

For every motion in life.

## Please Answer All Questions To Assist Us In Caring For You

Name Lname, Fname Date of Birth /DOB Age /Age  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_ Sex /Sex

- > What did you injure? \_\_\_\_\_ Date of injury or when symptoms started \_\_\_\_\_
- > What side did you injure? RIGHT LEFT BOTH
- > Is this a work related problem or injury for which a claim is being filed? YES NO (must answer)
- > Do you use tobacco products? YES NO If yes, what and how much? \_\_\_\_\_
- > Please list any medical problems you have. Examples: heart or lung disease, cancer, diabetes, hepatitis, HIV, anemia, stroke, blood clots, thyroid disease, high blood pressure....

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Please list any past surgeries you've had and the year occurred.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Please list all medications you are taking and the dosage.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Please list any allergies you have including medications.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

Do any close relatives have similar medical problems? What relative has what problem?

Are you presently experiencing any of these general medical symptoms? Circle all that apply.

<u>GU</u>	<u>Head &amp; Neck</u>	<u>Skin</u>	<u>Psych</u>
Urinary Problems	Headache	Change in Moles	Anxiety
Bloody Urine	Ringling in Ears	Skin Ulcers	Depression
Painful Urination	Loss of Vision	Rash	Confusion
Frequent Urination	Lumps or Ulcers	Itching	Memory Problems
	Tooth Pain	Bleeding Sores	
	Change in Voice		
	Ear Pain		

In relation to today's problem, do you have any of these symptoms? Circle all that apply.

Pain	Instability	Cracking Noises	Numbness
Swelling	Giving Way	Cracking Feelings	Tingling
Locking	Weakness	Redness or Warmth	Pain at night

What makes your problem worse? \_\_\_\_\_

What makes your problem better? \_\_\_\_\_

Is there anything else you would like us to know about your problem? \_\_\_\_\_

If you are 65+ years old, have you been screened (DXA scan) for osteoporosis? Y N Results: \_\_\_\_\_

Have you been prescribed medication to prevent/treat osteoporosis? Y N Meds: \_\_\_\_\_

I certify that the above information is fact and authorize OrthoNeuro to provide this information to my insurance company to assist in processing my medical claim in a timely manner.

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

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

## AUTHORIZATIONS

### **Section 1: 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: \_\_\_\_\_

### **Section 2: 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 3: 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 4: Patient Information**

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

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

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

**By signing below, I am acknowledging that I have read and understand this form.**

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
If applicable, Parent/Guardian Name  
(Please Print)

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

\_\_\_\_\_  
Date