MIDLANDS **orthopaedics** & NEUROSURGERY

LAST NAME:	**FIRST NAME:**	**MIDDLE INITIAL:**
GENDER:	**DATE OF BIRTH:**	**SS#:**

MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

HOME #:	**MOBILE #:** **CONSENT TO TEXT:** YES or NO	**WORK #:**

Email: Consent to call: YES or NO	**Contact preference: (please circle)** Home # Cell # Work # Email Mail Portal

LANGUAGE: DECLINE TO ANSWER ☐	**RACE:** DECLINE TO ANSWER ☐	**ETHNICITY:** DECLINE TO ANSWER ☐

MARITAL STATUS:	**Emergency Contact Name/Relationship:**	**Mobile #:** **Home #:**

PATIENT'S EMPLOYER: **OCCUPATION:**	**Referring Doctor:** ☐ **Self-Referred**	**How did you hear about us?** Friend/Family Google Social Media Billboard Website Physician Referral TV/Radio Other:

GUARANTOR - PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR OR STUDENT:

LAST NAME:	**FIRST NAME:**	**RELATIONSHIP:**

MAILING ADDRESS:	**CITY:**	**STATE:**	**ZIP CODE:**

DATE OF BIRTH:	**SS#:**	**HOME #:**	**MOBILE #:**	**WORK #:**

*INSURANCE INFORMATION *COPIES OF YOU INSURANCE CARDS ARE REQUIRED**

INSURANCE #1 (PRIMARY INSURANCE)		**INSURANCE #2 (SECONDARY INSURANCE)**	
INSURED'S NAME:	**RELATIONSHIP TO PATIENT:**	**INSURED'S NAME:**	**RELATIONSHIP TO PATIENT:**
SS# OF INSURED (IF DIFFERENT FORM PATIENT): ☐ Same as above		**SS# OF INSURED (IF DIFFERENT FORM PATIENT):**	
DATE OF BIRTH OF INSURED: ☐ Same as above		**DATE OF BIRTH OF INSURED:**	
INSURED'S EMPLOYER		**INSURED'S EMPLOYER**	

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Midlands Orthopaedics & Neurosurgery, PA , all health insurance benefits available for services provided to me. I understand that fees for services provided by Midlands Orthopaedics & Neurosurgery, PA, are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

Patient/Guarantor:______________________________ Date:__________________

MIDLANDS ORTHOPAEDICS & NEUROSURGERY (MON) AUTHORIZATIONS AND ACKNOWLEDGEMENTS

1. **NOTICE OF PRIVACY POLICIES**: I have been offered a copy of the *MON Notice of Privacy Policies* detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law. I understand that MON is permitted to disclose my PHI without my authorization to facilitate treatment, payment and health care operations. This Notice is always available on the MON website *(www.midorthoneuro.com)* and at each office location upon request.

2. **FINANCIAL POLICY:** I have been offered a copy of the *MON Financial Policy* and acknowledge its requirements. This Notice is always available on the MON website *(www.midorthoneuro.com)* and at each office location upon request.

3. **ePrescribe**: I understand that MON utilizes electronic health record software which incorporates ePrescribing technology. I understand that MON may access and use my prescription history through ePrescribing software to facilitate appropriate treatment.

4. **PAPERLESS BILLING:** MON delivers paperless billing statements via our patient portal. I understand that I am automatically enrolled to receive paperless billing statements via the email address provided at registration. Changes to statement preferences may be made via the patient portal at any time.

5. **PATIENT PORTAL:** The patient portal is the most efficient tool to securely request appointments and communicate with our staff members, allowing you to bypass our phone system completely. Registering by smartphone is fast and easy. Ask the front desk staff to send a text with the registration link. Use the link and temporary password to login. You may also follow the Patient Portal link on our website (www.midorthoneuro.com), and click "Sign Up Today." You will need to enter your name, date of birth and email address as they appear in your MidOrthoNeuro account.

I acknowledge understanding of the items described on this Authorizations & Acknowledgements form.

____ ____________________

Patient/Guardian Signature *Date*

HIPAA PRIVACY AUTHORIZATION

I hereby authorize Midlands Orthopaedics & Neurosurgery, PA, to use and/or disclose the protected health information below to: [Name of individual, Address, and Telephone Number] (i.e. Spouse, Family member, Doctor, etc)

NAME	CONTACT INFORMATION

Authorization for Release of Information:

-Covering the period of health care from:

Date:______________________to_____________________ ***OR*** ☐ All past, present and future periods

-Covering the following protected health information:

☐ I hereby authorize the release of my complete health record.

