midwest
ORTHOPEDIC PAIN & SPINE

Patient Name: _____ Date of Birth: ____/____/_____

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

Home Phone: _____ Cell Phone: _____ Work Phone_____

Social Security Number: _____ Age: _____ Gender: Male Female

Marital Status: S M D SEP W Spouse: _____

Who referred you to our office? _____

Email: _____ Primary Care Doctor: _____

Cardiologist: _____ Date Last Seen Primary Doctor: _____

Employer: _____ Occupation: _____

If under 18, legal parent or guardian: _____

Emergency Contact: _____ Phone number: _____

Race: _____ Ethnicity: _____ Language: _____

**** Payment is required at time of service****

Primary Insurance

Insurance Company: _____ ID: _____ Group Number: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's DOB: ____/____/_____ Insured's SSN: _____

Insured Address: _____

Secondary Insurance

Insurance Company: _____ ID: _____ Group Number: _____

Name of Insured: _____ Relationship to Patient: _____

Insured's DOB: ____/____/_____ Insured's SSN: _____

I certify that the information given by me is applying for payment and medical treatment is correct. I request that payment of authorized benefits be made to Midwest Orthopedic Group on my behalf.

Signature: _____ Date: ____/____/_____

Patient Name (Print): _____

Guardian Name: _____ Date: ____/____/_____

PATIENT NAME: _____ DOB: _____ DOS: _____

Reason for visit

What are we seeing you for today? □ Left □ Right _____

Was there an injury? □ No □ Yes

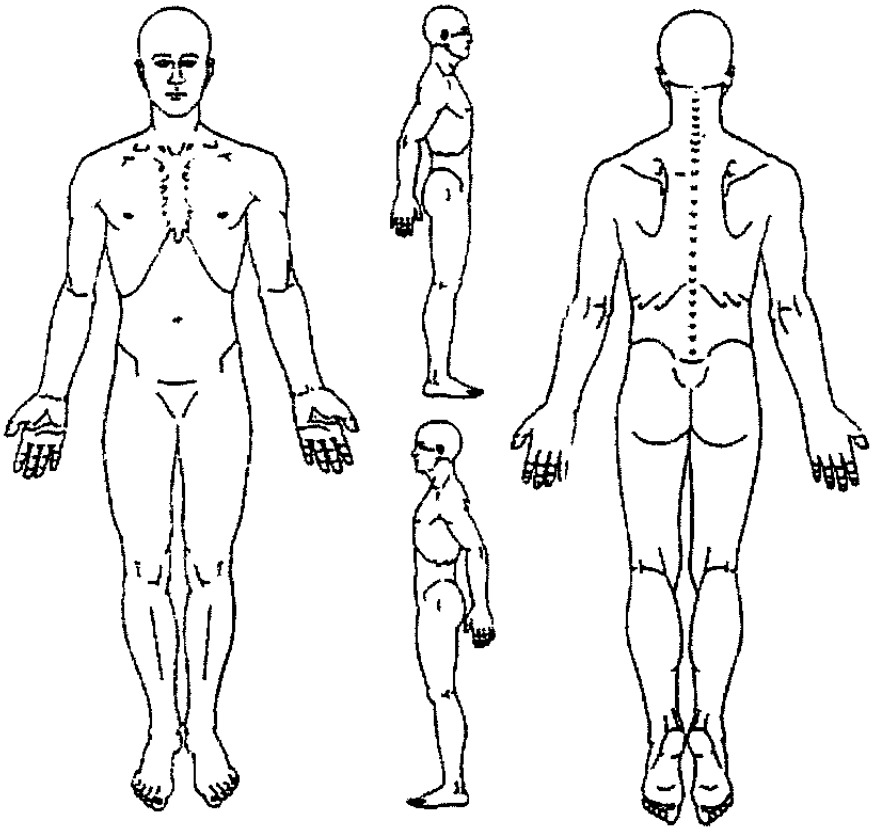
How did the injury occur? _____

_____

Is the injury work related? □ No □ Yes Date of injury _____/_____/_____

Use the diagram to describe the pain

A	Aching
PN	Pins and Needles
N	Numbness
S	Stabbing
B	Burning



Please rate your pain. Circle the number that indicates what your pain is currently.

1 2 3 4 5 6 7 8 9 10

Have you been treated for this issue in the past? □ No □ Yes Who? _____

What kind of treatment have you received?

