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? (Please circle) 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*

INSURNACE #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 EMPLOYER (IF DIFFERENT FROM PATIENT): ☐		INSURED EMPLOYER (IF DIFFERENT FROM PATIENT):	

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 expenses incurred in their entirety.

Patient/Guarantor:_____Date:_____

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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*

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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

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GENERAL MEDICAL INFORMATION

Reason for your visit today? _____

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

CURRENT Height:_____ **Weight**:_____

ALLERGIES AND REACTIONS (list allergies to Medications, Metals or Latex)	
Name of Allergy:	Reaction:

FAMILY HISTORY please check any that has 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	

PAIN SCORE ***(please circle what applies to you)***	
Current Pain score:	**0 1 2 3 4 5 6 7 8 9 10**
Pain score at worst:	**0 1 2 3 4 5 6 7 8 9 10**
Pain score at best:	**0 1 2 3 4 5 6 7 8 9 10**
Average pain score:	**0 1 2 3 4 5 6 7 8 9 10**

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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 you are a current smoker, how often do you smoke cigarettes? Every Day | Some Days

If you are a 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:

If employed, what type of work do you do?

Are you currently involved in a lawsuit/pending lawsuit?

Are you on disability?

How much does your pain interfere with your ability to work/daily activities?
[ ] No Interference [ ] Moderate Interference [ ] Extreme Interference

SOCIAL/PSYCHOLOGICAL HISTORY	**Yes**	**No**
Do you have a personal history of alcohol abuse?		
Do you have a personal history of illegal drug use?		
Do you have a personal history of prescription drug abuse?		
Do you have a personal history of preadolescent sexual abuse?		
Do you have a history of ADD/ADHD, OCD, bipolar, or schizophrenia?		
Do you have a history of depression?		
Have you ever received outpatient psychiatric treatment or counselling?		
Have you ever been hospitalized for a psychiatric reason?		
Have you ever used prescription medications inappropriately?		
Do you use street drugs?		
Do you ever have nightmares or flashbacks about traumatic experiences? Do you smoke? If so, how many packs per day and for how long?		
Are you currently taking any narcotic/opioid medications?		

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Diagnostic Tests: Please circle all that apply

X-Rays MRI CT Scan Myelogram Discogram Bone Scan EMG/NCS

Other:_____

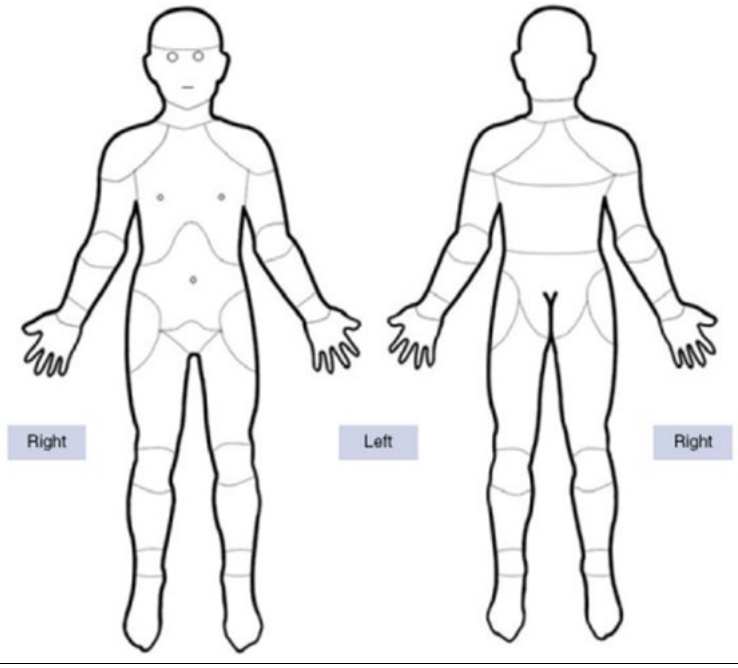
Procedures Tried: Please circle all that apply

Trigger point injection	Epidural Steroid Injection	Spinal Cord Stimulator
Sympathetic nerve block	Vertebroplasty/kyphoplasty	Intrathecal pump
Facet joint injection	Medical branch block	Radiofrequency ablation
Shoulder injection	Hip injection	Knee injection
Sacroiliac joint injection	Genicular nerve block/ablation	Pirformis injection

Surgical History/Broken Bones/Recent Hospitalizations:	**ALL Medications that your take every day & as needed**

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

If you have pain that radiates, please indicate with a line.



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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 Heartbeat	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

Do you have cardiac stents, pacemaker or AICD: If yes, please list date(s):

Do you have any implantable devices: If yes, please list device and date(s):

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

Constitution	**Eyes**	**Gastrointestinal**	**Hematology**
Fever/chills Weight loss Malaise/fatigue Night sweats Weakness Swollen lymph nodes	Blurred/changes to vision Light sensitivity Eye pain Eye discharge Dry eyes	Heartburn Nausea/Vomiting Abdominal pain Diarrhea Constipation Incontinence of stool	Easy bruising Easy bleeding Blood clots
Skin	**Cardiovascular**	**Genitourinary**	**Neurological**
Rash Itching Hair loss Fingers turn white with cold	Chest pain Palpitations Difficulty breathing when lying flat Ankle/leg swelling	Painful urination Blood urine Flank pain Incontinence of urine	Dizziness Lightheadedness Headaches Tingling Tremor Sensory change Seizures
Ears/Nose/Throat	**Respiratory**	**Musculoskeletal**	**Psychiatric**
Hearing loss Ear pain Sinus pain Sore throat Swollen lymph nodes Dry mouth Nose bleeds	Cough/cold Sputum production Shortness of breath Wheezing	Muscle pains Neck pain Back pain Joint pain Recent falls Loss of height	Depression Suicidal thoughts Hallucinations Anxiety Difficulty sleeping Memory loss

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