OIO | Orthopaedic Institute of Ohio
Get well. Get moving again.

Orthopaedic Institute of Ohio

Demographic Information

Date:_____

Patient Name	**Home Phone**	**Cell Phone**	**Employer Phone**

Mailing Address (include PO Box and Apt. #)	**Family Doctor Name and Phone Number**
City, State, Zip	**Referring Doctor Name and Phone Number**

Age	**Date of Birth**	**Sex**	**Marital Status**	**Social Security Number**

Employer's Name	**Employer's Address**

SPOUSE/PARENT/GUARDIAN INFORMATION (Please circle which one)

Name	**Social Security #**	**Date of Birth**	**Relationship to patient**	**Marital Status**

Mailing Address

EMERGENCY CONTACT (phone number cannot be the same as patient's home or cell number)

Name	**Relationship**	**Phone**

INSURANCE INFORMATION (please present your insurance cards so that we may obtain a copy for our records)

Primary Insurance Company			**Secondary Insurance Company**		
Policy Holder's Name	**SS#**		**Policy Holder's Name**	**SS#**	
Date of Birth / **Co-Pay**	**Relationship to patient**		**Date of Birth** / **Co-Pay**	**Relationship to patient**	
Policy Holder's Address			**Policy Holder's Address**		
Policy Holder's Employer			**Policy Holder's Employer**		

If BWC: Date of Injury	**Pharmacy Card (company name)**	**ID Number**	**Phone**

E-mail Address	**I authorize OIO to leave a message at (please initial all that apply)**
	☐ Home ☐ Work ☐ Cell

Race:
- ☐ White/Caucasian
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ Hispanic or Latino

Ethnicity:
- ☐ Latino or Hispanic
- ☐ Not Latino or Hispanic

Language:
- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Other

Pharmacy Name	**Location**	**Pharmacy Phone Number**

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PATIENT AUTHORIZATION

I hereby authorize Orthopaedic Institute of Ohio, to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I also authorize the release of any necessary information, including medical information if requested by the above named insurance company. I permit a copy of this authorization to be used in such instances.

By signing below, I agree to pay all charges for services rendered by OIO which are not covered by the above referenced insurance coverage. If it becomes necessary for OIO to seek judicial action to enforce the above agreement, I agree to pay all collection fees and all attorneys' fees of OIO for such action.

I expressly consent to receiving telephone calls from an automatic telephone dialing system, artificial and/or pre-recorded messages, emails, text messages, or other electronic communication from Orthopaedic Institute of Ohio, and/or their contractors, servicers, debt collection agencies, or agents for any reason by using any telephone number, email address, and/or mailing address associated with my account or obtained by such entities. I agree that my consent may only be revoked by sending a written notice to Orthopaedic Institute of Ohio or their agents. I agree to arbitrate any claims under the Telephone Consumer Protection Act, and I waive any right/ability to bring a class action against claims, against Orthopaedic Institute of Ohio, and/or their contractors, servicers, debt collection agencies, or agents.

REFERRALS

I understand that I am responsible for obtaining a valid referral from my primary care physician if required by my insurance company.

PRE-CERTIFICATION

I understand that OIO will attempt to obtain a pre-certification as a courtesy for me. I understand that OIO is not obligated to obtain pre-certification for me and it is my responsibility to obtain or to make sure any required pre-certification has been obtained for me prior to my procedure. I agree to advise and confirm with OIO that a pre-certification has been obtained for me. I understand in the event pre-certification is not obtained by me, I will be responsible for any amounts not paid, reduced or denied by my insurance company.

POLICY CONCERNING PAYMENT OF MEDICAL BILLS

I agree to promptly pay all charges when billed for medical services rendered. As a parent or guardian, I agree legal responsibility for all charges incurred by the patient named on the previous page.

POLICY CONCERNING MEDICAL RECORDS

I hereby authorize OIO to release my medical information as I have directed. I understand that OIO does not copy records and that such record copying services are performed by the independent records copying company. Therefore, such record copying may be subject to a copying charge. I also understand that since OIO does not copy records that records must be requested at least two weeks in advance of desired receipt date. If there is a charge for copying my records, I understand that I will be billed by the independent records copying company based upon allowable charges under current Ohio law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not workman's compensation), physician change, or relocation from the area are subject to a copying charge. There will be no charge for copying records for a referral to another physician made by an OIO physician, or workman's compensation issues or any other situations covered by Ohio law.

PHOTOGRAPHY CONSENT

I give OIO permission to photograph my child for security purposes. I understand the picture will be retained in their medical record and used for identification purposes only.

PATIENT RIGHT TO PRIVACY/CONFIDENTIALITY

Orthopaedic Institute of Ohio is committed to patient privacy and confidentiality. In our Patient Bill of Rights, we state that our patients have a right to privacy and confidentiality. Therefore, you will be asked for your permission prior to the release of your records. Your medical information will be kept confidential to the degree required under existing law and regulation. However, from time to time we may need to contact you at home or work. If we need to contact you, may we have your permission to leave a message with regards to your care, any lab results, and appointment information, if you are unavailable or do not answer the phone? I understand that I may receive a copy of the Privacy Practices upon request.

External Prescription History

I give OIO permission to review external prescription history.

