ORTHOPAEDICS NEW ENGLAND

Patient Information Form & Medical History

This form asks important information that we need to document for medical, legal, and insurance purposes.
All information is confidential and kept as part of the medical chart in this office.

Patient Name: _____ Date:__/___/____

Primary Care MD: _____ Date of Birth:_____ Age_____

□ Female □ Male Height ____' _/_____" Weight_____lbs

Occupation: _____Employer: _____

Are you currently working: □Yes □No If **No, how long have you been off work?** _____

If working, can you please describe what's involved? (e.g, heavy lifting, desk work, etc. _____

_____

Did you bring your x-rays or MRI films with you today? □ Yes □ No

Who requested that you visit this office?_____ or □ Self-Referral?

May we send a letter to the referring physician and /or your Primary Care MD? □ Yes □ No

_____

What body part is/are involved? (Right / Left / Both)_____

Can you please describe the nature of your problems?

_____

_____

Have you had a **prior** problem with this same condition in the past? (explain below if yes)

_____

How long has this problem been present? _____

Check the ONE box which best fits how your problem started.(Use as much space to the right as needed)

□ **NO INJURY** (for example: arthritis pain) (Onset was □ **Gradual** or □ **Sudden**)

Why do you think it started? _____

□ **AUTO ACCIDENT** □ **WORK RELATED** □ **INJURY** (other than an auto accident or work injury)

Date _____ Where and How did it Happen? _____

The pain or problem is : □Constant □Comes and goes (Intermittent)

Severity of pain/problem: 0= no pain and 10= severe pain

Check one □ 1□ 2□ 3 □4 □5 □6 □7 □8 □9 □10

What is the **Quality** of the pain? □Sharp □Dull □ Stabbing □ throbbing □ Aching □ Burning □ Other _____

Are there associated symptoms? □ Swelling □ Numbness □ Weakness □Redness □Other _____

Since the problem started, is it: □Getting better □ Getting Worse □ Unchanged

What makes your symptoms **worse?** □ Activity □ Exercise □ Work □ Other _____

Does anything make you feel **better?** □ Ice □ Heat □ Rest □ Elevation

Have you tried any of the following for this problem? □ Brace □ Cane □ Crutches □Walker
□ Orthotics/prescription shoes □ Other _____

Have you tried **physical therapy** for this problem? If so, how recently? _____

Have you ever had any **steroid (cortisone) injections** for this problem? If so, how recently? _____

Have you ever had any **Synvisc, Hyalgan, Supartz, or Euflexxa** injections for this problem? If so, how recently ? _____

HAVE YOU TAKEN ANY OF THE FOLLOWING FOR THIS PROBLEM: (Circle all that apply)

Advil Ibuprofen/Motrin Lodine Naprosyn Tylenol Ultram/Tramadol Celebrex Mobic Aspirin
How long have you taken them? _____

ARE YOU A DIABETIC? ☐ YES ☐ NO

IF DIABETIC, CURRENT TREATMENT: ☐ Insulin ☐ Oral Medications ☐ Diet ☐ None

PAST SURGICAL HISTORY: What operations have you had in what years? ☐ None

_____

_____

Have you ever had a reaction to anesthesia? ☐Yes ☐ No

If yes, please elaborate: _____

Have you ever had a blood transfusion? ☐Yes ☐ No

Did you have any problems with it? _____

Do you have any Allergies? ☐ Yes ☐ No Food ☐ Metal ☐ Medicine ☐List them: _____

FAMILY HISTORY: Have any direct relatives had any of the following disorders?

☐ **Diabetes** ☐ High Blood Pressure ☐ Heart disease ☐ Arthritis ☐ Cancer

Any direct relative with the **same Orthopaedic condition** you are being seen for today?

_____

Do you currently use tobacco? ☐None ☐ Yes : Packs per day _____ ☐ Used to smoke, but stopped _____years ago.

Alcohol use? ☐ None ☐ Yes How often? _____ How much? _____

(Please check all that apply, or make None)	**None**	**Year**	**Explain Details/Comments**
☐ Weight loss ☐ Loss of appetite ☐ Fever ☐ Cancer	☐		
☐ Glasses ☐ Contacts ☐ Double vision ☐Cataract ☐ Blindness	☐		
☐ Hearing Loss ☐ Hoarseness ☐ Ringing in Ears	☐		
☐ High Blood Pressure ☐ Heart condition ☐ Blood clots ☐ Atrial Fib	☐		
☐Asthma ☐ Cough ☐ Short of breath ☐ Tuberculosis	☐		
☐ Stomach Ulcer ☐ Hepatitis ☐ Blood in Stool	☐		
☐ Pain with Urination ☐ Blood in Urine ☐ Kidney disease	☐		
☐ Skin Ulcers ☐ Rash ☐ Lumps ☐ Blisters	☐		
☐ Seizures ☐ Stroke ☐ Balance Problem ☐ Headaches	☐		
☐Depression ☐ Sleep disorder ☐ Other psychiatric illness	☐		
☐ Easy bleeding ☐ Easy bruising ☐ Anemia ☐ Other (describe)	☐		

Patient Name: _____

LEGAL INFORMATION FOR ALL PATIENTS (including Worker's Comp)

Do you have any current or pending litigation involving this problem for which we are seeing you today?

□ Yes □ No

If so, should we expect requests for information from any parties involved? _____

*Everything I have answered is true and correct to the best of my knowledge. I understand that this is a confidential record of my medical history and will be kept in my chart. *Information contained here will not be released without my authorization to do so.*

Patient Signature: _____ Date: _____

Patient Printed Name: _____

FOR WORKMAN'S COMPENSATION CASES ONLY: WC CLAIM #: _____

Date of Injury: _____ First date of disability: _____ Last date worked: _____

If out of work now, who has taken you out of work?_____

_____

Financial Agreement, Privacy Practices Acknowledgement

For Patients having Medicare, Participating and Non-participating Insurance Programs and non-covered services:

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Orthopaedics New England, P.C.(ONE)for services furnished by ONE, P.C. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer or agency show. ONE, P.C. accepts Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Participating Insurance and Non-covered services: I understand that ONE, P.C. may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. ONE, P.C. may also tell my health plan and/or referring physician about treatment I am going to receive to obtain prior approval or to determine whether my plan will cover the treatment, and to facilitate payment. I agree to cooperate with ONE, P.C. to obtain necessary plan authorizations. I accept full financial responsibility for all items and services which are determined by my insurance plan not to be covered.

Non- Participating Insurance: I further understand that I am individually obligated to pay the full charge of all services rendered to me by ONE, P.C. if I belong to a plan that ONE, P.C. does not participate with.

Financial Agreement: I agree that in return for services provided to the patient by ONE, P.C. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ONE, P.C. for payment. If I miss a scheduled appointment, I will be responsible for payment of $45-75 per visit.

Acknowledgement of Privacy Practices: I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for ONE, P.C. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this Notice should it be amended, modified or changed in any way. You agree to allow us to call and leave a message on your home or cell phone to remind and confirm patient appointments.

Notice of Quality Improvement Study: Drs. Keggi & Kennon are committed to promoting the scientific basis for the practice of medicine. ONE reviews patient results, surgical techniques, the effects of treatment and other measures. Any review of information outside of ONE is done in a manner that removes your name and any other identifying information in order to protect your privacy and in compliance with HIPAA policies.

Patient Signature:_____**Print Patient Name**: _____

Signature of Patient's Representative: _____ **Date**:_____

Office: Patient refused or declines to sign acknowledgement, □ appt cancelled _____ Staff initial (please print)