



**OHIO ORTHOPAEDICS
& SPORTS MEDICINE, INC.**

ADVANCED SPECIALTY CARE
CENTER OF EXCELLENCE SINCE 1974™

Ohio Orthopaedics & Sports Medicine Inc

1501 Bright Road
Findlay, OH 45840
(419) 424-0131

PATIENT INFORMATION									
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS			CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE		DAY PHONE		EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
PRIMARY EMPLOYER					SECONDARY EMPLOYER (if Applicable)				
ADDRESS					ADDRESS				
CITY, STATE ZIP					CITY, STATE ZIP				
WORK PHONE					WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)									
NAME (Last, First Middle)					SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)				
HOME PHONE		DAY PHONE		EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE		
RELATIONSHIP TO PATIENT									

PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY					POLICY#				
NAME OF INSURED					GROUP#				
ADDRESS OF INSURANCE COMPANY					COPAY AMT \$				
CITY, STATE ZIP			PHONE		DEDUCTIBLE \$				
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE		

SECONDARY INSURANCE (if Applicable)									
NAME OF INSURANCE COMPANY					POLICY#				
NAME OF INSURED					GROUP#				
ADDRESS OF INSURANCE COMPANY					COPAY AMT \$				
CITY, STATE ZIP			PHONE		DEDUCTIBLE \$				
RELATIONSHIP TO PATIENT					EFFECTIVE DATE		EXPIRATION DATE		

I hereby authorize the release of any medical information necessary to process a claim for me and/or my dependent(s). I also authorize the payment of medical benefits directly to Ohio Orthopaedics & Sports Medicine, Inc. for services rendered in my care and/or the care of my dependent(s), realizing I am personally responsible for the charges incurred, including items determined to be non-covered. I also acknowledge that I have been given or have been offered a copy of the practice's privacy notice as required by law.

SIGNATURE OF PATIENT/GUARDIAN

DATE

Ohio Orthopaedics & Sports Medicine, Inc.
Patient Medical History Form

Rev. 011/02/2009 LB

Name _____ Date _____

Primary Care Physician _____

Preferred Pharmacy _____ City _____ Phone _____

Height _____ Weight _____ Left Handed Right Handed

Acid Reflux	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rheumatic Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>
AIDS or HIV	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Bypass (CABG)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Scoliosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Angina	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis – Osteoarthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sleep Apnea	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis – Rheumatoid Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Congestive Heart Failure	Yes <input type="checkbox"/> No <input type="checkbox"/>	CPAP or BIPAP used?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cortisone in the past year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Coronary Artery Stents	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Murmur	Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma controlled by meds?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pacemaker / Defibrillator	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do your symptoms continue?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma meds taken occasionally?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Atrial Fibrillation (A-fib)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Transfusions	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosed Bleeding Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abnormal Liver Tests?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood Clots / DVT	Yes <input type="checkbox"/> No <input type="checkbox"/>	Jaundice	Yes <input type="checkbox"/> No <input type="checkbox"/>	Type _____	
Taking Non-Aspirin Blood Thinners?	Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure (BP)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Urinary Incontinence	Yes <input type="checkbox"/> No <input type="checkbox"/>
Phlebitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	BP controlled by meds?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Urinary Retention Post Op	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Inflammatory Bowel	Yes <input type="checkbox"/> No <input type="checkbox"/>	Previous Anesthesia Problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bronchitis / Pneumonia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Infections	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Type _____		Dialysis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Medical History	Yes <input type="checkbox"/> No <input type="checkbox"/>
COPD / Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lupus	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Home Oxygen or Nebulizer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Migraines	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____	
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Prostate Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Last Tetanus Shot	Date/Year: _____
Treatment: Diet <input type="checkbox"/> Oral <input type="checkbox"/> Insulin <input type="checkbox"/> None <input type="checkbox"/>		Fibromyalgia	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Date Unknown	
		Depression	Yes <input type="checkbox"/> No <input type="checkbox"/>		

MEDICATIONS (Please list all medications, dosage and frequency)

No Medications

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

ALLERGIES (Please list all allergies and associated reactions).

