

World-class care.

First-class caring.

## ***Perimeter Drive Welcome Packet***

The physicians and staff of the Ohio Orthopedic Center of Excellence (OOCE), welcome you to our practice and thank you for choosing OOCE to assist with your orthopedic or pain related needs.

If you previously have had x-ray or MRI testing, be certain to bring with you to your appointment, the *reports and images* on film or disc. If you have not previously had x-ray and your physician determines x-rays are needed, they may be performed the day of your appointment.

The difference at Ohio Orthopedic Center of Excellence lies in our comprehensive full service state-of-the-art facilities and exceptional personal attention to your needs.

The Ohio Orthopedic Center of Excellence Features:

- Board Certified, Fellowship Trained Physicians
- Digital X-Ray
- MRI Diagnostics
- Osteoporosis Diagnosis, Prevention and Treatment
- Physical Therapy Services
- Outpatient Surgery onsite at the Ohio Orthopedic Surgery Institute

“World Class Care, First Class Caring” is the philosophy by which we approach each and every guest who visits our facility.

Our entire team is dedicated to making this health care experience the best you have ever had.

Thank you for the opportunity to be a partner in your road to recovery. Please, do not hesitate to ask any member of our staff for assistance.

Sincerely,

The Physicians and Staff at the Ohio Orthopedic Center of Excellence

### **Ohio Orthopedic Center of Excellence**

4605 Sawmill Road  
Upper Arlington, Ohio 43220

Phone 614-827-8700  
Fax 614-827-8701  
[www.ohio-ortho.com](http://www.ohio-ortho.com)

6840 Perimeter Drive  
Dublin, Ohio 43016

# Our Surgeons & Specialists

## Area of Specialty

	Foot & Ankle Surgery	Hand Surgery	Physical Medicine & Rehabilitation	Podiatry	Spine Surgery	Shoulder Reconstruction	Sports Medicine	Total Joint Replacement	Trauma
William D. Barker, M.D.							✓		
Kelley Clem, M.D.							✓		
Peter H. Edwards, Jr., M.D.							✓		
William R. Fitz, M.D.			✓						
Milan B. Herceg, M.D.					✓				
James Latshaw, M.D.						✓	✓	✓	✓
Michael A. McShane, M.D.								✓	
Paul G. Melaragno, M.D.								✓	
William R. Miely, M.D.					✓				
Joseph Mileti, M.D.						✓	✓	✓	✓
John FM. O'Leary, M.D.								✓	✓
David B. Robie, M.D.							✓		
William Scott, D.P.M.				✓					
Mark J. Triffon, M.D.							✓		
Kurt L. Unverferth, M.D.								✓	
Louis J. "Jack" Unverferth, M.D.							✓		
Scott Van Aman, M.D.	✓								✓
Scott J. Van Steyn, M.D.							✓		✓
Marlo O. Van Steyn, M.D.		✓							✓
Nancy M. Vaughan, M.D.			✓						
Larry W. Watson, M.D.							✓		
Claire V. Wolfe, M.D.			✓						
John S. Wolfe, M.D.								✓	



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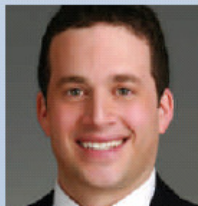
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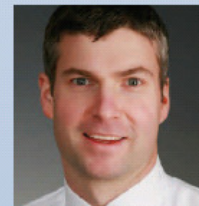
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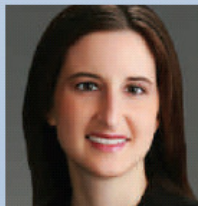
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# The Ohio Orthopedic Center of Excellence ... Our Areas of Expertise ...

## Foot & Ankle Surgery

With fellowship trained and board certified foot and ankle surgeons, Ohio Orthopedic Center of Excellence offers the complete spectrum of world class foot and ankle care. Many problems can be solved with conservative management which may include directed physical therapy, accommodative shoe modification, orthotics, bracing and casting, as well as diagnostic and therapeutic injections. When surgery is necessary, our specialists offer the most advanced reconstructive techniques for this complex area of the body.

