

PATIENT DEMOGRAPHICS

DATE: _____

DOCTOR: _____

PATIENT INFORMATION:

Email _____

Name _____ SSN# _____ - _____ - _____
Last Name First Name Middle Initial

Sex: M F Birth Date ____/____/____ Marital Status: Single Married Widowed Divorced
(circle one) month day year (circle one)

Address _____ City _____ State _____ Zip Code _____

Home Phone # (____) _____ Cell Phone # (____) _____

Employer _____ Work Phone (____) _____

Is this worker's compensation? yes no If yes, do not complete the section below. Do not give us insurance cards.

RESPONSIBLE PARTY INFORMATION:

Name _____ SAME AS ABOVE
Last Name First Name Middle Initial

Birth Date ____/____/____ SSN# _____ - _____ - _____ Relationship to Patient _____
month day year

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone (____) _____

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship to Patient _____

Phone #'s HOME(____) _____ WORK (____) _____ CELL (____) _____

I consent to the use or disclosure of my protected health information by Orthopaedic Associates, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I hereby guarantee payment of all charges and authorize and direct payment from any insurance company, to include, but not limited to, Medicare, Medicare supplement, Medicaid, employer, attorney or their representative to be made directly to Orthopaedic Associates, Inc. in accordance with federal, state, local and carrier billing regulations and guidelines. In the event my account becomes more than 30 days past due and is referred to a collection agency, I agree to pay collection agency fees, reasonable attorney and/or court costs.

Medical forms are to be completed by medical records staff and not by the physician. Charges may apply.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO THE APPOINTMENT.

**I UNDERSTAND MY CO-PAY IS DUE ON EVERY DATE OF SERVICE.
IF UNABLE TO MAKE THE REQUIRED CO-PAY, I MAY BE
RESCHEDULED.**

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

If the above signature does not belong to the patient, please list your relationship. _____

ORTHOPAEDIC ASSOCIATES PATIENT HISTORY FORM

Print Name _____

Date _____

Were you injured on the job? YES NO Has accident been reported to employer? YES NO

Is this a college athletic injury? YES NO Which college? _____ Which sport? _____

Primary Care Physician _____

Were you seen at the ER for this problem? YES NO If so, where? _____ When? _____

Have you had x-rays for this problem? YES NO Where? _____ When? _____

Is there a possibility of pregnancy or are you currently pregnant? YES NO

Age _____ Weight _____ Height _____ Right handed Left handed

Location of Pain: _____

Duration: When did the pain start or date of injury: _____

If there was an injury, please state how it occurred: _____

Previous Evaluation/Treatment: _____

Quality of pain: Circle all that apply: · sharp · stabbing · toothache-type · throbbing · dull · other _____

Severity: Rate the intensity of your pain (0 = no pain, 10 = the worst pain you can imagine)
0 1 2 3 4 5 6 7 8 9 10 (circle the number that applies)

Timing: Circle all times that pain occurs: · day · night · while working · with activity · constant ·

Modifying factors: What makes your symptoms better/worse _____

Associated signs and symptoms: i.e. numbness/tingling, weakness, swelling, radiation of pain, deformity, popping, catching/locking, etc. _____

Current Medications and Dosages (Use the back of this sheet if necessary) None

Allergies to Medications and Allergic Reactions/Symptoms: None

Past Significant Illnesses/Injuries (Do not include surgical procedures) None

Previous Surgical Procedures: Please list the approximate date next to the corresponding procedure.

Tonsillectomy _____	Hysterectomy _____	Prostate _____	Knee _____
Hip _____	Spine _____	Ear/Nose Throat _____	P.E. Tubes _____
Heart Surgery _____	Bypass Graft (CABG) _____	Stent Placement _____	Appendectomy _____