□ NSAIDS □ Injections □ Ice □ Brace □Physical Therapy □ Imaging (X-ray/ MRI)

Patient Name: _____ DOB: _____

Medication List

Please include ALL medications, even over the counter medication and vitamins

Medication Name	Dosage	Medication Name	Dosage

Allergies

Personal Medical History

	Please list any other medical conditions/diagnosis below:
□ Vascular Disease	
□ Heart Disease	
□ Stroke	
□ Neuropathy	
□ Diabetes Type : _____	
□ Seizures	
□ Kidney Disease	
□ Osteoarthritis	
□ Rheumatoid Arthritis	
□ Blood Clots	
□ Cancer	
□ High Blood Pressure	
□ Mental Illness	
□ Thyroid Disease	
□ Bleeding Disorder	
□ Osteoporosis	

Social History

Cigarettes: YES or NO Packs/Day: _____ If yes, what age did you start smoking? _____

Quite Smoking? YES or NO If yes, when did you stop smoking? _____

Chewing Tobacco: YES or NO Cans/Day: _____

Alcohol use? Yes or No Amount and how often: _____

Family Medical History

	Mother	Father	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother
Heart Disease	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Children:_____ Son(s):_____ Daughter(s):_____

Siblings: _____ Brother(s):_____ Sister(s):_____

Surgical History

Please list ALL previous surgeries

YEAR	PROCEDURE(S)

Height: _____ ft _____in What Pharmacy do you routinely use?

Weight: _____ _____

Review of Symptoms

Constitutional Symptoms:	YES	NO
Are you in good general health?	☐	☐
Recent weight changes?	☐	☐
Fatigue?	☐	☐
Fever?	☐	☐
Headaches?	☐	☐

Ears/Nose/Mouth/Throat:	YES	NO
Hearing loss or ringing in ears?	☐	☐
Earaches or drainage?	☐	☐
Chronic sinus problems/rhinitis?	☐	☐
Nose bleeds?	☐	☐
Bleeding gums?	☐	☐
Sore throat or voice changes?	☐	☐
Swollen glands in neck?	☐	☐
Sleep apnea?	☐	☐

Eyes:	YES	NO
Eye disease or injury?	☐	☐
Wear glasses or contacts?	☐	☐
Blurred vision or double vision?	☐	☐
Glaucoma?	☐	☐

Cardiovascular:	YES	NO
Heart trouble?	☐	☐
Chest pain?	☐	☐
Palpitations?	☐	☐
Shortness of breath?	☐	☐
Swelling of the feet, ankles, hands?	☐	☐

Respiratory:	YES	NO
Chronic or frequent cough?	☐	☐
Spitting up blood?	☐	☐
Asthma?	☐	☐

Gastrointestinal:	YES	NO
Loss of appetite?	☐	☐
Nausea or vomiting?	☐	☐
Frequent diarrhea?	☐	☐
Constipation?	☐	☐
Rectal bleeding or blood in stool?	☐	☐
Abdominal pain?	☐	☐
Heartburn?	☐	☐
Peptic ulcer?	☐	☐

Genitourinary:	YES	NO
Frequent urination?	☐	☐
Burning or painful urination?	☐	☐
Blood in urine?	☐	☐
Change in force/strain of urine?	☐	☐
Incontinence or dribbling?	☐	☐
Kidney stones?	☐	☐

Musculoskeletal:	YES	NO
Joint pain?	☐	☐
Joint stiffness?	☐	☐
Joint swelling?	☐	☐
Weakness of muscles or joints?	☐	☐
Muscle pain?	☐	☐
Muscle cramps?	☐	☐
Back pain?	☐	☐

Skin:	YES	NO
Rash?	☐	☐
Itching?	☐	☐
Change in skin color?	☐	☐
Varicose veins?	☐	☐

Endocrine	YES	NO
Glandular or hormone problem?	☐	☐
Thyroid disease?	☐	☐
Excessive thirst?	☐	☐
Excessive urination?	☐	☐
Heat or cold intolerance?	☐	☐
Skin changes?	☐	☐

Psychiatric:	YES	NO
Nervousness?	☐	☐
Depression?	☐	☐
Insomnia?	☐	☐

Hematologic/ Lymphatic:	YES	NO
Slow to heal after cuts?	☐	☐
Bleeding or bruising tendency?	☐	☐
Anemia?	☐	☐
Phlebitis?	☐	☐
Past transfusion?	☐	☐

ADVANCE DIRECTIVE/LIVING WILL

I understand that if an emergency medical condition should occur I will be transferred to the local hospital for further evaluation and treatment. I understand that if I have an advance directive or living will, Midwest Orthopedics and Podiatry will not honor any requests not to resuscitate and will still transfer me to the hospital which will make decisions about following any advance directives or living will.