Common Pathologies:	Common Surgical Procedures:
Athletic injuries	Ankle Arthroscopy
Arthritis and Tendonitis	Arthritis Reconstruction and Fusion
Diabetic Complications	Bunion and Hammertoe Correction
Fractures and Dislocations	Flatfoot Reconstruction
Neuromuscular Disorders	Fracture Reduction
Post-Traumatic Deformity	Tendon and Ligament Repair
Rheumatologic Conditions	

## Hand Surgery

The Hand is a very special area of the body made up of a complex system of bones, joints, nerves, tendons and ligaments. As such, advanced training that of general orthopedics is helpful to properly evaluate and correct injury or deformity. Ohio Orthopedic Center of Excellence offers fellowship trained expertise in the field of hand surgery.

Common Pathologies:	Common Surgical Procedures:
Trigger Finger	Carpel Tunnel Release
Hand and Wrist Arthritis	Trigger Finger Release
Hand and Wrist Fracture	Wrist Fracture Fixation
DuPuytren's Contracture	Ganglionectomy
Work and Sport Injury	Metacarpal Fracture Fixation
Nerve Compression	

## Physical Medicine & Rehabilitation

With specialized training in pain and function, "Physiatrists" are qualified experts in the non surgical treatment of injury or illness. Ohio Orthopedic Center of Excellence physiatrists are specially trained in the area of nerves, muscles, and bones and as such are experts in treating a wide variety of conditions from the back and neck to the extremities with the goal of reducing pain and increasing activity or performance without surgery.

Common Conditions:	Procedures/Treatments:
Arthritis	Lumbar Epidural Steroid Injections
Low Back Pain	EMG
Neck Pain	Cervical & Lumbar Facet Joint Nerve Ablations
Fibromyalgia	Radiofrequency Facet Joint Nerve Ablations

## (Physical Medicine & Rehabilitation Continued)

Common Conditions:	Procedures/Treatments:
Traumatic Injury	Pain Management
Work or Sport Related Injury	Trigger Point Injections
Post Polio	

## Podiatry

At the Ohio Orthopedic Center of Excellence we pride ourselves on the complete care of each individual patient. Podiatry in conjunction with our certified foot and ankle surgeon(s) offers a truly integrated approach to the expert foot and ankle care of each patient. With a focus on prevention, diagnosis, and complete care, our integrated team of foot and ankle surgeons and specialists offer personalized and complete world class care.

Common Conditions:	Procedures/Treatments:
Bunions	Diabetic Foot Infections
Hammer Toes	Foot Wound Care
Ingrown Nail/Nail Infection	Plantar Fasciitis
Neuromas	Warts
Heel/Ankle Pain	

## Spine Surgery

Perhaps one of the more delicate areas of the human body is the spine. With its complex system of nerves it is of the utmost importance that your spine surgeon has the knowledge, training, and experience to perform. Ohio Orthopedic Center of Excellence spine surgeons are renowned for their expertise and positive outcomes in the field of spine surgery. Board certified and fellowship trained, they offer the highest level of surgical expertise in this delicate area of the body.

Common Conditions:	Common Procedures:
Degenerative Disc Disease	Cervical Spine Surgery
Stenosis of the Spine	Lumbar Spine Surgery
Spinal Trauma	Minimally Invasive Spine Surgery
Scoliosis	Spinal Microsurgery
Compression Fractures	Disc Replacement
Spondylolisthesis	Spinal Fusion
Herniated Discs	

## Shoulder Reconstruction

While often less common than total knee or hip joint surgery, total shoulder surgery can be as effective. Many advancements have been made in the specialized field of Shoulder Reconstruction that offer effective surgical intervention and subsequently reduce pain and improve motion for this important joint of our body. The shoulder reconstructive specialists at Ohio Orthopedic Center of Excellence bring with them advanced expert training from world renowned programs such as the Mayo Clinic and Charles Rockwood facility. When conservative treatments fail, these specialized surgeons are ready and able to help.

