Ortho***Neuro***

For every motion in life.

Orthopedic History

Please Answer All Questions To Assist Us In Caring For You

Name _____ Date of Birth _____ Age _____

Height _____ Weight _____ Occupation _____ 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. _____

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: _____

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.

Fever	Headache	Nausea	Chest Pain
Chills	Ringing in Ears	Vomiting	Shortness of Breath
Rash	Blurred Vision	Constipation	Abdominal Pain
Fatigue	Fainting	Diarrhea	Urinary Problems

Other _____

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

Comments: _____

_____

_____

_____

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 _____

Ortho***Neuro***

Podiatry and Wound Care

PODIATRY HISTORY

What is the chief complaint for which you came to be treated? (Include foot, ankle, knee, thigh, and hip complaints)

Have you ever been to a Podiatrist before? □ YES □ NO

If YES, please list: Name _____ Last Visit: _____

Date of last visit with Primary Care Physician: _____

Other Physicians and Specialists (eye doctor, endocrinologist, etc.) _____

Athletic Activities in which you participate (please list and indicate frequency) _____

Indicate which foot problems you now have or have had in the past:

Ankle Pain	□ YES	□ NO	Notes
Athlete's Foot	□ YES	□ NO	
Bunions	□ YES	□ NO	
Hammertoes	□ YES	□ NO	
Corns and Calluses	□ YES	□ NO	
Cramps or Numbness in Feet or Legs	□ YES	□ NO	
Flat Feet	□ YES	□ NO	
Foot or Leg Cramps	□ YES	□ NO	
Heel Pain	□ YES	□ NO	
Ingrown Toenails	□ YES	□ NO	
Plantar Warts	□ YES	□ NO	
Swelling in Ankles or Feet	□ YES	□ NO	
Wound Healing Problems	□ YES	□ NO	

WOUND CARE HISTORY (If applicable)

Where is/are the wound(s) that you are seeking treatment for? _____

How did you get this wound(s)? _____

How long have you had this/these wound(s)? _____

Do you have wound pain? □ Yes □ No Pain level____ (0 being no pain and 10 being the worst)

Who is doing your wound care? _____

What physician(s) have you seen for your wound(s)? _____

What have you or your physician done to treat this/these wound(s)? _____

_____ _____

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
☐ Prescriptions & Ancillary Equipment
☐ Other _____
☐ Test Results
☐ Copies of Medical Records

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