



**FAMILY HISTORY****Do any of your close relatives have?**

- Cancer (Type: \_\_\_\_\_)    Heart disease    Bleeding disorders    Blood clots  
Stroke    High blood pressure    Diabetes    Other: \_\_\_\_\_

**REVIEW OF SYSTEMS****Do you have any of the following?****Constitutional:**  Fevers  Chills  Weight loss  Weight Gain**Skin:**  Rashes  Bruising  Ulcers  Itching  Redness**Gastrointestinal:**  Heartburn or ulcers  Nausea  Vomiting  Diarrhea  Bloody stools**Endocrine:**  Diabetes  Thyroid disease  Heat or cold intolerance  Excessive thirst or urination**Eye:**  Blurred vision  Double vision  Vision loss  Corrective lenses**ENT:**  Hearing loss  Hoarseness  Trouble swallowing**Cardiovascular:**  Chest pain  Palpitations  Fainting  Murmurs**Respiratory:**  Cough  Shortness of breath  Wheezing  Snoring**Genitourinary:**  Painful Urination  Blood in the urine  Incontinence  Difficult urination**Neurologic:**  Headaches  Dizziness  Seizures  Weakness  Tremors  Numbness/Tingling**Psychiatric:**  Depression  Drug/alcohol addiction  Sleeping disorder  Hallucinations**Hematologic:**  Easy bleeding  Easy bruising  Anemia**Musculoskeletal:**  Joint Pain  Swelling  Stiffness  Instability  Muscle pain  Redness  Heat**ARE YOU POSITIVE or HAVE YOU BEEN EXPOSED TO:**  HIV  AIDS  Hepatitis C**SOCIAL HISTORY****Smoking status:**  Nonsmoker  Current smoker  Former smoker (year quit: \_\_\_\_\_)**Do you drink alcohol?**  Yes  No **How many drinks?** \_\_\_\_\_ **How often?** \_\_\_\_\_ **Do you use any illegal drugs?**  Yes  No**Are you Working?**  Yes  No **Where?** \_\_\_\_\_ **Occupation?** \_\_\_\_\_**SIGNATURES**

SIGNATURE OF PATIENT

Date:

SIGNATURE OF PERSON FILLING OUT THIS FORM (IF DIFFERENT FROM ABOVE)

Date:

**PLEASE DO NOT WRITE BELOW THIS LINE (OFFICE USE ONLY)**

PHYSICIAN SIGNATURE

Date

**OrthoNeuro Authorizations and Financial Policy**

**Section 1: Appointment of Personal Representative to Receive Protected Health Information**

You may rely upon your spouse, relatives or friends to be involved in your medical care. OrthoNeuro can disclose your Protected Health Information to these people if you appoint them as your "personal representatives." To appoint an individual as your personal representative, complete this section:

**I hereby appoint the following individual as my personal representative:**

**Name:** \_\_\_\_\_ **Relationship to me:** \_\_\_\_\_

**I hereby authorize OrthoNeuro to disclose the following Protected Health Information to my personal representative:**

All Protected Health Information

*OR One or more of these choices:*

Times of Appointments

Test Results

Prescriptions & Ancillary Equipment

Copies of Medical Records

Other \_\_\_\_\_

I may revoke my appointment of a personal representative at any time in writing. I understand that revocation of my appointment will NOT affect any action OrthoNeuro took in reliance on my appointment before it received written notice of my revocation. **Please initial:** \_\_\_\_\_

**Section 2: Receipt of Notice of Privacy Practices**

I hereby acknowledge receiving a copy of OrthoNeuro's Notice of Privacy Practices that outlines my privacy rights and explains how OrthoNeuro is permitted to use and disclose my Protected Health Information. I should call OrthoNeuro's Privacy Officer at (614) 890-6555 if I have a question or concern about my privacy rights. **Please initial:** \_\_\_\_\_

**Section 3: Patient Information**

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Language: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Section 4: Photography and Recording Policy**

Patients, family members, and other visitors shall not take photographs and shall not record video or audio in OrthoNeuro's offices.

This policy includes recording an individual's voice using technology capable of capturing audio and recording an individual's likeness using photography, video recording or any technology capable of capturing an image. **Please initial:** \_\_\_\_\_

**Section 5: Financial Policy**

**I have reviewed OrthoNeuro's Financial Policy and Authorizations (collectively, the "Financial Policy"), hereby acknowledge my responsibilities set forth in the Financial Policy, and hereby make the authorizations set forth in the Financial Policy. Please initial:** \_\_\_\_\_

**By signing below, I am acknowledging that I have read and understand the financial policy and authorizations of OrthoNeuro**

\_\_\_\_\_  
Patient Name (please print)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
If applicable, Parent/Guardian Name

\_\_\_\_\_  
If applicable, Parent/Guardian Signature

\_\_\_\_\_  
Date