## (Shoulder Reconstruction Continued)

Common Conditions:	Common Procedures:
Shoulder Arthritis	Total Shoulder Replacement
Shoulder Fracture	Reverse Total Shoulder
Shoulder Trauma	Shoulder Arthroscopy
Rotator Cuff Tears	Elbow Arthroscopy
Athletic Shoulder & Elbow Injuries	Rotator Cuff Repair

## Sports Medicine

From professional to youth athletes, the fellowship trained Sports Medicine surgeons and specialists at Ohio Orthopedic Center of Excellence provide expert care in the diagnosis, treatment and prevention of injuries that occur primarily during sports and other physical activity. Actively helping to advance the science of sports medicine, these specialists stay continually at the forefront of injury prevention, diagnosis, treatment, surgery, full service rehabilitation, and performance enhancement.

Common Conditions:	Common Treatments:
Shoulder, Elbow, Knee Injuries	Arthroscopic Surgery (Knee, Elbow, Shoulder)
Fractures	Rotator Cuff Repair
Athletic Injuries	ACL Reconstruction
ACL and/or Meniscal Tears	Cartilage Transplant
Rotator Cuff Tear	Plasma Injections
Arthritis	Visco Supplementation
	Fracture Care

## Total Joint Replacement

When it comes to advancing technology, the field of total joint replacement continues to experience unparalleled growth. With advances in surgical devices, implants, techniques, medications, and rehabilitation, patients are able to look forward to faster recovery, less pain, better motion, and longer lasting implants than ever before. Leading the way in these quality focused advancements are the fellowship trained total joint surgeons of Ohio Orthopedic Center of Excellence. Personalized detail with each patient ensures that each patient receives the most appropriate device and technique to provide the best outcome.

Surgical Procedures:
Total Knee Replacement
Total Hip Replacement
Revision of Knee and Hip Replacement
Orthopedic Trauma and Fracture Care
Total Shoulder Replacement

OOCE is pleased to offer educational information on orthopedic conditions and procedures. For your convenience, this information is located in an "orthopedic educational animations" portal on our website, [www.ohio-ortho.com](http://www.ohio-ortho.com) and can be viewed and even printed in a brochure format.



World-class care.

First-class caring.

## Ohio Orthopedic Center of Excellence Financial Policy

**All new patients are required to present a copy of their health insurance card. If you are unable to do so, you will be considered self pay and will be required to follow our self payment policy as explained below under “Self Pay Patients”.**

**Co-Payments:** If your insurance policy requires a co-payment you are required to make that payment at the time of visit. **We accept cash, personal checks, and Visa, MasterCard, Discover, and American Express credit cards.** If you are not able to pay for your co-payment at the time of service, you will be asked to reschedule your appointment.

**Worker’s Compensation Claims:** If your injury is a work related injury we request that you notify the front desk when checking in. We also request that you have available your worker’s compensation claim number, the date of injury, and the name of the Managed Care Group that will be handling the claim. You will also be asked to present a copy of your health insurance card for your records. If your claim is denied, you or your health insurance will be billed.

**Self Pay Patients:** If you are not covered by a health insurance policy you will be required to follow our self payment policy. This policy requires that all new patients pay a deposit of \$135 at their first visit and \$90 at any subsequent visits at the time of check in. **This is only a deposit and any balance over the deposit will be billed to you.** Any surgeries or diagnostic testing (EMG, MRI, Bone Density) require that you contact our Billing Department to set up a payment schedule prior to the surgery. You can reach the Billing Department at 614-827-8700.

**Auto Accidents and Liability Claims:** If your visit is related to an auto accident or a liability injury you will be required to follow our Auto Accident/Liability Claim policy which requires the same deposit/payment plan for self pay patients. Please notify the front desk and they will give you a copy of the policy if you have not already received one. You will be required to make these deposits at time of check-in. You will also be required to present a copy of your health insurance card for our records. Be prepared to give information on the auto insurance company and/or lawyer you are dealing with, phone number, contact name, claims number and any other pertinent information related to your claim.

