



ORTHOPAEDIC & SPINE Patient Information Sheet INSTITUTE, LLC.

PATIENT NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

HOME PHONE: () _____ ALT./CELL PHONE: () _____ WORK PHONE: () _____

SS#: _____ E-MAIL: _____ WOULD YOU LIKE INFO ON NEW SERVICES VIA EMAIL? Y/N

DOB: ____/____/____ AGE: _____ MALE () FEMALE () MARITAL STATUS: M () S () D () W ()

SPOUSES INFORMATION:

SPOUSES NAME: _____

ADDRESS: _____ PHONE #: () _____ DOB: ____/____/____

EMPLOYER NAME: _____ PHONE #: () _____

EMERGENCY CONTACT (OTHER THAN SPOUSE):

NAME: _____

RELATIONSHIP: _____ PHONE#: () _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

*****WERE YOU INJURED ON THE JOB? YES / NO IS THIS A MOTOR VEHICLE ACCIDENT? YES / NO

EMPLOYER INFORMATION

CURRENT EMPLOYER: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PHONE#: () _____ OCCUPATION: _____

PRIMARY CARE/REFERRING/TREATING PHYSICIAN: (EVEN IF SENT FROM E.R.):

CLINIC NAME: _____ PHYSICIAN NAME: _____

ADDRESS: _____

PHONE#: () _____ FAX#: () _____

INSURANCE: CIRCLE ONE: / PRIVATE / WORKER'S COMP / LEGAL

PRIMARY INSURANCE:

INS. NAME: _____ ID#: _____ GRP#: _____

POLICY HOLDER'S NAME: _____ DOB: ____/____/____ SS#: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF SPOUSE CHILD OTHER: _____

SECONDARY INSURANCE:

INS. NAME: _____ ID#: _____ GRP#: _____

POLICY HOLDER'S NAME: _____ DOB: ____/____/____ SS#: _____

RELATIONSHIP TO PATIENT: (CIRCLE ONE) SELF SPOUSE CHILD OTHER: _____

MEDICARE ASSIGNMENT FOR COVERED SERVICES: I CERTIFY THAT THE INFORMATION ABOVE INCLUDING MY ID IS CORRECT AND HEREBY REQUEST PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. ASSIGNMENT OF BENEFITS: I HEREBY AUTHORIZE PAYMENT TO ORTHOPAEDIC & SPINE INSTITUTE, LLC. (OSI) FOR MEDICAL SERVICES. I REPRESENT THAT I HAVE INSURANCE COVERAGE AND DO HEREBY AUTHORIZE (OSI) TO RELEASE AND OBTAIN ALL INFORMATION NECESSARY TO SECURE PAYMENT OF SAID BENEFITS. I HAVE ALSO SIGNED AN ABN FOR MEDICAL SERVICES THAT MEDICARE WILL NOT COVER THAT WILL BE KEPT ON FILE. IF MY INSURANCE FAILS TO PAY (OSI) FOR ANY REASON, INCLUDING HMO CO-PAYS, DEDUCTIBLES, CO-INSURANCES, OR FAILURE TO REPORT CHANGES OF BENEFITS, I AGREE TO PAY ALL UNPAID BALANCES. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF KNOWLEDGE. I WILL NOTIFY ORTHOPAEDIC AND SPINE INSTITUTE, LLC. OF ANY CHANGES IN PERSONAL INFORMATION, CO-PAY, OR TERMINATION OF BENEFITS.

SIGNED: _____

DATE: _____



SPINE & ORTHOPAEDIC INSTITUTE

21 SPURS LANE, SUITE 245
SAN ANTONIO, TX 78240
PHONE: 210-487-7463 FAX: 210-487-7468

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Please print your name

Last Name

First Name

MI

What is your age and date of birth?

Print numbers in the boxes.

Age Month Day Year

What is your sex? Mark ONE circle

Male Female

What is your height and weight?

Print numbers in the boxes.

