

NEW PATIENT UPDATE

DR: _____

DATE: _____

PATIENT ACCOUNT #: _____

Patients Legal Name:

(First) _____ (Middle) _____ (Last) _____ Sex: M F

Social Sec. # _____ DOB: _____ Age: _____ Marital Status: M S W D

Address: _____ City, State and Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

School Name (if student): _____

Religious Preference: _____

Primary Physician Name and Phone: _____

EMERGENCY CONTACT

Name _____ Phone# _____ Relationship _____

RESPONSIBLE PARTY If the patient is a minor, person responsible for billing account

Name: _____ Relationship to patient: _____ Sex: M F

Address: _____ DOB: _____

City, State and Zip: _____ Social Security # _____

Phone: _____ Employer: _____

PRIMARY INSURANCE

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

SECONDARY INSURANCE/ WC/ MYA

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

DOI: _____

THIRD INSURANCE/ OTHER

How were you referred to us?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Employer | <input type="checkbox"/> Seminar/Screening | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Friend/Relative/Former Patient | <input type="checkbox"/> Hospital | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other |
| (circle one) | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Television | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> HMO/PPO | <input type="checkbox"/> School | <input type="checkbox"/> Radio | |

Name	Address	Phone
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PLEASE READ:

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

SIGNED (Patient or Guardian) _____ DATE _____

AUTHORIZATION AND ASSIGNMENT

I authorize The Orthopedic Center to release information regarding my treatment to my insurance company, to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work-related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served with a Subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

SIGNED (Patient or Guardian) _____ DATE _____



David M. Brown, M.D.
Matthew F. Gornet, M.D.
Lyndon B. Gross, M.D., Ph.D.
John O. Krause, M.D.
Paul S. Lux, M.D.

Mark D. Miller, M.D.
Michael J. Milne, M.D.
George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Consent to Release Information

I, _____, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends or legal counsel that we are allowed to discuss your treatment or billing issues with.)

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Patient Signature: _____ Date: _____

(Parent or Guardian Signature if a minor)



David M. Brown, M.D.
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George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Dear Friends and Patients,

Welcome. Thank you for choosing **the Orthopedic Center of St. Louis**.

The Orthopedic Center of St. Louis constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 10 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital xrays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the 1st floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1st floor
- Electrodiagnostic testing on the 3rd floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3rd floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and the **Corner Pharmacy** delivers medications to each of the following surgical facilities to save you a trip to the drugstore after surgery.

If surgery is required, **Timberlake Surgery Center** is located on the 1st floor. The **St. Louis Spine and Orthopedic Surgery Center** and **Advanced Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

Some of the individual physicians at the Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website www.TOC-STL.com

We appreciate the opportunity to serve you and your family.

Signed: _____

Date: _____

Printed Name: _____

TOC: _____

**The Orthopedic Center of St. Louis
Notice of Health Information Practices**

This notice describes how your medical information may be used or disclosed and how you can access this information. Please review it carefully.

Uses and Disclosures:

We will use and disclose elements of your protected health information (PHI) in the following ways.

- Basis for planning your care and treatment
- Communication among the health professionals who may contribute to your care
- Legal document describing the care you receive
- Means that you, your insurance company or a third party payor can verify that services billed were actually provided
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Source we can assess our data to improve the care we render and the outcomes we achieve
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences
- To use an automated telephone system to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights:

- Request a restricted access to all or part of your private health information as provided by 45 CFR 164.522, if we are unable to abide by this request we will notify you
- Inspect or receive a copy of your medical record as provided by 45 CFR 164.524
- To get updates or reissue of this notice, at your request
- To request a list of disclosures of your medical records as provided by 45 CFR 164.528
- To receive correspondence of confidential information by alternate means or location as long as the request is reasonable
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our duties:

We are required by law to maintain the privacy of your private health information. We must abide by the terms of this notice or any update of this notice. If this notice is updated we will notify you by mail to the address you've supplied us.

To obtain more information or report problems please contact The Orthopedic Center of St. Louis's HIPAA Compliance Officer at 314-336-2555. **Full explanation of notice is posted in our waiting room. To request your own copy, please see our receptionist.**

If you believe your privacy rights have been violated, you can file a complaint with the administrator or operations manager. If, after contacting, The Orthopedic Center of St. Louis, you are not satisfied with the response you may contact the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date of this notice is April 14, 2003.

Acknowledgement:

Signature: _____ Date: _____

Print the name of the Patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

Dear Friends and Patients,

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by Dr. Milne today. It is designed to help you recall your history and to provide details that will help in your diagnosis and treatment plan. Thank you.