**Forms Completion Fees:** There is a fee for the physician to complete forms for you. The fee is \$5.00 for each page but will not exceed \$25.00 for each set of forms. It is important all areas of the form to be completed by you, is done at the time you submit for physician portion. This includes but is not limited to disability insurance forms and family leave of absence forms.

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# Ohio Orthopedic Center of Excellence

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE READ IT CAREFULLY.**

**This Notice is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.** This practice has an obligation to maintain all medical information in the strictest of confidence. Our practice cannot release information without your written consent, including medical records, conversations, reminder calls, test results and other confidential issues. Patient information about health care is identified as “PHI” or protected health information. This new policy requires that you, the patient, identify at the time of registration with us specific information about release of information. **You can change this information at any time with written notification or verbal notification, followed up in writing.** Changes can only impact the care or information from that point forward.

## **Uses and Disclosures**

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of **Ohio Orthopedic Center of Excellence**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

We will share your protected health information with third party “business associates” that perform various activities (transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

## **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to object.**

We may disclose your protected health information in the following situations without your consent or authorization. These situations include:

**Required by Law.** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Law enforcement.** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Health Oversight.** We may disclose protected health information to health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system.

**Abuse or Neglect.** We may disclose your protected health information to a public authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Coroners, Funeral Directors, and Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Worker's Compensation.** Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-established programs.

**Inmates.** We may disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

## **Additional Uses of Information**

**Appointment reminders.** Your health information will be used by our staff to call/send you appointment reminders.

Who may we leave this information with over the phone?

Can we leave a message on voicemail or answering machine?

Can we email you with this information?

**Information about treatments.** Your information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

## **Individual Rights**

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclose of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

## **Ohio Orthopedic Center of Excellence Duties**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

## **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next visit. The revised policies and practices will be applied to all protected health information that we maintain.

## **Information Requests to inspect protected Health Information**

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our medical records department.

## **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Office of Civil Rights – Regional Manager Department of Health & Human Services  
233 N. Michigan Avenue, Suite 240 Chicago, Illinois 60601**

**Patient Information Manager  
Ohio Orthopedic Center of Excellence  
4605 Sawmill Rd., Ste.-100  
Upper Arlington, OH 43220  
614-827-8700**

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

**You will not be penalized or otherwise retaliated against for filing a complaint.**

EFFECTIVE DATE 04/14/03  
Revised 1/06 LA

# Ohio Orthopedic Center of Excellence

## Privacy Consent- For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

**I hereby give my consent to OHIO ORTHOPEDIC CENTER OF EXCELLENCE to use and disclose my protected health information for the purposes of treatment, payment and operations of my healthcare and this practice.**

**Consent for treatment:** I, with my signature, authorize Ohio Orthopedic Center of Excellence and any employee working under the direction of the physician, for the purpose of evaluating my health, diagnosing medical condition, and providing treatment.

**Consent for payment and operations:** I also authorize this practice to furnish my health information as needed to obtain payment for my health care services. This may include certain activities that my insurance plan may undertake before it approves or pays for health care services we recommend, such as: making determination of eligibility or coverage for insurance benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care.

**Consent related to the Privacy Notice:** I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice Privacy Officer by phone or writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Patient Name Printed \_\_\_\_\_ DOB: \_\_\_\_\_

Guardian Name Printed (if Applicable): \_\_\_\_\_

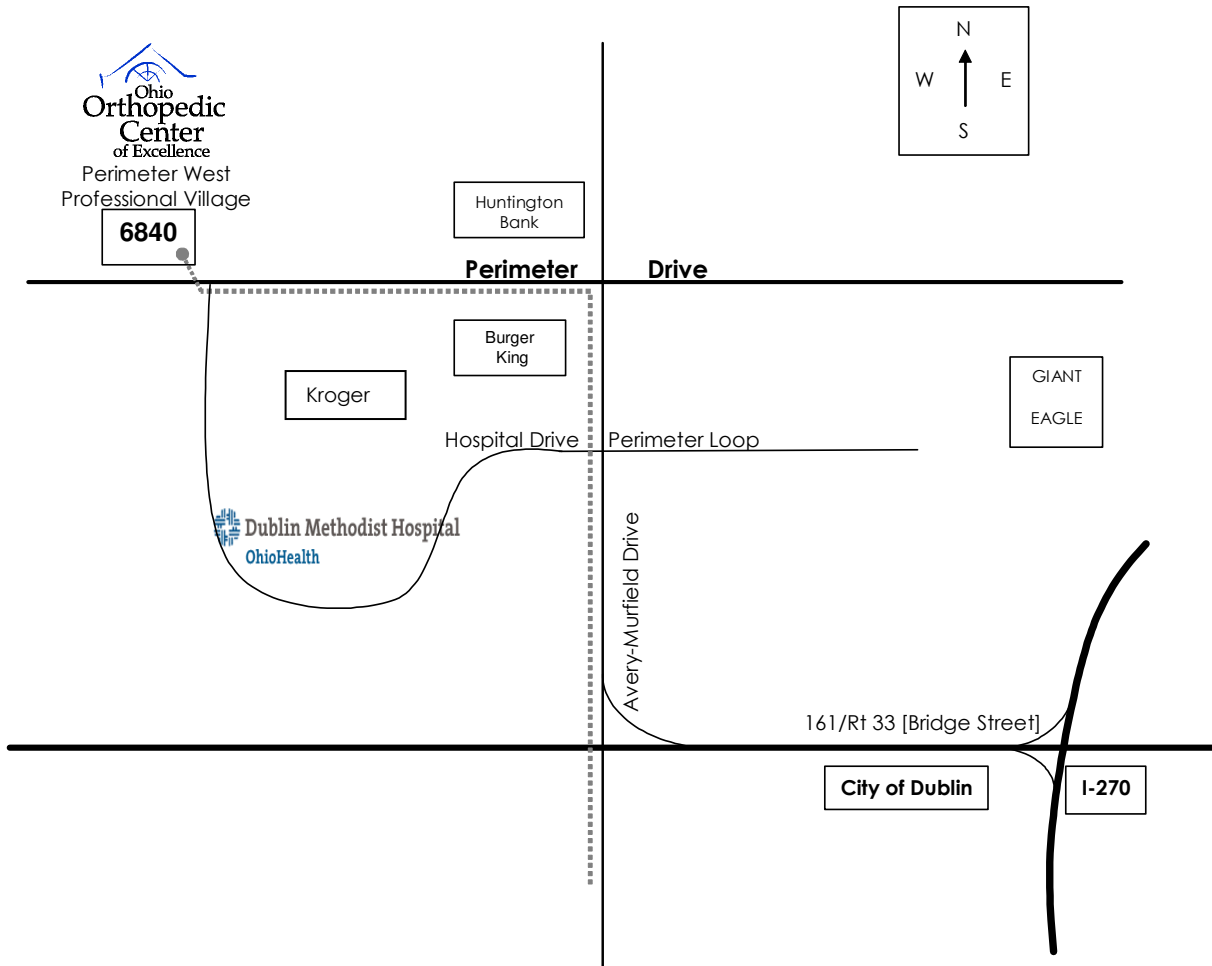
Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not Patient, relationship: \_\_\_\_\_

Patient unable to sign due to: \_\_\_\_\_ Refusal to sign Date: \_\_\_\_\_

# PERIMETER ROAD OFFICE

6840 Perimeter Drive · Dublin, Ohio · 43016



## Directions from North:

- Take 23 or 71 South to I-270 West
- Take the 161 West (this is exit #17B)
- Take a right onto Avery-Muirfield Drive
- Followed by a left onto **Perimeter Drive**
- Our center is on the right

