The Orthopedic and Sports Medicine Institute

Michael Boothby MD Bret Beavers MD G. Todd Moore DO G. Keith Gill MD
William J Shaw IV-PA-C Jeff Curtis PA-C Megan Landon PA-C

Today's Date: _____

Patient Name: _____
Last First Middle Initial

Date of Birth: _____ Age: _____ Social Security Number: _____ Gender: M F

Preferred Phone: _____ Secondary Phone: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Employer: _____ Job Title: _____

Financial Responsible Party (if different than patient or if patient is a minor): _____

Social Security Number: _____ Date of birth: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Ethnicity (Please Select One):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Race (Please Select One):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Decline

Date of Injury (if applicable): _____ **Will this injury be filed with Worker's Compensation?** ☐ Yes ☐ No

Worker's Compensation Information (If Applicable, please fill out completely)

Claim Number: _____ Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Phone: _____ Adjustor Name: _____ Adjuster Phone: _____

Personal Insurance Information

Primary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____

Secondary Insurance Carrier: _____

Member ID: _____ Group Number: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security Number: _____ Relationship to Policy Holder: _____

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

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Preferred Pharmacy: _____ Pharmacy Phone: _____

Are you currently taking any medications? ☐ Yes ☐ No ☐ See list provided

****Please include all blood thinning medications and any prescribed weight loss pills on the list below.****

Medication	Dose	Frequency

Have you had any past problems with anesthesia? ☐ Yes ☐ No If yes, please explain:

_____

Height: _____ Weight: _____

Chief Complaint

Reason for your visit today (Please specify Left and/or Right Side):

_____

Symptoms (Check all that apply): ☐ Sharp Pain ☐ Dull Pain ☐ Numbness ☐ Tingling ☐ Stiffness ☐ Burning Sensation

Additional Symptoms Not Listed:

_____

Date of Injury or when symptoms started: _____

Describe how the injury or problem occurred: _____

_____

_____

What treatments have you already tried: _____

Was this injury work-related? ☐ Yes ☐ No **Was this injury due to an auto accident?** ☐ Yes ☐ No

****Please be advised that OSMI does not treat injuries acquired by an accident where a third party entity is held liable for the incident (i.e. auto insurance, homeowner's insurance, etc.). OSMI only files claims on personal health insurance or worker's compensation, and accepts self-pay patients. Any appointment under other circumstances may be cancelled.****

I have completed the above information to the best of my abilities and all above information is true to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

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Acknowledgement and Acceptance of Privacy Notice and Practices (HIPAA)

I acknowledge I have been given an opportunity to read the offices' Privacy Practices. I give my consent to release personal information for the purposes of treatment, referrals, and payment or healthcare operations and understand that I may withdraw this consent at any time in writing. I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the office of all liability. I give my consent to fax my records for the purposes of treatment, payment, or healthcare operations and understand that I may withdraw this consent at any time in writing. I also understand that I have the right to request restrictions as to how my health information may be used or disclosed. I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Other person(s) permitted to receive my medical records other than listed in the above paragraph:

- ☐ No restrictions: OSMI may release information, if requested, to anyone.
- ☐ Restrictions: Please list who we may release information to regarding your healthcare below

_____

_____

I wish to be contacted in the following manner (Check all that apply):

Home/Cell ph#: _____

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Work ph #: _____

- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Office policies

Please be advised that our office houses physicians, physician's assistants, and a physical therapy center. After you sign in, our receptionists will process your paperwork and get you in an exam room as quickly as possible. It is very important that you notify our receptionists of any address, phone number or insurance change **before** you are seen. The office may verify insurance coverage prior to services being rendered, however, it is ultimately the patient's responsibility to be mindful of their own insurance benefits; including any required referrals or authorizations. All charges will be submitted to your insurance company. Any remaining balance is the responsibility of the patient or their financial responsible party.

Prescription Request

Please contact your pharmacy to request medication refills. Your pharmacy will notify our office of your refill request. We require 24 hours for refill requests. Please be aware that refills received on Fridays or holidays may not be authorized until the next business day.

Clinical Questions

Please be aware if you call our office with a clinical question, our physicians and nursing staff are in clinic during the day and may not be called away from patients to speak to you. Our receptionists will get your message to our clinical staff and they will return your call as soon as possible. (NOTE: if you have recently had surgery, please notify our receptionist of any problem you are experiencing and she will immediately notify a member of our clinical staff.)

Patient Forms

Please be aware that we charge $20.00 to complete the paperwork for any of the following: FMLA, long term or short term disability, third-party insurance (i.e., AFLAC, Unum, etc.). We require 4 business days to complete paperwork.

No Show Policy

Please be aware there will be a $25.00 charge for any appointments that are missed or not cancelled 12 hours prior.

I have read and fully understand the above information.

Patient or Guardian Signature: _____ Date: _____

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Privacy Notice & Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. You can revoke your consent.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time.

Individual Rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions concerning your care. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the practice manager. You also may send a written complaint to the U.S. Department of Health and Human Services.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Please let the front desk know if you would like a copy of this document.

Medical disorders: If you have had any of the following, Place Mark inside Circles

- O No Medical History
- O AIDS/HIV
- O **Alcoholism**
- O **Alzheimer's**
- O **Anemia**
- O **Rheumatoid Arthritis**
- O **Asthma**
- O **Blood Clot Leg**
- O **Blood Clot Lung**
- O **Other Disease** (list below)
- O Stroke
- O Cancer Breast
- O Cancer **Colon**
- O Cancer **Lung**
- O Cancer **Prostate**
- O **COPD**
- O **Depression**
- O **Diabetes**
- O **Drug Abuse**
- O **Blood thinners (Coumadin, Plavix, aspirin, etc)**
- O Sleep Apnea
- O Gout
- O Heart Attack
- O High Blood Pressure
- O Hepatitis
- O Kidney Disease
- O Osteoarthritis
- O Seizures
- O Ulcers, Bleeding

Surgical History: If you have had any of the following, Place Mark inside Circles

- O No Surgical History Reported
- O Carpal Tunnel Left Wrist
- O Arthroscopy Left Elbow
- O Arthroscopy Left Shoulder
- O Arthroscopy Left Ankle
- O Arthroscopy Left Knee
- O Arthroscopy Left Hip
- O Left Hip Replacement
- O Left Knee Replacement
- O Spinal Fusion
- O Other Surgery (list in the box below)
- O Cardiac (Heart)
- O Carpal Tunnel Right Wrist
- O Arthroscopy Right Elbow
- O Arthroscopy Right Shoulder
- O Arthroscopy Right Ankle
- O Arthroscopy Right Knee
- O Arthroscopy Right Hip
- O Right Hip Replacement
- O Right Knee Replacement
- O Laminectomy
- O Fracture Surgery

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box