Other Surgeries not listed: _____

Name: _____ Date: _____ Doctor: _____

Example: Weight loss •

Review of Systems

- | | | | | | |
|--------------------|-----------------------|---------------------|-----------------------|-----------------------------|-----------------------|
| Weight loss | <input type="radio"/> | Eye Injury | <input type="radio"/> | Other Psychiatric Disorders | <input type="radio"/> |
| Excessive Fatigue | <input type="radio"/> | Chest pain | <input type="radio"/> | Asthma | <input type="radio"/> |
| Hearing loss | <input type="radio"/> | High Blood Pressure | <input type="radio"/> | Chronic Cough | <input type="radio"/> |
| Ear infections | <input type="radio"/> | Irregular Pulse | <input type="radio"/> | Shortness of breath | <input type="radio"/> |
| Ringing in ears | <input type="radio"/> | High Cholesterol | <input type="radio"/> | Chronic Bronchitis | <input type="radio"/> |
| Diabetes | <input type="radio"/> | Seizures | <input type="radio"/> | Arthritis | <input type="radio"/> |
| Thyroid Disorder | <input type="radio"/> | Weakness | <input type="radio"/> | Back Pain | <input type="radio"/> |
| Increased Appetite | <input type="radio"/> | Stroke | <input type="radio"/> | Joint Swelling | <input type="radio"/> |
| Excessive thirst | <input type="radio"/> | Blurred Vision | <input type="radio"/> | Broken Bones | <input type="radio"/> |
| Bleeding Disorders | <input type="radio"/> | Nausea | <input type="radio"/> | Blood in urine | <input type="radio"/> |
| HIV Positive | <input type="radio"/> | Vomiting | <input type="radio"/> | Painful Urination | <input type="radio"/> |
| Hepatitis Type A | <input type="radio"/> | Loose stools | <input type="radio"/> | Allergy to food | <input type="radio"/> |
| Hepatitis Type B | <input type="radio"/> | Abdominal pain | <input type="radio"/> | Immune disorders | <input type="radio"/> |
| Hepatitis Type C | <input type="radio"/> | Anxiety | <input type="radio"/> | Allergies to LATEX | <input type="radio"/> |
| Eye Infections | <input type="radio"/> | Depression | <input type="radio"/> | | |

Healthy, no known medical problems

Other than what has been chosen from above, no other known medical problems

Social History

Work Status Full-time Part-time Retired Unemployed Disabled

Marital status Single Married Divorced Widowed

Tobacco use Yes No : Packs/day 1 2 or more Cig/pipe Smokeless Tobacco

Alcohol use Yes No Rarely

Family History

High Blood Pressure Rheumatoid Arthritis Gout

Diabetes Thyroid Condition Stroke

Congestive Heart Failure Cancer Osteoarthritis

No Known Medical Problems



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Telephone (812) 424-9291 □ 1-800-264-1208 □ Fax (812) 491-7046

APPOINTMENT OF PERSONAL REPRESENTATIVE TO RECEIVE PROTECTED HEALTH INFORMATION

You may rely upon your spouse, relatives or friends from time to time to visit your physician, acquire prescriptions, get test results, or help you understand your treatment options and alternatives. However, the federal Health Insurance Portability and Accountability Act (HIPAA) and Indiana law do not allow us to disclose any of this information to these people unless you appoint them as a Personal representative@.

To appoint an individual as your personal representative, complete this form.

I HEREBY AUTHORIZE ORTHOPAEDIC ASSOCIATES, INC. TO RELEASE THE FOLLOWING PROTECTED HEALTH INFORMATION TO THE INDIVIDUAL(S) I HAVE DESIGNATED:

Print name of personal	Relationship patient	Information to be released, such as, appointment times, all personal health information
_____	_____	_____
_____	_____	_____
_____	_____	_____

I MAY REVOKE THIS APPOINTMENT AT ANY TIME. MY REVOCATION WILL NOT AFFECT ANY ACTIONS THAT HAVE BEEN ALREADY TAKEN IN RELIANCE ON MY ORIGINAL APPOINTMENT.

Indiana law provides that the designation of a personal representative is only valid for 60 days. If you want your designation to last until you choose to revoke it, you must specifically say so. To select which option you desire, check ONLY ONE OF THESE TWO CHOICES:

- 60 days from the date I sign this form.
- My appointment is good for 60 days. It will renew automatically for additional 60 day periods unless I revoke this appointment in writing. I understand that I may revoke this appointment at any time.

_____	_____	_____
Print Patient's Name	Patient's Signature	Date
_____	_____	_____
Patient=s Address: Street	City	State Zip