Height: ft. in. Weight: lbs.

In the event you can't be reached, we need your permission to leave information on your voice mail system.

Yes, you can leave information pertaining to my medical care on my voice mail system.

No, you may not leave information pertaining to my medical care on my voice mail system.

How did you hear about our office?

Mark ONE circle.

ER Physician Friend
Internet Newspaper Radio
Phone book Other—Print other below.

Who is your family physician?

Print last name.

Who is the physician that referred you to our office?

Print last name.

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today? Mark ONE circle

Pain Tingling Instability
Stiffness Numbness Weakness
Swelling Other—Print other below

2. Where is the location of your primary orthopaedic problem? Mark ONE circle

Right side Left side Both sides
a. If both sides, which side bothers you the greatest? Right Left

3. What body part is involved with your primary orthopaedic problem?

Mark all that apply

Neck Upper Back Shoulder
Arm Elbow Forearm
Wrist Hand Thumb
Index Finger Middle Finger Ring Finger
Pinky Mid Back Low Back
Pelvis Hip Buttocks
Thigh Knee Lower Leg
Calf Ankle Foot
Toe Other—Print other below

4. What is your dominant hand?

Right Left Ambidextrous

5. When was the onset of your current problem?

Unknown Gradually
Suddenly, without injury
Suddenly, after an injury or accident
a. Date of injury or accident.

Gradually after an injury or accident
a. Date of injury or accident.

6. If after an injury or accident, where did the injury or accident take place?

Mark ONE circle

Home School Sports
Motor Vehicle Accident (See 6a)
Work related (See 6b)
Other—Print other below

CONTINUE on page 2.

PatientName: _____

Date: _____

Continue question #6.

a. If your condition is due to a motor vehicle accident answer the questions below.

- Do you have an attorney representing you?
 - No Yes
 - If yes, name of the attorney representing you.

- Where were you when the accident happened?
 - Driver
 - Passenger
 - Pedestrian
- If you were the passenger, where were you sitting?
 - Front Seat
 - Back Seat
- Were you wearing a seat belt?
 - No
 - Yes

b. If your condition is due to a work accident or injury answer the questions below.

- Name of the employer where the work injury or accident occurred.

- Date reported to your employer
- Not reported

7. How did the injury or accident occur?
Please write complete sentences in the space below.

8. Have you been treated for this problem in the Emergency Room? No Yes

a. If yes, which Emergency room or Hospital were you treated.

b. What treatment did you receive.

c. Were you admitted to the hospital.
 No Yes

9. Have you been seen by another physician for this problem? No Yes

a. If yes, who was the treating physician?

10. Have you received Physical Therapy for this problem? No Yes

Continue question #10

a. If yes, where did you receive your Physical Therapy treatment?

b. How long did you receive Physical Therapy?

< 1 month	1 month
2 months	3-6 months
7-12 months	Over 1 year

11. What medications are you taking for this problem?

Advil	Aleve	Arthrotec
Aspirin	Celebrex	Codeine
Daypro	Flexeril	Motrin
Naprosyn	Percocet	Skelaxin
Steroid Inj.	Tylenol	Vicodin
Voltaren	Other—Print other below	

12. In the space provided, list all other medications you are taking including non-prescription medications. Do not include the medications you have previously listed. None

13. Indicate any past testing you've had done for this problem.

X-rays	MRI	Bone Scan
CAT Scan	Discogram	EMG
Ultrasound	Lab Tests	
Other—Print other below		

14. Have you had prior injuries of a similar nature? No Yes *If yes, explain below.*

15. Since the onset, what is the status of your symptoms?

Improved Worsening No change

CONTINUE on page 3.

