

# Welcome to OrthoNeuro

## Martin T. Taylor, D.O., Ph.D.

**OrthoNeuro**  
A Multi-Specialty Center of Excellence

Your appointment is for a neurologic consultation with Dr. Martin Taylor. He is board certified in neurology and he completed his residency at the University of Rochester in Rochester, New York. He is originally from Texas and earned his medical degree from the University of North Texas Health Science Center in Fort Worth. He also holds a Ph.D. in biomedical science from the same institution.

A neurologist is a fully licensed physician (D.O. or M.D.) with special training in disorders of the nervous system including the brain, spinal cord, and peripheral nerves. Neurologists do not perform surgery but they work closely with neurosurgeons and orthopedic surgeons in cases that require a surgical consultation. As a general neurologist, he diagnoses and/or treats all of the conditions listed to the right. Dr. Taylor's special interests and areas of expertise are listed below.

### **Botulinum Toxin (Botox®) Therapy**

Dr. Taylor has extensive training and experience in the use of Botox® to treat multiple medical conditions. This amazing medication can be used to treat many conditions of muscle dysfunction. Treatments performed in our office include the treatment of conditions such as neck and back pain, tension headaches and migraines, torticollis, facial spasm, spasticity associated with stroke, cerebral palsy or multiple sclerosis, hyperhidrosis (excessive sweating), fibromyalgia, and jaw pain. Neurocosmesis (Cosmetic Botox®) is also performed.

### **Non-Surgical Treatment of Neck, Head and Neuropathic Pain**

Multiple minimally invasive techniques are used along with medications to reduce symptoms of pain and to improve quality of life and sleep patterns which are commonly disrupted in chronic pain. These may include the use of physical therapy, counseling, muscle injections such as trigger point injections or Botox®, nerve block or spinal electrical stimulation as appropriate. Narcotic medications are used in select patients for occasional use only.

### **Nerve Conduction Studies (NCS)/Electromyography (EMG)**

This testing is an important diagnostic tool for the evaluation of muscle and nerve-related problems. This testing can help determine the cause of symptoms such as numbness, tingling, muscle weakness and arm/leg or neck/back pain.

### **Clinical Research**

New medical treatments are currently being tested for headaches and other pain syndromes.

Please feel free to ask for more information regarding these services and treatments for yourself or for family/friends.

### **What Conditions are Diagnosed and Treated by a Neurologist?**

- ALS (Lou Gehrig's Disease)
- Balance Problems
- Bell's Palsy
- Brain Tumors
- Carpal Tunnel Syndrome
- Cerebral Palsy
- Dementia (i.e. Alzheimer's Disease)
- Dizziness
- Guillan-Barre Syndrome
- Head Trauma
- Hydrocephalus
- Movement Disorders
  - Dystonia
  - Huntington's Disease
  - Parkinson's Disease
  - Tourette's Syndrome/Tics
  - Torticollis
  - Tremor
  - Writer's Cramp
- Multiple Sclerosis
- Muscular Dystrophy
- Myasthenia Gravis
- Myopathy (muscle weakness)
- Neuropathy (disease of the peripheral nerves)
- Numbness/Tingling
- Pain Syndromes
  - Back pain
  - Headache
  - Migraine
  - Neck pain
  - Neuropathic Pain
  - Trigeminal Neuralgia
- Pseudotumor Cerebri
- Radiculopathy (pinched nerve in the neck or back)
- Restless Legs Syndrome
- Seizures/Epilepsy
- Sleep Disorders
- Stroke
- Spasticity
- Syncope (passing out spells)
- TIA (Transient Ischemic Attack)
- Transverse Myelitis



### **What is Our Philosophy of Care?**

We are dedicated to providing the highest quality of neurological care. We pride ourselves on being up to date on the latest developments in diagnostic testing, treatments and techniques for neurological conditions. Our knowledge is passed on to our patients through educational discussions and various reading materials. It is very important that our patients understand their neurological diagnosis and that they feel comfortable with the treatment plan. We encourage questions during your visit or at any time a concern may arise.