No Known Drug Allergies

1. _____	Reaction _____	4. _____	Reaction _____
2. _____	Reaction _____	5. _____	Reaction _____
3. _____	Reaction _____	6. _____	Reaction _____

SURGICAL HISTORY (Please list all surgeries and the year they occurred)

No Surgical History

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

SOCIAL HISTORY

Smoker Yes No Former
 Cigarettes Cigars Pipe Snuff/Chew
Packs per Day _____ How Long? _____
Illegal Drug Use Yes No Former How much? _____
Alcohol Use? Yes No Former How much? _____

OFF WORK / WORK-RELATED

Have you been off work for this problem? Yes No
Who put you off work? When? _____
Is this a work-related injury/problem? Yes No Date _____

FAMILY HISTORY

Patient Adopted / Family History Unknown

Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tuberculosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Malignant Hyperthermia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Stroke	Yes <input type="checkbox"/> No <input type="checkbox"/>
High / Low Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
DVT / Blood Clots	Yes <input type="checkbox"/> No <input type="checkbox"/>		

RECENT HEART TESTING

Stress Test Yes No Where/When _____
Echocardiogram Yes No Where/When _____
Heart Cath Yes No Where/When _____

NSAIDS / MEDICATIONS

Does your family physician permit you to take any of the following?
Motrin Yes No Ibuprofen Yes No
Aleve Yes No Aspirin Yes No

OHIO ORTHOPAEDICS & SPORTS MEDICINE, INC.

FINANCIAL POLICY

Effective 10/28/2009

General Payment:

All charges for services rendered in the office will be due and payable at the time of service. We accept cash, check or credit card (Visa, MasterCard, Discover or Care Credit) as forms of payment. Exceptions to this policy are given for insurance companies that we contract with, Aetna, all Blue Cross & Blue Shield plans through Anthem, Ball Metal's Insurance Program, CIGNA, Medical Mutual of Ohio, Integrated Health Plans, Interplan Health, Ohio Health Reach, Northwest Ohio Health Partners, Ohio Health Choice, Central Benefits, American Community Mutual Insurance, Whirlpool Corporation's Insurance Program, United Healthcare, Workers' Compensation, Hancock County Medicaid (Buckeye Community Health and Ohio Medicaid) and Medicare. Co-payments on any of these companies are due at the time of service. In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Regarding your insurance:

As a courtesy to you, we will submit medical claims to your insurance company, both primary and secondary. Any balance after processing of our claim by your carrier is your responsibility. Your insurance policy is a contract between you, your employer and your insurance company. You are responsible for verifying if providers are in-network with your insurance plan. We cannot bill your insurance company unless you provide us your complete insurance information. It is your responsibility to know your insurance benefits; they may not cover all of the services provided to you.

Returned Check Policy: A fee of \$25.00 will be applied to your account for any returned checks.

Regarding Personal Injury:

We require a financial arrangement be established for payment in full at the time of service for personal injury cases. We are not a party to any litigation suits being filed for personal injuries. We will provide you with medical records pertaining to your care for your litigation. We do not accept letters of protection from attorneys.

Regarding Work-Related Injuries:

We will file Workers' Compensation claims with your employer's MCO. Written or telephone authorization is required from your employer prior to treatment. If prior authorization is not obtained, you are responsible for full payment at the time of service. If your company's MCO has not paid your account in full within 90 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date.

Divorce Decree:

In the instance of a divorce, the responsibility for payment for services rendered to any dependent child is the responsibility of the parent who seeks treatment. We are not a party to the divorce decree.

Phone Requests for Prescription Refills:

There will be a charge of \$10.00 for all phone requests for prescription refills. Refills can be obtained during your appointment at no charge.

Assistants in Surgery:

Your physician may determine that it is in your best interest to have an assistant during your surgical procedure. The assistant on your case will be one of our other physicians or one of our physician assistants. We cannot guarantee payment for this service by your insurance company. We will bill your insurance company for the assistant's services. If they allow this service we will only bill you for what they **allow**. If they do not allow the assistant, we will bill you a base charge of \$300.00 for the assistant's services regardless of what is submitted to the insurance company. This basic amount will be your responsibility.

Patient / Guardian Signature

Date

Patient Printed Name