PatientName: _____

Date: _____

16. How long have the symptoms been present?

Mark ONE circle. Not sure
1 2 3 4 5 6 7 8 9 10 11
Days
Weeks
Months
Years

17. On the scale below, mark the severity of your pain, 10 being the highest.

Mark ONE circle
None Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10
Right
Left

18. How can the current problem be characterized?

Intermittent Dull Throbbing
Constant Sharp Aching
Burning Stabbing Cramping

19. What additional symptoms are you experiencing?

Chills Stiffness Swelling Loss of bowel control Loss of bladder control Limit of motion Radiation of pain
Fever Tingling Instability
Numbness Weakness Fatigue
Loss of feeling Sleep disturbance Difficulty walking Headaches

20. Symptoms improve with:

Rest Ice/cold Climbing Stairs
Activity Heat
Medication Walking

21. Symptoms feel worse with:

Rest Ice/cold Climbing Stairs
Activity Heat
Sitting Walking

22. Are the symptoms worse during the day or night?

No difference Day Night

MEDICAL, PERSONAL, SOCIAL HISTORY

23. Do you have any allergies or reactions?

No known allergies.
Sulfa Iodine dyes Feathers Adhesive Tape Other—Print other below
Penicillin Anesthesia Eggs Environmental
Latex Codeine Animals

24. Have you had any surgeries?

No Yes

If yes, select from the list below.

Arthroscopy Knee Total Knee Replacement Rotator Cuff Repair Back Surgery Appendectomy Hysterectomy Malignancy Other—Print other below
Arthroscopy Shoulder Total Hip Replacement Carpal Tunnel Release Neck Surgery Gall Bladder Hernia Bowel Surgery

25. Indicate past medical conditions.

No significant medical history
Anemia Bleeding Disorder BPH/Prostate dis. Cancer Coronary Artery dis Diabetes Angina/Arrhythmia GERD Gout Intestinal Disease Liver dis./Hepatitis Osteoarthritis Osteomyelitis Phlebitis Seizures Stroke/TIA/CVA
Asthma Blood Transfusions Bronchitis COPD Depression Elev. Cholesterol Fibromyalgia Glaucoma Hypertension Kidney/Renal Disease Obesity Osteoporosis Peripheral Vascular Rheumatoid Arthritis Stomach Ulcers Thyroid Disease

26. Indicate your father's medical conditions.

No medical conditions
Arthritis Gout TB High blood pressure a. What is your father's health status?
Cancer Heart Disease Hereditary Defects
Diabetes Stroke
Living Deceased Unknown

27. Indicate your mother's medical conditions.

No medical conditions
Arthritis Gout TB High blood pressure a. What is your mother's health status?
Cancer Heart Disease Hereditary Defects
Diabetes Stroke
Living Deceased Unknown

CONTINUE on page 4.

PatientName: _____

Date: _____

Continue question #37

Page 4

28. Indicate your sibling's medical conditions.

- No medical conditions
- Arthritis Cancer Diabetes
- Gout Heart Disease Stroke
- TB Hereditary Defects
- High blood pressure
- a. What is your sibling(s) health status?
 - All living All deceased
 - Some living/some deceased
 - Unknown

29. What is your marital status?

- Mark ONE circle
- Single Married Divorced
 - Separated Widowed

30. Do you live alone? No Yes

31. Are there stairs in your home?

- No Yes

32. What is your level of Education/School?

- N/A Current Student
- Less than 12th grade High School
- Trade/Vocational College
- Professional

33. Do you drink caffeinated beverages?

- Mark ONE circle No Yes
- a. If yes, how many per day?
- 1-2 cups/cans 3-4 cups/cans
 - 5+ cups/cans

34. Do you drink alcohol? Mark ONE circle

- No Yes
- a. If yes, how frequently do you drink?
 - Rarely Socially (2 to 3 per week)
 - Daily

35. Do you smoke tobacco?

- Mark ONE circle No Yes
- a. If yes, how many per day?
- Less than one pack One pack
 - Two packs Three+ packs
- b. How many years have you smoked?
- 1-5 years 6-10 years
 - 11-20 years 20+ years

