OSU Orthopaedics
Patient Information Form

Today's Date: ______________

Please verify all information and fill in all blank areas

Patient Name:	Medical Record Number:
Address:	Maiden Name:
City, State: Zip:	Number of Children:
Home Phone:	Employer:
Work Phone:	Marital Status:
DOB: Age:	Spouse/Guardian:
Race: Sex:	Spouse/Guardian Work Phone: ( )

Referring Physician

Name: ______________________________________

Address: ____________________________________

City: _________________ State: ____ Zip: ______

Phone: ( ) _______________________________

Family Physician

(a doctor who should receive your report)

Name: ______________________________________

Address: ____________________________________

City: _________________ State: ____ Zip: ______

Phone: ( ) _______________________________

Insurance Information

Primary Insurance Company: __________________________________

Policy Holder Name: __________________________________ SS#: ________________________ DOB: _______________

Policy/ID#: ___________________ Group#: ______________ Pre-certification Phone #: _______________

Secondary Insurance Company: ________________________________

Policy Holder Name: __________________________________ SS#: ________________________ DOB: _______________

Policy/ID#: ___________________ Group#: ______________ Pre-certification Phone #: _______________

Employment Information

Are you currently employed? Y N If yes, what is your occupation: _________________________________

Please indicate number of hours you sit, stand, carry per day? ____

Does your job require manual labor activities? Y N If yes, please describe: _________________________

For Office Use Only

Diagnosis: ____ ICD-9 Code: _________________________

OSU Orthopaedics
General Patient Medical History Form

Patient Name:	MRN:

1. History of Present Illness

   What is the problem you are being seen for today? ____________________

   ____

   Location of pain: ____________________

   Severity of pain on a scale of 1 (little or no pain) to 10 (severe pain): ____________________

   Duration (how long have you had the pain): ____________________

   Associated signs/symptoms: ____________________

2. Please list all prior hospitalizations and surgeries:

Year	Operation/Illness	Year	Operation/Illness

3. List all medications you are now taking or have taken in the last two weeks:

Medicine	Dose/Times per day	Reason for Taking

4. Please list any allergies to medicines, food, x-ray dyes, environmental items, adhesive tapes, latex:
   (Example: Penicillin, causes a rash, eggs cause hives, pollen causes sneezing.)
   No known allergies (check here if you have no known allergies)

Allergy	Reaction

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Patient Name:	MRN:

5. Height: ______________________________ Weight: ______________________ Age: _________________

6. Past Medical History:

Diabetes	Yes	No	Liver Disease	Yes	No
High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Strokes	Yes	No	Seizure Disorder	Yes	No
Blood Clots	Yes	No	Congestive Heart Failure	Yes	No
Lung Disease	Yes	No	Have you ever had a heart cath or stress test?	Yes	No
Cancer	Yes	No	Other:		

7. Please circle any condition that applies to you. If a condition is not circled, it will be assumed that it does not apply to you.

GENERAL			**CARDIOVASCULAR**		
Fever	Chills	High Blood Pressure	Chest pain	Rapid heart beat	Leg swelling
Weight loss / gain	Dizziness	Weakness	Palpitations	Slow heart beat	Difficulty breathing while sitting
GENITOURINARY			**RESPIRATORY**		
Pain with urination	Unusual fluid leaking from bladder	Increased frequency of urination	Shortness of Breath	Chest pain with breathing	Coughing up blood
Pelvic pain	Irregular menses	Flank pain	Shortness of breath at night that wakes from sleep	Cough that produces mucus	Difficulty breathing with exertion
Blood in urine					
METABOLIC			**MUSCULAR**		
Fatigue	Weakness	Increased level of thirst	Muscle aches	Neck/Back pain	Redness
			Joint aches	Inflammation	Heat
GASTROINTESTINAL			**SKIN**		
Nausea	Diarrhea	Pain	Rash	Bruising	Abrasions
Vomiting	Constipation	Blood in stool	Swelling	Cuts	
HEAD / NEUROLOGIC			**HEMATOLOGY**		
Trauma	Dizziness	Headache	Bruising	Increased size of lymph nodes	Bleeding
Tenderness	Seizures		Multiple new areas of skin discoloration		

8. Do you have any known family history of:

Difficulties with anesthesia	Yes	No
Heart disease	Yes	No
Heart attack or angina	Yes	No
High blood pressure	Yes	No
Blood clots	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Bleeding tendencies	Yes	No
Tuberculosis (TB)	Yes	No

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9. Do you use any special breathing equipment at home? Yes No
   If yes, Nebulizer Inhalers Oxygen Breathing treatments CPAP

10. Do you have a history of TB? Yes No
    Have you been exposed to TB? Yes No
    Date of exposure: ____________________
    History of TB skin test: positive negative unknown
    Date of skin test (approx): ____________________

11. Date of last vaccinations (if known): Influenza (Flu): ______________ Hepatitis: ____________________
    Tetanus: ____________________ Pneumonia: __________________
    Other: ____