## Directions from South:

- Take I-270 West and take the 161 West (this is exit #17B)
- Take a right onto Avery-Muirfield Drive
- Followed by a left onto **Perimeter Drive**
- Our center is on the right

## Directions from West:

- Take I-270 North and take the 161 West (this is exit #17B)
- Take a right onto Avery-Muirfield Drive
- Followed by a left onto **Perimeter Drive**
- Our center is on the right

## Directions from East:

- Take I-270 North around to the 161 West (this is exit #17B) Take a right onto Avery-Muirfield Drive
- Followed by a left onto **Perimeter Drive**
- Our center is on the right

Patient Profile

Doctor: \_\_\_\_\_ Appointment Date/ Time \_\_\_\_\_

Patient Information:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Cell  Other  
Phone: \_\_\_\_\_  Home  Work  Cell  Other

Patient ID #: \_\_\_\_\_ Med. Rec. #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Sex \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Patient Employment:

Employed?  Yes  No  
Place of Employment: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_  
Occupation: \_\_\_\_\_

Primary Insurance:

Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Co-pay: \_\_\_\_\_

Responsible Party: Same as Patient:  Yes  No

Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Secondary Insurance:

Insured Party: \_\_\_\_\_  
Insured Phone: \_\_\_\_\_  
Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Co-pay: \_\_\_\_\_

Emergency Contacts:

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**DATE OF INJURY OR ONSET OF PROBLEM:** \_\_\_\_\_  
**ACCIDENT RELATED: Y N WORK RELATED? Y N AUTO ACCIDENT? Y N**  
**IF WORK RELATED INJURY:**  
**EMPLOYER AT TIME OF INJURY: \_\_\_\_\_ INDUSTRIAL CLAIM # \_\_\_\_\_**

**AUTHORIZATION:** I hereby authorize OOCE, Inc. to furnish information to insurance carriers concerning this illness/accident and assign to the doctor all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by my insurance

χ \_\_\_\_\_  
**Responsible party Signature** **Date**

**FOR PATIENTS WITH MEDICARE, PLEASE READ AND COMPLETE THE FOLLOWING:**

I certify that the information given by me applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its intermediaries or carrier, information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

χ \_\_\_\_\_  
**Responsible party Signature** **Date**

**MEDICAL HISTORY Page 1 of 2**

*The following information is very important to your health, please take time to fully and accurately complete this form.*

PATIENT NAME:		ACCOUNT NO:	Date:
SS#:	Referring Physician Information:		Family Physician Information:
DATE OF BIRTH:	Name:	Name:	
Weight	HEIGHT	Age	Address:
<input type="checkbox"/> LEFT HANDED <input type="checkbox"/> RIGHT HANDED		Address:	Phone:
Occupation: _____		Place of Employment: _____	

**MEDICATIONS (List all current medications - prescription and non-prescription, vitamins and supplements)**

Medication	Dose and How Often	Medication	Dose and How Often

**ALLERGIES and REACTIONS (List allergies to Medications, Metals or Latex)**

Name of Allergy Item	Reaction	Name Allergy Item	Reaction

**HISTORY OF PRESENT PROBLEM**

Describe your problem or reason for your visit.

Is your problem the result of an injury? If YES, how did the injury occur? \_\_\_\_\_ Date of Injury \_\_\_\_\_

YES  
 NO

Where did the injury occur?(work, home, car etc) \_\_\_\_\_

**EVALUATION OF PAIN / DISCOMFORT**

What body part is affected? \_\_\_\_\_  LEFT  RIGHT

When did the problem start? \_\_\_\_\_

When does the problem occur? \_\_\_\_\_ How long does it last? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

What makes it feel worse? \_\_\_\_\_

PAIN SCALE	MILD	MODERATE	SEVERE
(Circle one number)	NO PAIN	1 2 3	4 5 6 7 8 9 10 SEVERE PAIN

