OSU Orthopaedics
Patient Information Form
Please verify all information and fill in all blank areas

Today's Date: _____

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 Oncology
Patient Medical History Form

Patient Name:	MRN:

Height: _____ Weight: _____

Allergies: _____

*****Please bring copies of all x-ray films, including MRI, CT and bone scans to your appointment*****
Please <u>check</u> any of the following medical conditions YOU may have:

Alcoholism	AIDS/HIV	Asthma
Arthritis	Anemia	Drug Addiction
Blood Disorder	Diabetes	Heart Problems
High Blood Pressure	Infectious Disease	Stomach Problems
Cancer	Stroke	Blood Clots
Liver Disease	Lung Disease	Thyroid Disease
Seizure Disorder	Congestive Heart Failure	TB/or exposure to & when

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	Increased frequency of urination	Increased level of thirst	Muscle aches	Neck/Back pain	Redness
Weakness			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	Multiple new areas of discoloration on skin	Increased size of lymph nodes	Bleeding
Tenderness	Seizures		Bruising		

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Patient Name:	MRN:

Medications: Please list any medication you are currently taking, including over-the-counter medications such as aspirin, antacids, vitamins, etc…

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Please check any of the following medical conditions your FAMILY MEMBERS may have:

Difficulties with anesthesia	Heart disease
Heart attack or angina	High blood pressure
Blood clots	Stroke
Diabetes	Bleeding tendencies
Tuberculosis (TB)	Cancer

Do you use tobacco? What kind/how much: _____

Date quit: _____

Do you drink? What kind/how much/how often: _____

_____

Do you use street or recreational drugs? What kind/how much/how often: _____

_____

Have you ever had any problem or complication associated with surgery and/or anesthesia? _____

_____

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TUMOR INFORMATION

This information will help us to evaluate any mass, lump, pain or lesion that may be associated with a tumor problem.

Location of mass, pain or lesion: _____

When was this problem discovered and by who (yourself/physician)? _____

_____

Did you have any kind of accident/injury around the time you noticed this problem? If so, what happened?

_____

Has this mass been getting larger? _____

Has your pain been getting worse? _____

Does the pain wake you up at night? _____

Does anything relieve the pain (medications, rest, etc..)? _____

When did you first see a physician about this problems? _____

Have you had any surgery for this problem and if so, when and what hospital? _____

_____

Have you ever had a problem in the past with a tumor or cancer and if so, what was it? _____

_____

Have you ever had radiation therapy and if so, what hospital, physician and when? _____

_____

Have you ever had chemotherapy and if so, what hospital, physician and when? _____

_____

If you have a family history of cancer or tumors, please list relationship of the person to you and the type of tumor or cancer they had.

Family Member	Type of Tumor/Cancer
_____	_____
_____	_____
_____	_____

OSU Orthopaedics Oncology
Patient Medical History Form

Patient Name:	MRN:

Please list all past hospitalizations and surgeries.

Year	Operation/Illness	Physican/Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Form completed by: _____ Date: _____

If other than 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: _____