Name: _____ Nickname: _____ Date: _____

O Right Handed O Left Handed **Are you pregnant?** O Yes O No Did this Problem result from a WORK injury? Yes No

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ O Male O Female

Best Phone Number: _____ Best Email Address: _____

Do you have a primary doctor? Yes No Doctor's Name: _____

Address: _____ Phone: _____

Medical History – Please circle **ALL** current or previous medical conditions you have currently or have ever had:

Cardiovascular: Heart disease, High cholesterol, High Blood Pressure, Irregular heart beat, Other: _____

Pulmonary: Asthma, Emphysema, Chronic Bronchitis, Lung Disease Other: _____

Gastrointestinal: Ulcers, Reflux, Indigestion, Hernias, Crohn's IBS Other: _____

Genitourinary: Kidney disease, Frequent Urinary Tract Infections, Kidney Stones Other: _____

Endocrine: Diabetes, Thyroid Disease, Genetic Diseases Other: _____

Musculoskeletal: Lupus, Raynaud's, Osteoarthritis, Rheumatoid Arthritis, Osteoporosis, Gout, Fibromyalgia Other: _____

Hematology/Oncology: Blood Clots, Bleeding Disorders, Stroke, Cancer Other: _____

Neurologic: Strokes, Seizure Disorder, Diabetic Peripheral Neuropathy Other: _____

Psychiatric: Depression Anxiety Bipolar ADHD Narcolepsy Other: _____

Have you ever had a blood transfusion: O Yes O No If yes, when? _____

Have you ever tested **positive** for: Hepatitis TB HIV/AIDS

Have you or anyone in your family had any problems with anesthesia? O Yes O No Explain: _____

_____ Do you have sleep apnea? _____

Surgical History – Please list **ALL** previous surgeries and serious injuries, broken bones, illnesses:

<u>Date</u>	<u>Surgery/Illness/Injury</u>	<u>Surgeon's Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications

Please list all medications that you are currently taking. List **ALL** prescriptions, **blood thinners**, aspirin, vitamins, **over the counter medications**, supplements, and complementary and alternative medicines.

<i>Name</i>	<i>Dose</i>	<i>Frequency</i>	<i>How Long?</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

allergies? Yes No

<i>Medication</i>	<i>Reaction</i>	<i>Medication</i>	<i>Reaction</i>
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to **LATEX or Adhesives**? Yes No Any other allergies? Yes No If yes, to what? _____

Family History – Do any of the following run in your family?

<i>Yes</i>	<i>No</i>	<i>Who</i>	<i>Yes</i>	<i>No</i>	<i>Who</i>
<input type="radio"/>	<input type="radio"/>	Bleeding Problems _____	<input type="radio"/>	<input type="radio"/>	Diabetes _____
<input type="radio"/>	<input type="radio"/>	Blood Clots _____	<input type="radio"/>	<input type="radio"/>	Arthritis _____
<input type="radio"/>	<input type="radio"/>	Cancer _____	<input type="radio"/>	<input type="radio"/>	Genetic Problems _____
<input type="radio"/>	<input type="radio"/>	Heart Problems _____	<input type="radio"/>	<input type="radio"/>	Osteoporosis _____
<input type="radio"/>	<input type="radio"/>	Lung Problems _____	<input type="radio"/>	<input type="radio"/>	Collagen Disorders _____

Has anyone in the family died at a young age or unexpected cause? If yes, who and what cause? _____

Social History:

Do you smoke? Yes No If yes, how much? _____ How long? _____ Quit Date: _____

Do you drink alcohol? Yes No How much per day/week? _____ Have you ever used rec. drugs? Yes No

Are you employed? Yes No Employer: _____ Student Homemaker Retired

Marital Status: Single Married Separated Divorced Widowed Committed Relationship Spouse's Name: _____

If you are a student, where? _____ What grade? _____ Sports? _____

Coach/Trainer's Name: _____ Phone Number, if known: _____

Do you live alone? Yes No If no, name of contact at home: _____ Relation? _____

Hobbies: Golf Tennis Soccer Baseball Football Wrestling Hockey Running Track/XC Lacrosse Basketball
Hunting Skiing Bowling Hiking Softball Volleyball Field Hockey Weight Lifting Swimming Other _____

Review of Systems – Check if you have **CURRENT** symptoms or current known medical problems in the following areas.

