OHIO ORTHOPAEDICS & SPORTS MEDICINE, INC.
ADVANCED SPECIALTY CARE
"CENTER OF EXCELLENCE SINCE 1974"™

Ohio Orthopaedics & Sports Medicine Inc
301 W Wallace St
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 ☐ Full-Time ☐ 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 ☐ Full-time ☐ 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

Name ______________________________ **Date** __________

Primary Care Physician ______________________________

Preferred Pharmacy ______________________________ **City** ______________ **Phone** ______________

Height ________ **Weight** ________ ☐ **Left Handed** ☐ **Right Handed**

Condition	Yes	No
Acid Reflux	Yes ☐	No ☐
AIDS or HIV	Yes ☐	No ☐
Anemia	Yes ☐	No ☐
Arthritis – Osteoarthritis	Yes ☐	No ☐
Arthritis – Rheumatoid Arthritis	Yes ☐	No ☐
Cortisone in the past year?	Yes ☐	No ☐
Asthma	Yes ☐	No ☐
Asthma controlled by meds?	Yes ☐	No ☐
Medications taken occasionally?	Yes ☐	No ☐
Back Problems	Yes ☐	No ☐
Diagnosed Bleeding Disorder	Yes ☐	No ☐
Blood Clots / DVT / Phlebitis	Yes ☐	No ☐
Taking Blood Thinners?	Yes ☐	No ☐
High Cholesterol	Yes ☐	No ☐
Bronchitis / Pneumonia	Yes ☐	No ☐
Cancer	Yes ☐	No ☐
Type ______________	Yes ☐	No ☐
COPD / Emphysema	Yes ☐	No ☐
Home Oxygen or Nebulizer?	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Treatment: ☐ Diet ☐ Oral ☐ Insulin ☐ None		
Heart Disease	Yes ☐	No ☐
Heart Bypass (CABG)	Yes ☐	No ☐
Angina	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐
Congestive Heart Failure	Yes ☐	No ☐
Coronary Artery Stents	Yes ☐	No ☐
Murmur	Yes ☐	No ☐
Pacemaker / Defibrillator	Yes ☐	No ☐
Hepatitis	Yes ☐	No ☐
Abnormal Liver Tests?	Yes ☐	No ☐
High Blood Pressure (BP)	Yes ☐	No ☐
BP controlled by meds?	Yes ☐	No ☐
Inflammatory Bowel	Yes ☐	No ☐
Jaundice	Yes ☐	No ☐
Kidney Disease	Yes ☐	No ☐
Infections	Yes ☐	No ☐
Dialysis	Yes ☐	No ☐
Lupus	Yes ☐	No ☐
Migraines	Yes ☐	No ☐
Prostate Disease	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐
Scoliosis	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Sleep Apnea	Yes ☐	No ☐
CPAP or BIPAP used?	Yes ☐	No ☐
Stroke	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐
Do your symptoms continue?	Yes ☐	No ☐
Transfusions	Yes ☐	No ☐
Tuberculosis	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐
Type ______________	Yes ☐	No ☐
Previous Anesthesia Problems?	Yes ☐	No ☐
Other Medical History	Yes ☐	No ☐

Last Tetanus Shot Date/Year: __________ ☐ Date Unknown

MEDICATIONS ☐ No Medications *(Please list all medications, dosage and frequency)*

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

ALLERGIES ☐ No Known Drug Allergies *(Please list all allergies and associated reactions).*

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

SURGICAL HISTORY ☐ No Surgical History *(Please list all surgeries and the year they occurred)*

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________
7. ______________
8. ______________
9. ______________
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? __________

FAMILY HISTORY

Condition	Yes	No	Condition	Yes	No
Heart Disease	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Malignant Hyperthermia	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
High / Low Blood Pressure	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐

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 __________

RECENT HEART TESTING

Test	Yes	No	Where/When
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 medications? Motrin Yes ☐ No ☐ Ibuprofen Yes ☐ No ☐ Aleve Yes ☐ No ☐ Aspirin Yes ☐ No ☐

OHIO ORTHOPAEDICS & SPORTS MEDICINE, INC.

FINANCIAL POLICY

Effective 05/14/2009

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 or Discover) 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, 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. An **Administrative fee of $10.00** will be applied to your account if full payment is not received by the statement due date, unless prior arrangements have been made. **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 the information to assist you with 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