As osteopathic physicians, we believe in the body's innate ability to heal itself. We realize that our role is to facilitate this process. The patient's role in maintaining or restoring health is pivotal. This participation may involve such things as discontinuing the use of tobacco products, altering dietary habits, exercising and maintaining awareness of your body symptoms or simply taking medications as directed on a regular basis. Therapeutic decisions are made through a mutual agreement between the patient and physician. Based on their individual needs, patients may be referred for testing or for consultation with other physicians or health care professionals. Neurological conditions frequently require working with specialists in areas such as physical therapy, health psychology and sleep medicine. Our practice encourages patients to work toward achieving wellness utilizing the best that both drug and non-pharmacologic treatment can offer through a multidisciplinary approach.

The physicians and staff realize that the patient is not the only one affected by illness. Often the entire family is affected and needs to be involved in maximizing the patient's health. Family members are encouraged to attend office visits and ask questions. As appropriate, we will put you in touch with support groups and other organizations to help you live with and understand your illness.

### **The first in focus.**

Founded more than 60 years ago, OrthoNeuro was the first private group in central Ohio to provide a multi-disciplinary center specializing in orthopedic surgery, sports medicine, neurology, neurosurgery and physical medicine and rehabilitation.

### **The foremost in care.**

Our focus ensures that our patients receive the highest quality of care in an environment that's committed to personal attention.

Our **SportMed** program provides comprehensive sports medicine care from injury prevention to injury treatment and rehabilitation.

Our **SpineMed** program calls upon a multi-disciplinary team of surgeons, physical medicine and rehabilitation physicians along with therapists to diagnose, treat and rehabilitate spinal injuries.

Our **WorkMed** program provides treatment and rehabilitation for industrial and occupational-related injuries. OrthoNeuro specializes in musculoskeletal and neurological disorders in the following areas:

#### **Orthopedic Services**

- Orthopedic Surgery
- Fracture Care
- Foot & Ankle Surgery
- Spine Surgery
- Arthroscopic Surgery
- Sports Medicine
- Hand Surgery
- Joint Replacement
- Spine Disorders

#### **Neurologic Services**

- Neurology
- Migraine Treatment
- Occupational Medicine
- Neurosurgery
- Headache Treatment
- Industrial Medicine

#### **Physical Medicine and Rehabilitation**

- EMG/EEG
- Physical Medicine
- Rehabilitation

#### **Imaging**

#### **Physical Therapy and Rehabilitation**

Spine**Med**

Sport**Med**

Work**Med**

**OrthoNeuro**

A Multi-Specialty Center of Excellence

### Patient Registration Form

**Please Complete Both Sides Entirely**

www.orthoneuro.com

Today's Date: \_\_\_\_\_

Last Name: _____		First Name: _____		M.I.: _____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			
Are you a student? <input type="checkbox"/> Yes		<input type="checkbox"/> No	Name of School: _____		
Spouse's Name: _____		SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Emergency Contact: _____		Phone: (____) _____ - _____		Relation to Patient: _____	

**If the patient is a minor under age 18, please list the responsible party.**

Last Name: _____		First Name: _____		Relation to Patient: _____	
Sex: <input type="checkbox"/> Male	<input type="checkbox"/> Female	SS#: _____ - _____ - _____		Date of Birth: ____/____/____	
Address: _____		City: _____		State: _____ Zip: _____	
Home Phone: (____) _____ - _____		Cell Phone: (____) _____ - _____		Other: (____) _____ - _____	
Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	<input type="checkbox"/> Other _____
Are you employed? <input type="checkbox"/> Yes		<input type="checkbox"/> No	<input type="checkbox"/> Disabled	<input type="checkbox"/> Retired	<input type="checkbox"/> Other _____
Employer: _____		Employer Phone: (____) _____ - _____			

### Medical Insurance Information

Primary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		<b>Insured DOB:</b> ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

Secondary Insurance Company: _____		Phone: (____) _____ - _____			
Claims Address: _____		City: _____		State: _____ Zip: _____	
Subscriber ID / Policy Number: _____		Group Number: _____			
Name of Insured: _____		<b>Insured DOB:</b> ____/____/____			
Insured's SS#: _____ - _____ - _____		Insured Employer: _____			