12. Have you ever had difficulties with anesthesia? Yes No

13. Do you use tobacco? No Pipe Cigar Chew Quit Date quit: ______________________
    Do you smoke? Yes No
    How many packs per day? ____________________ For how many years? ____________________

14. Do you drink alcohol? Yes No
    If yes, how much? _________________________ How often? __________________________
    Date of last drink? _________________________

15. Do you use street/recreational drugs? Yes No In a recovery program
    What kind? ____
    Date last used? ______________________

16. Are you currently employed? Yes No If yes, what is your occupation: ____________________
    If no, what kind of work have you done in the past? ______________________________
    Does your job require manual labor activities? Yes No If yes, please describe: ____________________

17. Do you have allergy to latex? Yes No
    Do you have an implanted cardiac device? Yes No
    Do you have any problems with your vision? Yes No Vision aids used: Glasses Contact Lenses
    Do you have any problems with your hearing? Yes No Hearing aids used: ____________________
    Do you have problems with (check all that apply) Taste Touch/Feel Smell

Form completed by: ____ Date: ____________________

If other than the patient, please identify the relationship: ____

Reviewed by: ____________________________ Title: ____________________ Date: ______________

OSU Specialty Care Network
Important Notice Regarding the Privacy of Your Health Information

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is a summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to inspect and copy your medical information
- A right to amend your health information
- A right to request restrictions on what information we use or how we disclose your health information
- A right to receive an accounting of certain disclosures we have made of your health information
- A right to receive a paper copy of our Notice of Privacy Practices

These rights do have special restrictions, so it is important that you read the full Notice.

We may use your health information and/or records to:

- Plan for your care
- Help your health care providers communicate and work together to care for you
- Submit bills to pay for your care
- Health care payors make sure services were actually provided
- Help improve the quality of health care. For example, after your visit we may contact you to see how you are doing and to find out how you felt about our service
- Disclose information to certain officials or organizations where we may, or are required to do so by the law

The Ohio State University Health System is an academic and research institution. Researchers who are working to find new treatments and cures, or important information to improve your health care and the health care of the general public may use or access your information. We may share your information to assist in the training and education of health care professionals. Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

We encourage you to carefully read the Notice, and ask to speak with the office manager for your provider's office or contact the Health System's Privacy Manager at (614) 293-4477 if you need more information. You may also access our Notice of Privacy Practices on our website,
http://www.osumedcenter.edu/health_services/community_care/primare_care.asp

I have received the Notice of Privacy Practices for the Ohio State University Health System's Specialty Care Network.

Patient Name: Medical Record Number:

Signature (Patient, Parent, or Guardian): ______________________________________ Date: ______________

Office Use Only:

Documentation of attempt: ____________________
Date ________________ Initials ______________

Approved by OSUHS HIPAA Steering Committee 02/06/03

OSU Orthopaedics – Office Policies

Welcome and thank you for choosing the OSU Orthopaedics for your health care needs! We realize that you have a choice in medical providers and we appreciate your business. The following policies have been developed to ensure an optimal experience for our patients.

- Registration must be performed at every time you visit our clinic. Please arrive 15 minutes prior to your appointment to allow time for registration.
- Please inform us at check-in if you have any changes to your name, address, phone number, insurance or other demographic information.
- Please bring your insurance card and a photo identification card to every visit.
- Most health insurance plans require that patients pay a co-pay at the physician office at the time of service. Please be prepared to pay your co-pay if applicable.
- For all self-pay patients (patients who do not have health insurance), $100 is due prior to seeing the physician on the first visit and $50 is due at each subsequent return visit. This payment does not represent your entire bill; it is merely an up-front payment for physician services. If you are not able to pay at the time of your visit, we will be happy to reschedule your visit.
- You may require additional paperwork depending on your injury. We charge $25 for completing forms that are not required by your insurance company. Please allow up to 10 business days for these forms to be completed by our personnel (physicians / office staff). Examples of these forms include: short term and long term disability forms.
- We gladly accept requests for copies of your medical records. Please allow up to 30 days for processing of medical records requests.
- You must show photo identification when picking up prescriptions at the clinic.
- If your prescription is stolen, you must complete a police report and give your physician a copy of the report. After receipt of the police report, you may be given a new prescription. You will not be given a new prescription without a police report or until the original prescription expires. Prescription refills or replacements will be processed within 48-hours of receipt of the request.
- If you find yourself running late, please call our main number at 614-293-BONE (2663). As a courtesy to our other patients, we will request that your visit be rescheduled if you are running 30 minutes or more behind.

We appreciate your cooperation in assisting us in providing you the best patient experience possible. By signing, you acknowledge that you have read and understand the policies listed above.

Patient Name: Medical Record Number:

Signature (Patient, Parent, or Guardian): ______________________________________Date: ______________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physicians and outpatient staff in attendance on this case to release medical information to the pertinent insurance company(s) or third party carriers and request payment to be made directly to the billing entity. I understand that I am financially responsible for any balance not covered by the insurance carrier.

Signature (Patient, Parent, or Guardian): ______________________________________Date: ______________