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>			
Chest Pain	<input type="radio"/>	<input type="radio"/>	Nervousness	<input type="radio"/>	<input type="radio"/>	Voice Changes	<input type="radio"/>	<input type="radio"/>	Tingling	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	Unusual Thirst	<input type="radio"/>	<input type="radio"/>	Sinusitis	<input type="radio"/>	<input type="radio"/>	Memory Loss	<input type="radio"/>	<input type="radio"/>
Short of Breath	<input type="radio"/>	<input type="radio"/>	Nosebleeds	<input type="radio"/>	<input type="radio"/>	Hearing Loss	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>
Heavy Sputum	<input type="radio"/>	<input type="radio"/>	Bruise Easily	<input type="radio"/>	<input type="radio"/>	Ringing in Ears	<input type="radio"/>	<input type="radio"/>	Freq. Urination	<input type="radio"/>	<input type="radio"/>
Nausea	<input type="radio"/>	<input type="radio"/>	Slow to Heal	<input type="radio"/>	<input type="radio"/>	Blurred Vision	<input type="radio"/>	<input type="radio"/>	Incontinence	<input type="radio"/>	<input type="radio"/>
Vomiting	<input type="radio"/>	<input type="radio"/>	Joint Pain	<input type="radio"/>	<input type="radio"/>	Double Vision	<input type="radio"/>	<input type="radio"/>	Pain Urinating	<input type="radio"/>	<input type="radio"/>
Diarrhea	<input type="radio"/>	<input type="radio"/>	Joint Swelling	<input type="radio"/>	<input type="radio"/>	Weight Gain	<input type="radio"/>	<input type="radio"/>	Lumps/Cysts	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Weakness	<input type="radio"/>	<input type="radio"/>	Weight Loss	<input type="radio"/>	<input type="radio"/>	Fatigue	<input type="radio"/>	<input type="radio"/>
Dizziness	<input type="radio"/>	<input type="radio"/>	Back/Neck Pain	<input type="radio"/>	<input type="radio"/>	Fevers	<input type="radio"/>	<input type="radio"/>	Sleep Apnea	<input type="radio"/>	<input type="radio"/>

Is your primary doctor aware of the above symptoms or known medical problems? Yes No

I certify that this information is true and correct to the best of my knowledge. Please sign **TWICE** below.

Patient or Responsible Parent (if under 17 years old)

Date

I have been provided and read privacy and HIPAA information. I give Dr. Milne and staff permission to disclose my pertinent medical information to individuals involved with my medical care or payment for my care (including but not limited to referring doctor or health care provider, consulting doctors, primary doctor, parent or family member, physical therapist, trainer/coach, medical supply representatives, pharmacy employees, insurance companies, work comp parties/employer, if applicable, etc.) as necessary.

Patient or Responsible Parent (if under 17 years old)

Date

I have reviewed the above information, made necessary changes, and entered it in this patient's medical record.

Staff Use: Date/Initial: _____

Name: _____

Date: _____

Problem for which you are seeing Dr. Milne today: Right Left

When did this problem start? _____ Over time, the condition is getting: Better Worse Same

How did the problem begin (specifically)? _____

Rate your pain from 1 to 10 with 10 being the most painful: Now _____ At its worst: _____

Location of pain: Front Back Inside Outside Deep Superficial Radiating The Whole Area

Is the pain?: Constant Dull Aching Intermittent Sharp Stabbing Throbbing Tingling Burning

Do you have: Weakness Stiffness Loss of Motion Locking Catching Popping Grinding Giving way Numbness

When do you experience it most? _____

Anything make it better? _____ Worse? _____

Occupation: _____ Did this Problem result from a WORK injury? Yes No

Currently Working? Yes No Full Duty? Yes Restricted Off Work Date Last Worked? _____

Who sent you to Dr. Milne? _____ Relation? _____

Do you have a primary doctor? Yes No Doctor's Name: _____

Address: _____ Phone: _____

When did you last see them? _____ Next visit is when? _____

Is your doctor aware of the current problem for which you are seeing Dr. Milne? Yes No

Who have you seen for this problem? ER Doc Urgent Care Trainer Occ Med Dr Family Doc Chiro PT Work Comp Doc

Have you seen an Orthopedic Surgeon for this Problem? Yes No Whom and when? _____

What was the surgeon's diagnosis of your problem? _____

What was the surgeon's recommendation for you? _____

What treatments have you tried? Rest Ice Compression Elevation Bracing Physical Therapy Exercise Chiropractic

Acupuncture Massage Injections Cortisone Trigger Point Synvisc Other: _____

Has anything helped? Yes No If yes, which? _____

Previous Surgeries for this problem? _____
(include when & surgeon name)

Medications you are currently taking for this problem: _____

Testing List all medical tests including X-ray, MRI, CT Scan, Bone Scan, Nerve (EMG/NCV), Bone Scan pertaining to this problem?

Date Test Performed Result

Are you represented by an attorney in this case? O Yes O No Name/address of attorney: _____