**For Workers' Compensation Claims – Please complete the following:**

Employer at time of injury: \_\_\_\_\_ Date of injury: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Workers' Comp Insurance Co: \_\_\_\_\_ CLAIM #: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Doctor of record for this claim: \_\_\_\_\_

**For Auto, or "Other" Insurance Claims – Please complete the following:**

Date of Accident or Injury: \_\_\_\_\_ CLAIM #: \_\_\_\_\_  
Auto or "Other" Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Adjuster's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
\_\_\_\_\_

**Is the patient allergic to any medications?**  Yes  No If yes, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How did you hear about us?**

Yellow Pages  Friend / Family Member / Patient  
 Internet Website  Advertisement  
 Physician (please complete below)  Other \_\_\_\_\_  
Referred By: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Do you have a Primary Care Physician (PCP)?  Yes  No  
Primary Care Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
\_\_\_\_\_

If you have any questions, or are not sure how to answer any of these questions, please do not hesitate to ask for help.

Is this visit related to an accident or injury?  Yes  No  
Is this visit related to an accident, injury or otherwise, related to your workplace?  Yes  No  
Is this visit related to an accident or injury at a school event?  Yes  No  
Is this visit related to an auto accident or injury?  Yes  No  
Is this visit related to an accident or injury other than auto, employment, or school event?  Yes  No  
If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to OrthoNeuro Consultants. I authorize OrthoNeuro Consultants to release any information, acquired in the course of my treatment, needed for my medical insurance claim(s). A photocopy of this authorization is to be considered valid as the original until revoked by me in writing. I understand that I am financially responsible for all charges made to my account whether or not an insurance company, attorney or other third party payor is involved with payment. I understand that I am responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. I understand that copays are expected at the time services are rendered.

I certify that the above information is correct to the best of my knowledge.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name \_\_\_\_\_

Date \_\_\_\_\_

**Review of Systems Continued**

	<u>Yes</u>	<u>No</u>
Any pain in your abdomen? .....	___	___
Do you have nausea or vomiting? .....	___	___
Do you suffer from constipation or diarrhea? .....	___	___
Do you have burning or pain on urination? .....	___	___
Do you urinate frequently? .....	___	___
Do you have sexual dysfunction? .....	___	___
Do you have weakness in the arms or legs? .....	___	___
Do you have tingling/numbness of the arms or legs? .....	___	___
Do you suffer from headaches or facial pain? .....	___	___
Do you suffer from neck or back pain? .....	___	___
Do you have joint pain or swelling? .....	___	___
Do you often feel depressed? .....	___	___
Do you often feel anxious or nervous? .....	___	___
Do you have problems falling or staying asleep? .....	___	___
Do you have problems with your memory? .....	___	___

(Physician Comments)

**Past Medical History**

Do you suffer from any of the following conditions?

_____ High blood pressure	_____ High cholesterol	_____ Cancer
_____ Diabetes	_____ Stroke	_____ Heart disease
_____ Depression	_____ Thyroid disease	_____ Blood clots
_____ Anxiety	_____ Arthritis	_____ Ulcers/GI reflux
_____ Migraines	_____ Seizure	_____ Lung Disease

Please list any other medical conditions.

**Family History**

Please comment on any close relatives with the following illnesses.

Include which side of the family (ie. Mother's Brother, Father's Mother)

<u>Condition</u>	<u>Relation</u>	<u>Condition</u>	<u>Relation</u>
_____ Headaches	_____	_____ Cerebral aneurysm	_____
_____ Stroke	_____	_____ Cancer	_____
_____ High Blood Pressure	_____	_____ Diabetes	_____
_____ Lung Disease	_____	_____ Seizures	_____
_____ Depression	_____	_____ Anxiety	_____
_____ Blood Clots	_____	_____ High Cholesterol	_____
_____ Arthritis	_____	_____ Other _____	_____
_____ Other _____	_____	_____ Other _____	_____



Name \_\_\_\_\_

Date \_\_\_\_\_