charges first, except insurance payments which are applied to the corresponding dates of service.

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

WORKERS COMPENSATION: I understand that if I do not provide my medical insurance and workers comp denies treatment that I am financially responsible.

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 PAYOR: Our office does not bill third party payors such as personal Injury, motor vehicles accidents, or attorneys. Our policy is we bill your regular insurance and once we receive payment from your third party payor we will reimburse your regular 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.

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. *You may opt-out at any time by notifying the office administrator.*

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

____ ____________________

Signature of Patient Date
(Or Guarantor, if applicable)

____

Please print the name of a patient

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.