HIE Notice

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Ben Broseke or Josh Baker.

Release of Medical Information Agreement

Federal and state law direct when the Practice may disclose a patient's Protected Health Information to persons involved in a patient's care. This form allows a patient to designate family members, friends or other individuals to whom the Practice may release Protected Health Information.

I, _____ (print patient name) hereby agree that the following person(s) involved in my care may receive medical information about me (friends or family members, not physicians).

_____	_____	_____
Name	Relationship to patient	Phone
_____	_____	_____
Name	Relationship to patient	Phone

This form is not intended as a full authorization to release all of your Protected Health Information. The individuals listed above will only receive Protected Health Information directly relevant to such individual's involvement in your care or payment related to your care. You may cancel or alter this designation at any time by informing OIO in writing of such change/alteration. Any cancellation or alteration can only apply to future disclosures or actions regarding your Protected Health Information and cannot cancel actions taken or disclosures made while the designation was in effect.

_____	_____	_____
Date	Patient/ Parent or Guardian Signature	Date of Birth

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Patient Information

Please darken bubbles completely and PLEASE PRINT CLEARLY

Patient Name:		**Appointment Date:**	
DOB:	**OFFICE USE ONLY: Height:**	**Weight:**	BP: Pulse:
Referring Doctor:	**Family Doctor:**	**Heart Doctor:**	

I. Have you seen another doctor in this practice within the last 3 years? O Yes O No

If yes, which doctor?_____

II. Which side is affected? O Right O Left O Bilateral(both sides)

III. Joint or part(s) that you are being seen for today:

☐ Neck ☐ Back ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist/Hand

☐ Hip ☐ Leg ☐ Knee(s) ☐ Ankle ☐ Foot/Toes

IV. Date of Injury: _____ V: Start of Pain/Cause of pain?_____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this a Worker's Comp Claim? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

Is there a Third Party responsible for payment? O Yes O No

If accident, where did the accident occur?_____

VI. Pain Description (Choose all that apply):

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: _____

VII. Have you been seen by a Dentist in the last year? O Yes O No

VII. Do you have any dental problems (Broken, chipped or loose teeth, abscess, gum disease) O Yes O No

If yes, please explain:_____

Medical History: - Do you have or have you had?					
Asthma/COPD	O Yes O No	Respiratory Problems	O Yes O No	Lung Disease	O Yes O No
Cancer Type_____	O Yes O No	Problems with Anesthesia	O Yes O No	Malignant Hyperthermia	O Yes O No
Heart Attack	O Yes O No	Heart Problems	O Yes O No	Hypothyroidism	O Yes O No
Seizures	O Yes O No	Diabetes Type I or II (circle type)	O Yes O No	GI Problems	O Yes O No
Stroke	O Yes O No	Blood Clot	O Yes O No	High Blood Pressure	O Yes O No
Depression	O Yes O No	Mental Illness	O Yes O No	Anxiety	O Yes O No
Kidney Trouble	O Yes O No	If Yes Please Explain	_____		
HIV	O Yes O No	Hepatitis	O Yes O No	Sleep Apnea	O Yes O No
CPAP Machine	O Yes O No	Do you use the CPAP Machine?			O Yes O No
Do you have a pacemaker or AICD (automatic internal cardiac defibrillator)?					O Yes O No
Latex Allergies	O Yes O No	Drug Allergies	O Yes O No	Bariatric Surgery Type _____	O Yes O No

ALLERGIES (metal, medications, food, seasonal etc.)	**REACTIONS/SYMPTOMS OF ALLERGIES**

Medical History (continued)	Have you been in close contact with someone who has had MRSA within the last year?	O Yes O No
Have you ever had or presently have MRSA?	O Yes O No	Are you a Health Care Worker?	O Yes O No

Social History							
				Do you consume alcohol?	O Yes O No		
Do you smoke?	O Yes O No	Chew Tobacco?	O Yes O No	Do you exercise?	O Yes O No		
What is your place of residence	O Home	O Nursing Home	O Assisted Living	O Other:_____			

Family History							
Arthritis	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Cancer	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Diabetes	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Stroke	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Heart trouble	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Lung Disease	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			
Malignant Hyperthermia	☐ Father	☐ Mother	☐ Siblings	☐ Grandparents			

Review of Systems						
Constitutional	Fatigue	O Yes O No	Fever	O Yes O No		
Gastrointestinal	Nausea/ Vomiting	O Yes O No	Stomach Ulcer/ Reflux	O Yes O No	Blood in Stool	O Yes O No
Cardiovascular	Chest pain	O Yes O No	Leg/Ankle Swelling	O Yes O No		
Neurological	Numbness/ Tingling	O Yes O No	Weakness/ Paralysis	O Yes O No		
Musculoskeletal	Joint pain	O Yes O No	Joint stiffness	O Yes O No	Joint Swelling	O Yes O No
Hematologic	Anemia	O Yes O No	Easy bruising	O Yes O No	Bleeding problem	O Yes O No

Current Medications:	**Please PRINT CLEARLY**	

Surgeries/Hospitalizations: **Please PRINT CLEARLY**

Procedure	**Date**

Print Patient Name: _____ DOB: _____

Patient/Guardian Signature: _____ Date: _____