What activities are you unable to do because of pain? \_\_\_\_\_

Does pain wake you during sleep?  NO  YES, Details: \_\_\_\_\_

**PREVIOUS TREATMENT FOR THIS PROBLEM**

Diagnostic Testing:  X-RAY  CT  MRI  EMG  OTHER: \_\_\_\_\_

Medications: \_\_\_\_\_

Physical Therapy/ Location: \_\_\_\_\_

Other treatment for this injury:	Names of Physicians
Have other Physicians seen you for this problem? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is this condition being covered by Worker's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Is there a lawsuit or litigation pending in regard to your injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Last Date Worked: \_\_\_\_\_

Current Work Restrictions \_\_\_\_\_ By Whom? \_\_\_\_\_

**TURN TO COMPLETE PAGE 2**

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

LIST PRIOR SURGERIES		LIST BROKEN BONES	
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:
Description:	Date:	Description:	Date:

**PAST MEDICAL HISTORY / CURRENT DIAGNOSES** Check all that apply

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Bladder Disease
<input type="checkbox"/> Staph Skin Infection	<input type="checkbox"/> Cancer	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Thyroid (Hypo or Hyper)	<input type="checkbox"/> Gout	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Prostate
<input type="checkbox"/> Parathyroid	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Blood Clots in legs or lungs	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Vascular Disease (Circulation problems)	<input type="checkbox"/> Skin Disorder
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pregnancy (Current or recent) Date: _____	<input type="checkbox"/> Gastrointestinal Disease	<input type="checkbox"/> Physician treatment for Sleep Apnea	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Problems with Anesthesia in the past, if yes: <input type="checkbox"/> Confused <input type="checkbox"/> Out of it <input type="checkbox"/> Nausea <input type="checkbox"/> Other _____	<input type="checkbox"/> Asthma	<input type="checkbox"/> Use a Breathing Aparatus at Night	<input type="checkbox"/> Other _____

**FAMILY HISTORY**

<input type="checkbox"/> Blood Clots in legs or lungs	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Muscle or Bone Disease	<input type="checkbox"/> Malignant Hyperthermia
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other: _____

**SOCIAL HISTORY**

Married  Single  Divorced  Widow/ Widower  Separated

**RESIDENCE**

Alone  With Family  With Friends  Nursing Home Retirement Home

Name of assisted living facility: \_\_\_\_\_  Other: \_\_\_\_\_

**USER OF:**

Tobacco: <input type="checkbox"/> No <input type="checkbox"/> Yes Pks/Day: _____ # of years _____	Alcohol: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor # of Servings _____ <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Other _____	Illicit Drug Use: <input type="checkbox"/> No <input type="checkbox"/> Yes Type: _____
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**CURRENT SYMPTOMS** Check all that apply (Review of Systems)

<input type="checkbox"/> Weight loss or gain	<input type="checkbox"/> Frequent or unusual headaches	<input type="checkbox"/> Nausea
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Fever	<input type="checkbox"/> Mouth or dental infections	<input type="checkbox"/> Diarrhea-Chronic
<input type="checkbox"/> Chills	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Frequency of urine
<input type="checkbox"/> Rashes	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Urgency of urine
<input type="checkbox"/> Birthmarks	<input type="checkbox"/> Productive cough	<input type="checkbox"/> Retention of urine
<input type="checkbox"/> Open wound or sores	<input type="checkbox"/> Chest pain or pressure	<input type="checkbox"/> Pain with urination
<input type="checkbox"/> Drainage	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Multiple joint pain	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Loss of sensation
<input type="checkbox"/> Multiple joint swelling	<input type="checkbox"/> Blood clots in legs or lungs	<input type="checkbox"/> Depression
<input type="checkbox"/> Multiple joint stiffness	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Episodes of mania
<input type="checkbox"/> Generalized muscle weakness	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Inability to sleep
<input type="checkbox"/> Deformity	<input type="checkbox"/> Traveled in past month how far? _____	<input type="checkbox"/> Other _____

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

By signing this form I attest that the above information is true and correct to the best of my belief

**HISTORY REVIEWED BY:**

Name: \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_

*Thank You*