

PATIENT INTRODUCTION

Patient information

Name _____ Date _____

Email _____ Age _____

Address _____
Street City State Zip

Sex _____ Birthdate _____ SS# _____ Telephone _____

Height _____ Weight _____ Have you been treated here before? No Yes

Family physician _____ Referred by _____
Address _____ Address _____

Employment information

Company _____ Telephone _____

Address _____
Street City State Zip

Type of work _____ Contact person _____

Emergency contact information

Name _____ Telephone _____

Address _____ Relationship _____

Responsible party information

Name _____ if same as patient check here Age _____

Address _____
Street City State Zip

SS# _____ Telephone _____ Birthdate _____

Employment _____ The patient is my _____

Insurance coverage information (primary)

Subscribers name _____ Date of birth _____

Medical Mutual Medicare Welfare Other _____

Certificate _____ Group no. _____

Industrial case: _____ Date of injury _____ Self insured _____ BWC _____

MCO: _____ Group no. _____

Sheffield Village Office

5001 Transportation Dr.
Sheffield Village, OH 44054
440-329-2800
440-329-2810 Fax

Oberlin Office

224 W. Lorain St.
Oberlin, OH 44074
440-329-2800
440-329-2810 Fax

Westlake Office

2211 Crocker Rd.
Westlake, OH 44145
440-329-2800
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PATIENT INTRODUCTION (PAGE 2)

Insurance coverage information (secondary)

Subscribers name _____ Date of birth _____

Medical Mutual Medicare Welfare Other _____

Certificate _____

PAYMENT AUTHORIZATION

- I AUTHORIZE CENTER FOR ORTHOPEDICS TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF.
- I REQUEST THAT ALL PAYMENTS OR BENEFITS FOR SERVICES RENDERED BY CENTER FOR ORTHOPEDICS BE PAYABLE TO, SENT TO CENTER FOR ORTHOPEDICS.
- I REALIZE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THESE CHARGES AND MY BALANCE NOT COVERED BY INSURANCE WILL BE MY RESPONSIBILITY.

Acknowledgement

Patient's Full Name: _____

Email address: _____

Signature: _____ Date _____

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ORTHOPEDIC HISTORY

Patient information

Name: _____ Today's Date: _____

SS#: _____ Date of Birth: _____ Age: _____

Chief Complaint

Why are you seeing the doctor today?

Current problem is a result of a(n): Check all that apply

Date of onset of injury _____

- Car Accident
 Work Related Injury or Accident
 Non-Work Related Injury or Accident
 Other

Medication	Dose	Reason for Medication	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: _____

Poor tolerance to: _____ Heat/Hot Pack/Moist Heat: _____ Cold/Ice: _____

Are all immunizations up to date? Yes No If no, which immunizations are due? _____

Are you pregnant? Yes No If so, due date _____

Medical History

Are you currently having or have you had problems with your:

Describe all Yes Responses

- | | | |
|--------------------------------|--|-------|
| Eyes | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Ears, Nose, Throat | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Lungs, Breathing/Asthma | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Digestion | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Bowel/Bladder problems | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Diabetes | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Stroke/CVA | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Heart Disease/Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Chest pain/Angina | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| High blood pressure | <input type="radio"/> Yes <input type="radio"/> No | _____ |
| Bleeding problems/Clots | <input type="radio"/> Yes <input type="radio"/> No | _____ |

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ORTHOPEDIC HISTORY (PAGE 2)

Medical History (continued)

Are you currently having or have you had problems with your:

Describe all Yes Responses

Balance problems	<input type="radio"/> Yes <input type="radio"/> No	_____
Numbness/tingling	<input type="radio"/> Yes <input type="radio"/> No	_____
Blackout/fainting	<input type="radio"/> Yes <input type="radio"/> No	_____
Psychological problems	<input type="radio"/> Yes <input type="radio"/> No	_____
AIDS	<input type="radio"/> Yes <input type="radio"/> No	_____
Cancer	<input type="radio"/> Yes <input type="radio"/> No	_____
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	_____
Polio	<input type="radio"/> Yes <input type="radio"/> No	_____
TB	<input type="radio"/> Yes <input type="radio"/> No	_____
Epilepsy/Seizures	<input type="radio"/> Yes <input type="radio"/> No	_____

Past Medical History

Surgeries/Hospitalizations	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
Previous Physical Therapy	Year	Complications
_____	_____	_____
_____	_____	_____

Have you ever had general anesthesia? Yes No

Have any problems with anesthesia? Yes No Describe: _____

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	<input type="radio"/>	<input type="radio"/>	____	_____
Grandfather (mom's)	<input type="radio"/>	<input type="radio"/>	____	_____
Grandmother (dad's)	<input type="radio"/>	<input type="radio"/>	____	_____
Grandfather (dad's)	<input type="radio"/>	<input type="radio"/>	____	_____
Father	<input type="radio"/>	<input type="radio"/>	____	_____
Mother	<input type="radio"/>	<input type="radio"/>	____	_____

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ORTHOPEDIC HISTORY (PAGE 3)

Family History (continued)

Member	Alive	Deceased	Age	Health status or cause of death
Sister/Brother	<input type="radio"/>	<input type="radio"/>	_____	_____
Sister/Brother	<input type="radio"/>	<input type="radio"/>	_____	_____
Sister/Brother	<input type="radio"/>	<input type="radio"/>	_____	_____
Sister/Brother	<input type="radio"/>	<input type="radio"/>	_____	_____

Social History

Employed
 Work in the home
 Student
 Daycare
 Retired
 Occupation: _____

Single
 Married
 Divorced
 Separated
 Widowed

Children?
 Yes
 No
 # _____

Do you live alone?
 Yes
 No
 # _____

Exercise?
 Daily
 Weekly
 Monthly
 Rarely
 Never

What type of exercise? _____

History of Substance Abuse?
 Yes
 No
 What? _____

Smoke currently?
 Yes
 No
 _____ Packs per day for _____ years

Quit Smoking?
 Yes
 No
 This year
 >1 year
 >5 years
 >10 years

Previously smoked _____ Packs per day for _____ years

Drink alcohol?
 Yes
 No
 Daily
 1-2 x/week
 1-2 x/month
 1-2 x/year

Acknowledgement

Patient's Full Name: _____

Email address: _____

Signature: _____ Date _____

All Medical History pages (1-3) reviewed by: _____ MD Date _____

All Medical History pages (1-3) reviewed by: _____ PT Date _____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient information

PATIENT NAME _____

BIRTHDAY _____

SOCIAL SECURITY NUMBER _____

Acknowledgement

I hereby acknowledge that on _____ I received the Notice of Privacy Practices from EMH Professional Services, Center for Orthopedics, which sets forth the ways in which my personal health information may be used or disclosed by EMH Professional Services or Center for Orthopedics, and outlines my rights with respect to such information.

Patient's Full Name: _____

Email address: _____

Signature: _____

Date _____

Guardian Signature for Minor Patient _____

Date _____

Authorized Representative of Patient _____

Date _____

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CONSENT FOR MESSAGES

Patient information

PATIENT NAME: _____

Consent

- I give my consent for the Center for Orthopedics staff to leave messages, with information pertinent to tests, surgery or appointment scheduling, on my personal voice mail or answering machine.

The messages can be left at the following numbers:

_____ **Home**

_____ **Cell (Alternate)**

- I give my consent for Center for Orthopedics staff to coordinate my treatment plan, appointment scheduling, etc. with the following people:

Parent(s) Name: _____

Spouse Name: _____

Other Family Member Name: _____

- At this time, I decline to have the Center for Orthopedics staff leave messages on my personal voice mail or answering machine. I understand that my tests, surgeries and other appointments may be delayed if I cannot be reached in a timely manner.

Acknowledgement

Patient's Full Name: _____

Email address: _____

Signature: _____

Date _____

Signature of Parent/Guardian (if applicable) _____

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