☐ I hereby authorize the release of my complete health record with the exception of the following Information:

____

____

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative Relationship to Patient

GENERAL MEDICAL INFORMATION

Reason for your visit today? ____

Was this the result of an accident?___No______Yes If yes, DATE of accident and please describe.

Date: __________ ____

____

____

Where did the injury occur?___Work___Auto___Home__Other__________________________

Primary Physician Information Name:	**Other specialists involved in care:**
Please provide your preferred pharmacy information.	
Preferred Pharmacy: Name: Address: Phone:	**Mail-In Pharmacy:** Name: Address: Phone:

Height:___________**Weight**:______________

Current Pain Scale: (circle one number)

	MILD			MODERATE			SEVERE			
NO PAIN	1	2	3	4	5	6	7	8	9	10	SEVERE PAIN

ALLERGIES AND REACTIONS (List allergies to medications, metals or latex)			
Name of Allergy:	Reaction:	Name of Allergy:	Reaction:

FAMILY HISTORY (Please check any that have occurred with a blood relative.)			
	Relationship		**Relationship**
Blood Clots in Legs or Lungs		Heart Disease	
Bleeding Disorder		Aneurysm	
Osteoporosis		High blood pressure	
Osteoarthritis		Diabetes	
Rheumatoid arthritis		Nerve Disease	
Muscle or Bone Disease		Depression	
Cancer		Lupus	
Thyroid disease		Malignant Hypothermia	

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Social History: *(please circle what applies to you)*

Are you a: Current Smoker | Nonsmoker | Former Smoker	
Tobacco-years of use (current and former smokers):	
If current smoker, how often do you smoke cigarettes? Every Day | Some Days	
If current smoker, how much do you smoke per day? ¼ PD | ½ PD | 1 PD | 1 ½ PD | 2PD | 3PD	
Cigar/pipe Use: Yes | No	
Chewing Tobacco: 1/day | 2-4/day | 5/day	
Alcohol: None | Occasional | Moderate | Heavy	
Number of Children?	
Marital Status: Married | Single | Divorced | Separated | Widowed | Domestic Partner	
Diet: Regular | Vegetarian | Vegan | Gluten free | Carbohydrate (limited) | Cardiac | Diabetic	
Work History: Disabled | Student | Homemaker | Retired	
Are you currently employed? Yes | No	**Are you currently working?** Yes | No
Occupation:	
Employer:	
Type of work:	

Surgical History/Broken Bones/Recent Hospitalizations:	**ALL Daily Medications**
Please List:	Please list:

Past Medical History: *(please circle all that apply to you)*		
Blood Clots in legs or lungs	Diabetes	Bronchitis
High Blood Pressure	Lupus	Skin Disorder
Congestive Heart Failure	Parkinson's Disease	Enlarged prostate
Heart Disease	Multiple Sclerosis	Bladder disease
Mitral Valve Prolapse	Hepatitis B or C	Kidney disease
Heart Attack	Stomach Ulcers	Seizure disorder
Irregular Heart Beat	Irritable Bowel	Thyroid Disorder
Congenital Heart Defect	Heartburn	Cancer
High Cholesterol	Liver Disease	Glaucoma
Stroke	Pneumonia	Osteoarthritis
Circulation problems	Tuberculosis	Rheumatoid Arthritis
Bleeding disorder	Emphysema	Restless legs
Gout	Infectious Blood Disease	Pregnancy (current or recent)

Do you have sleep apnea? Yes or No
If yes, do you use C-PAP or Bi-PAP? Yes or No Device Settings:

Do you have cardiac stents: Yes or No If yes, please list date(s):

Do you have a pacemaker or AICD? Yes or No If yes, please date of placement:

Review of Systems: *(Please circle all that apply to you)*

Mouth/Throat: sore throat | bleeding gums | snoring | dry mouth | mouth ulcers | oral abnormalities | teeth problems

Cardiovascular: shortness of breath | palpitations | heart murmur

Respiratory: coughing | wheezing | shortness of breath | coughing up blood | sleep apnea

Musculoskeletal: muscle aches | muscle weakness | joint pain | back pain | swelling in extremities | cramps | Osteoporosis | recent fracture | neck pain

Any additional information you would like to share:

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History of Present Illness: *(Please circle all that apply)*

