



**OSU Orthopaedics  
Patient Information Form**

Today's Date: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Employer: \_\_\_\_\_

**Parent/Guardian Information [complete only if patient is a minor]**

Mother's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Father's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**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 Date: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature (for minor patients) Date: \_\_\_\_\_

**OSU Orthopaedics**  
**General Patient Medical History Form**

Providers: Block, DiMeo, Ellis, Lakatos, Monson, Phieffer, Young, VanGorp, Rev. 01/08

Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Today's Date: \_\_\_\_\_

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

## OSU Orthopaedics General Patient Medical History Form

5. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

6. Past Medical History:

Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a heart cath or stress test?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<b>GENERAL</b>			<b>CARDIOVASCULAR</b>		
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
<b>GENTOURINARY</b>			<b>RESPIRATORY</b>		
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					
<b>METABOLIC</b>			<b>MUSCULAR</b>		
Fatigue	Weakness	Increased level of thirst	Muscle aches	Neck/Back pain	Redness
			Joint aches	Inflammation	Heat
<b>GASTROINTESTINAL</b>			<b>SKIN</b>		
Nausea	Diarrhea	Pain	Rash	Bruising	Abrasions
Vomiting	Constipation	Blood in stool	Swelling	Cuts	
<b>HEAD / NEUROLOGIC</b>			<b>HEMATOLOGY</b>		
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	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack or angina	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding tendencies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No

**OSU Orthopaedics**  
**General Patient Medical History Form**

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](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 Primary Care Network.

Printed Patient Name: \_\_\_\_\_

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

Rev. 02/2007

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. We developed these policies having the most optimal patient experience in mind.

- Please bring your insurance card to every visit. Your insurance card has all the required information for us to process an insurance claim on your behalf. We also use your insurance card to verify coverage and eligibility. We will make a copy of your card and place it in your chart.
- Please inform us, at check-in, if you have any changes to your name, address, phone number, insurance or other demographic items. This will allow us to update our database so that we may contact you if questions or issues arise after your visit.
- For all self-pay patients (patients who do not have health insurance), \$100 is due prior to seeing the physician at the initial visit and \$50 is due at all subsequent visits. This payment does not represent your entire bill. It is 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.
- From time-to-time, 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 to complete these forms since they must be completed by the physician. Examples of these forms include, short term and long term disability forms and family and medical leave forms.
- We gladly accept requests for copies of your medical records. Please allow up to 2 weeks for medical records requests.
- Most health insurance plans require that patients pay a co-pay at the physician office at the time of service. For your convenience, you may pay before or after seeing the physician.
- When picking up prescriptions at the clinic you must show photo identification. This is done so that we provide the right prescription to the right patient, to avoid a medical error. We will copy your photo ID, we ask that you sign the copy and then we place it in your chart as reference.
- 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 has expired. Prescription refills or replacements will be processed within 48-hours of receipt of the request.
- All of our schedules are busy, so if you find yourself running late please call our main number at 293-BONE (2663). As a courtesy for our other patients, if you are running 30 minutes or more behind we will request that your visit be rescheduled.
- Registration must be performed at Registration Desk every time you visit our clinic. Upon arrival, please stop at the Registration Desk on the first floor before heading to our Reception Desk.

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.

Welcome, and thank you for choosing OSU Orthopaedics.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_