36. Do you have a history of recreational drug use? Mark ONE circle

- No Yes Prior use

37. Select all problems you have had in the last 6 months?

- Fevers Sweats
- Weight gain Fatigue
- Weight loss (unexpl.) Hearing loss
- Weight loss (planned) Ringing in ears
- Vision changes Hoarseness

- Trouble swallowing
- Shortness of breath
- Chronic cough
- High blood pressure
- Irregular heartbeat
- Diarrhea
- Constipation
- Abdominal pain
- Vomiting
- Other joint pain
- Other muscle pain
- Rashes
- Loss of coordination
- Fainting
- Headaches/Migraine
- Anxiety
- Incontinence
- Burning urination
- Difficulty urinating
- Sore throat
- Wheezing
- Leg cramps
- Palpitations
- Chest pain
- Heartburn
- Nausea
- Fracture
- Bone pain
- Muscle spasms
- Skin ulcers
- Hives
- Weakness
- Numbness
- Depression
- Disoriented
- Discharge
- Freq urination
- Bleeding

Please sign and date this form

Signature _____

Date _____



Please return your completed form to the front desk.

ORTHOPAEDIC & SPINE INSTITUTE

CONSENT FOR SERVICES

Printed Name: _____

DOB: _____

CONSENT FOR TREATMENT: I voluntarily consent to evaluation, treatment, diagnostic testing, medication, nursing care and/or therapy which my physician or his designees, determines to be necessary. By signing this consent, I also acknowledge that I may be sent by my physician or his designees to a facility in which they have an ownership interest. I also acknowledge and agree that in rendering care for me, my physician and his designees may choose to use products in which they have an ownership interest. I understand that I have a choice in the facilities and/or products used to provide treatment of my condition(s). I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as the result of examination or treatment in this facility.

USE OF MEDICAL RECORDS IN RESEARCH: I authorize the use of my medical records for external medical or scientific research. By collecting information from medical records, researchers learn about new or better ways to diagnose and treat illnesses. Research results do not identify individuals by name or any other personally identifying characteristics. This authorization does not expire but may be revoked or limited in writing by me at anytime. You may disagree with the use of my medical record for this purpose by crossing through this paragraph and initialing in the left margin.

CONSENT FOR PHOTOS: I consent to the taking of photographs for medical record documentation and to still or motion pictures or video tapes of patient care for educational purposes providing my identity is not disclosed.

CONSENT FOR RELEASE OF INFORMATION: I consent to the release of information about my medical condition to myself and to any health care provider or office personnel involved with my current treatment. I understand that I may be contacted by an office representative who is conducting a quality of care review or study, and that information from my medical record has been made available to that representative.

INSURANCE CONSENT: I request that payment of authorized benefits be made to Orthopaedic & Spine Institute and to any affiliated physicians for any services furnished to me. I authorize this office to release to Medicare, and other accident or health insurers, medical or financial information as needed for claims processing, fraud investigation, or quality of care review and studies. I understand that I may revoke this consent for release of information at anytime by notifying the office in writing, but such revocation will not apply to information already released.

PRECERTIFICATION/PRIOR AUTHORIZATION AGREEMENT: I understand that I am responsible to comply with the rules and regulations of my insurance company regarding precertification and prior authorization requirements.

GUARANTEE OF ACCOUNT: I agree to pay Orthopaedic & Spine Institute for all charges for services not covered by any third party payor.

PATIENT OR LEGAL REPRESENTATIVE	LEGAL RELATIONSHIP	DATE
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NOTE: This authorization must be signed by the patient, unless the patient is a minor child or is mentally or physically unable to sign.

REASON PATIENT IS UNABLE TO SIGN: _____

FINANCIAL POLICY AGREEMENT

Our financial policy is designed to allow us to provide quality care to our valued patients. We are always happy to clarify or answer any questions you may have. The financial responsibility for services rendered rests with you, the patient, or the party held responsible as guarantor regardless of your agreement with your insurance company.