Body Part:____

Location: left | right | left & right | front | back | in the middle | on the side | deep | surface

Type of pain: aching | burning | gnawing | stabbing | throbbing | sharp | dull | superficial | deep | occasional | frequent | constant | worsening | improving | not changing

Severity: no pain | mild | moderate | severe | pain level_______/10 | worst pain_____/10

Duration: date of onset:_______| days_______| weeks_______| months_______|years_______| continuous since onset

Timing: cannot identify | acute | chronic | gradual | morning | daytime | nighttime | recurrent | rare | occasional | intermittent episodes lasting:____________________________

How did injury occur: fall | bending | lifting | twisting | sports injury | work injury | MVA | assault | overuse | cut | no injury

What helps ease the pain/discomfort: nothing helps | sitting | standing | lying down | position change | heat | ice | r e s t | elevation | exercise | stretching | limited weight bearing | PT/OT | chiropractic care | ESI | over the counter medication | narcotics | NSAIDs | cortisone injection | viscosupplement injection | orthotics | previous surgery | brace |crutches | cane | wheelchair |walker

What movements cause pain/discomfort: cannot identify | sitting | standing |lying down | walking | lifting | carrying | twisting | bending/squatting | pushing/pulling | weight-bearing | exercise | previous surgery | changing clothes | getting out of bed | going from sit to stand | upstairs | downstairs | morning | d aytime | nighttime | cold weather | damp weather

Describe the pain/discomfort: weakness | numbness | tingling | swelling | redness | warmth | bruising | catching/locking | popping/clicking | buckling | grinding | instability | radiation down leg | drainage | fever | chills | weight loss | loss of consciousness | weakness | numbness | seizures | dizziness | headaches | migraines | restless legs | loss of bowel/bladder habits

Previous Surgery:(on affected body part): none | Yes, date:________________________________

Prior Imaging: no recent studies | x ray | MRI | CT scan | bone scan | EMG

Previous Injections: none | did not help | helped a little | helped temporarily | helped significantly

Previous Physical Therapy: none | did not help | helped a little | helped temporarily | helped significantly

Working: no | regular duty | modified duty

When did your pain first start? (date or approx. month/year): __________________________

When did it worsen? (date and event, if applicable) ___________________________________

Rate the severity of your pain on a scale from 1 to 10, with 1 being the least painful and 10 being the most severe:
1 2 3 4 5 6 7 8 9 10

Type of pain (circle all that apply):

Aching Cramps Numbness Shooting Swelling Tingling

Burning Dull Sharp Stiffness Throbbing

Does the pain interfere with any of the following activities of daily living? (Circle all that apply)

Bathing Feeding Grooming Sleep Work

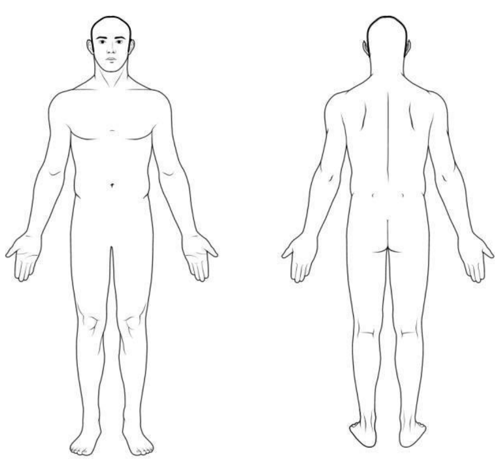
Dressing Food preparation Housework Toilet hygiene

How often are you having pain? _______Constant ______ It comes and goes

Activities or movements that are painful to perform: (circle all that apply)

Bending Lying down Sitting Standing Walking

Mark "X" on the picture where you are having pain, numbness or tingling:



In the past 6 months, have you received any formal therapy <u>for this condition</u>? ___Yes ___No
If yes, when? ________________________________

Do you perform home exercises/stretches <u>for this condition</u>?_Yes_ No

Have you received an Epidural Steroid Injection <u>for this condition</u>?_Yes_ No
If yes, when? ______________________________

What percentage relief did the injection provide?
____

For how long? _________________ (hours, days, weeks, months)
When did the pain return? (date)
____

Have you tried any of the following for pain relief?	YES	NO	Did this provide relief?	Name of Medication
Heat				
Ice				
Over the Counter Medications				
Prescription				

Are you claustrophobic (fear of being in a closed/confined place)? _____Yes _____No

Do you have metal in your body? ____Yes ___ No If yes, where? _________________________________