COPY GIVEN TO MIDWEST ORTHOPEDIC AND PODIATRY

I have the following:

___	Living will	__yes __no
___	Health care surrogate, proxy or durable power of attorney	__yes __no
___	Power of attorney	__yes __no
___	Guardianship	__yes __no
___	NONE of the above	__yes __no

Date of Birth: _____

Patient Signature: _____ Date: _____

Print Name: _____

Midwest Orthopedic Pain & Spine

606 Maple Valley Dr., Farmington, MO 63640
Telephone: 573-756-7779

I, _____, acknowledge that I have received a copy of Midwest Orthopedic Pain & Spine HIPAA Notice of Privacy Practices.

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (Check one):
[ ] Parent [ ] Guardian [ ] Power of Attorney [ ] Other: _____

****Please Note: It is your right to refuse to sign this Acknowledgement indicating that we have offered you a copy of our Notice of Privacy Practices.**

OFFICE USE ONLY

I tried to obtain written Acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: (Please Specify): _____

_____

_____ _____
Staff Member Signature Date

MIDWEST ORTHOPEDIC GROUP

Patient payment responsibility policy

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-insurance amounts, or any other balances not paid for by your insurance company.

NO SHOW FEE

IN THIS OFFICE THERE IS A $25.00 NO SHOW FEE CHARGED TO ACCOUNTS WHEN AN APPOINTMENT IS NOT RESCHEDULED OR CANCELLED 24 HOURS PRIOR TO THE TIME OF THE APPOINTMENT. THIS FEE WILL BE DUE IN FULL PRIOR TO MAKING ANOTHER APPOINTMENT.

COLLECTION ACCOUNTS

If this account is assigned to an attorney/collection agency for collection and/or suit, you as the responsible party agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to the collection agency of not less the 30% of the total collection amount. Such contingency fee will be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

BANKRUPCTY

If you should file bankruptcy and include your account with Midwest Orthopedic Group we reserve the right to discharge you from our practice.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of these portions of the patient's record.

I thereby assign all medical and/or surgical benefits to include major medical benefits to which the patient is entitled, including Medicare, Medicaid, private insurance, and other health plans to: Midwest Orthopedic Group 606 Maple Valley Dr. Farmington, Mo 63640.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee all information necessary to secure the payment.

Responsible Party (please print) Date

Signature

MIDWEST ORTHOPEDIC GROUP

Patient Consent for use and disclosure of protected health information

With my consent, Midwest Orthopedic Group may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Midwest Orthopedic Group's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Midwest Orthopedic Group reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Midwest Orthopedic Group- Attn: Patricia Pierce, Privacy Officer at 606 Maple Valley Drive, Farmington, MO 63640.

With my consent, Midwest Orthopedic Group may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others

With my consent, Midwest Orthopedic Group may review my RX history through my insurance company.

Signature of Patient/ Guardian/ Parent Printed Name Date

I have the right to request that Midwest Orthopedic Group restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke this consent; Midwest Orthopedic Group may decline to provide treatment to me.

Signature of Patient/ Guardian/ Parent Printed Name Date

Permission to Contact and Release of Information

In order to improve communications between the office and our patients, an automatic service may be utilized to confirm your appointment. Please check the following options below to receive your confirmation call:

Please contact me at : ◻ HOME ◻ CELL ◻ WORK

You may leave me a message at : ◻ HOME ◻ CELL ◻ WORK

There may be times when we need to speak to you personally regarding your appointment, to confirm your appointment, or to discuss your confidential health information. Please provide how and where you would like to be contacted. Please check the boxes below to indicate your preference.

Please contact me at : ◻ HOME ◻ CELL ◻ WORK

_____I request that you leave a message on my voicemail but only to indicate you have called and I will return your call.

_____ You may at any time release my confidential health information to: (If no names are listed, we will not release any information.)

Name Relationship to Patient Phone Type Phone Number

Name Relationship to Patient Phone Type Phone Number

Signature of Patient/ Guardian/ Parent Printed Name Date