For all office visits, services and procedures for which the patient has insurance coverage, we abide by the plans, agreements, and terms, of each individual insurance policy and will submit every bill to your insurance carrier within a timely manner. If your insurance requires a referral, this must be submitted on or before the time of service.

If for any reason there is a part of the fee not covered by the insurance, the remainder of the bill must be paid in full by 90 days after the service is rendered.

Any account for which the insurance company is requiring a co-pay, co-insurance, or deductible payment in full is expected at the time of services. For our patients' convenience, we accept cash, checks, Visa or Master card.

SOI is a "Participating Physician Group" for Medicare patients. On services covered by Medicare, we may accept assignment. We will verify if the initial yearly deductible is met. If it has not, we will require that it be paid at the time of services. In the case that it has been met, Medicare will send a check to our office for 80% of the approved amount and you will be held responsible for the 20% portion of patient responsibility. As a service, we will file Medicare supplemental insurances that we are in-network with (if a referral is required, as most Medicare replacement plans are HMO's, then it must be submitted on or before the time of service). Although SOI may accept assignment for Medicare patients we require that EVERY patient sign an ABN. Which by law, binds you, the patient, to be held responsible for any portion of the approved amount not covered by Medicare, supplemental, or the secondary insurance carrier.

We are happy to provide treatment for work-related injuries (Workers' Compensation). We will verify with the carrier/adjuster to retain approval of the injury for which you are being referred over and any other compensable injury that we may be able to provide treatment for.

Charges incurred after workers' compensation has denied claim or near denial has stated that no further treatment was necessary will be then be the responsibility of the patient.

Payment for services rendered to dependent children of divorced parents is the responsibility of the guardian who is seeking treatment for the patient, regardless of court-ordered responsibility.

After three statements sent to the patient of any delinquent accounts with no payment, our billing system will then automatically turn over the patient and account balance to our collections agency. If a statement is returned "ADDRESS UNKNOWN." The account will immediately be turned over to collections as it is patients' responsibility to notify us of any changes. After the account has been placed with a collector or a patient has taken bankruptcy relief, the patient will be seen on a CASH ONLY BASIS at the time of service. For service to you, we do allow to put any patients with balances on a

Payment Plan Agreement. This form must be signed after an agreement has been made for clearing out the incurred balance. On this basis, **AND ONLY THIS BASIS**, will we consider calling the collections agency and removing you on terms that we have internally agreed that you we fulfill your agreement to pay the total balance.

There will be a \$35.00 service charge for all returned checks. If returned checks are not picked up and redeemed by cash or money order within 10 working days of notification, the account will be turned over to the collections agency.

There is a "No Show Policy". If you have a Co-pay: For any missed appointments without a 24 hour cancellation notice, you will be billed your co-pay amount. If you do not have a co-pay: For any missed appointments without a 24 hour cancellation notice, you will be billed a \$25.00 charge. After 3 no show appointments, you will automatically be dismissed from the clinic. We have this policy in place and strictly enforce it for the benefits of our patients. If we have enough cancellation notification from one patient, it allows us to fit in another patient who may be waiting to see the same physician.

RECEIVED AND ACKNOWLEDGED

Signature _____

Date _____



**ORTHOPAEDIC & SPINE
INSTITUTE, LLC.**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

<p><i>For office use only:</i></p> <p>Patient Name: _____</p> <p>Medical Record #: _____</p> <p>Date of Admission: _____</p>
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By signing this form, you acknowledge that ORTHOPAEDIC & SPINE INSTITUTE has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

- I have received ORTHOPAEDIC & SPINE INSTITUTE'S Privacy Notice.
- ORTHOPAEDIC & SPINE INSTITUTE has given me the chance to discuss my concerns and questions about the privacy of my health information.

Patient's Signature

Date

ORTHOPAEDIC & SPINE INSTITUTE's staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

- Yes No

Please explain why the patient was unable to sign an acknowledgement form and ORTHOPAEDIC & SPINE INSTITUTE's efforts in trying to obtain the patient's signature:
