❑ 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/ MVA

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?

- ❑ Referring Physician
- ❑ Friend/Relative/Former Patient (circle one)
- ❑ HMO/PPO
- ❑ Employer
- ❑ Hospital
- ❑ Case Manager
- ❑ School
- ❑ Seminar/Screening
- ❑ Yellow Pages
- ❑ Television
- ❑ Radio
- ❑ Newspaper
- ❑ Other
- ❑ Workers Compensation

____

Name Address Phone

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)

14825 N. Outer Forty Rd. • Suite 200 • Chesterfield, MO 63017 • (314) 336-2555 • Fax (314) 336-2557

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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: ____________________

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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 in 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: ______________________________

New Patient Questionnaire
David M. Brown, M.D.

Please answer all questions that apply to you and be as specific as possible. Thank you.

NAME: ______________________________

REFERRAL INFORMATION

Who referred you or how did you hear about Dr. Brown?______________________________

Who is your primary care or family physician?______________________________

Are you here for a work-related injury? ☐ Yes ☐ No
Have you filed a work comp claim for this problem? ☐ Yes ☐ No
Have you ever had a work comp claim before? ☐ Yes ☐ No
If yes, please list: ______________________ ______________________
______________________ ______________________
Are you involved in any litigation related to this problem? ☐ Yes ☐ No ☐ Maybe
Are you represented by an attorney for this problem? ☐ Yes ☐ No

What is your dominant hand? ☐ Right ☐ Left ☐ Ambidextrous

ACTIVITIES AND INTERESTS

Are you involved hobbies or sports outside of work (i.e. lift weights, garden, play tennis, play a musical instrument?
☐ Yes ☐ No
If yes, please list:
____
____

HEALTH HISTORY

Do you have diabetes?	☐ Yes	☐ No	Do you have osteoarthritis?	☐ Yes	☐ No
Do you have rheumatoid arthritis?	☐ Yes	☐ No	Do you have lupus?	☐ Yes	☐ No
Do you have a thyroid problem?	☐ Yes	☐ No	Do you have gout?	☐ Yes	☐ No
Do you have any heart problems?	☐ Yes	☐ No	Do you have any lung problems?	☐ Yes	☐ No
Do you have any bleeding disorders?	☐ Yes	☐ No	Do you have stomach ulcers	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No	Do you have or have you had hepatitis?	☐ Yes	☐ No
Do you have depression?	☐ Yes	☐ No	Do you have any other mental illness?	☐ Yes	☐ No
Do you have cancer?	☐ Yes	☐ No	Do you have any kidney trouble?	☐ Yes	☐ No
Do you have seizures?	☐ Yes	☐ No	Do you have anemia?	☐ Yes	☐ No
If you are a women are you pregnant?	☐ Yes	☐ No			

Explain all yes answers and list any other medical problems:
____
____
____
____
____
____

PAST SURGICAL HISTORY (List all surgeries you have had)

TYPE OF SURGERY	DATE (or approx. date)	WHERE	NAME OF SURGEON

MEDICATIONS: (List all medications you are currently taking)

MEDICATION	STRENGTH	HOW OFTEN

ALLERGIES

Have you ever had an allergic reaction to a medication? ☐ Yes ☐ No If yes, please list:

MEDICATION	REACTION

Have you ever had a bad reaction to aspirin or a non-steroidal anti-inflammatory type medication (i.e. Motrin, ibuprofen) ☐ Yes ☐ No If yes, what was the name of the medication and what happened?

____

____

FAMILY MEDICAL HISTORY

Do any of your relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) have any of the following medical problems?

Diabetes? ☐ Yes ☐ No

Rheumatoid arthritis? ☐ Yes ☐ No

A thyroid problem? ☐ Yes ☐ No

Heart problems? ☐ Yes ☐ No

Any other medical problems? ☐ Yes ☐ No

Osteoarthritis? ☐ Yes ☐ No

Lupus? ☐ Yes ☐ No

Gout? ☐ Yes ☐ No

Lung problems? ☐ Yes ☐ No

Please explain all yes answers:

____

____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No How much and for how long? ______________

Have you ever had an alcohol or drug problem? ☐ Yes ☐ No If yes please describe: ______________

____

GENERAL SYSTEM REVIEW

If you have had any recent symptoms in any of the following areas place a check mark in the box next to the category and briefly explain:

☐ Fever	☐ Unexplained weight loss	☐ Ears, nose or throat	☐ Heart
☐ Lung	☐ Neurological or psychiatric	☐ Stomach or intestinal	☐ Infection
☐ Eyes	☐ Kidneys, bladder or urinating	☐ Immunological or blood	☐ Skin

Briefly explain: ____

____

____

TRAUMATIC INJURY

Did you have a specific traumatic injury to your extremity that caused your problem? ☐ Yes ☐ No

If You Had a Specific Traumatic Injury, What was the Date Of Injury: ______________________

Describe What Happened, and specifically what happened to your injured extremity:

____

____

____

____

SYMPTOMS

Where Are Your Symptoms Located (i.e. Right Hand, Left Elbow, Both Wrists, Neck, Shoulder etc):

____

____

____

Describe Your Symptoms in detail:

____

____

____

____

____

____

When Did You First Notice Your Symptoms?

____

PRIOR TREATMENT

Have You Had Any Prior Treatment For This Problem? (What, When, By Whom, Did it help?)

____

____

____

____

PRIOR TESTS

Have You Had Any Prior Tests done For This Problem? (i.e. Nerve conduction studies, MRI, Bone scan etc) (What, When, What did they show?)

____

____

____

____

Complete this section only if you are here for a work related problem

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible

WORK HISTORY

What is your current occupation? ______________________

What company do you currently work for? ______________________

What was your occupation when you developed the problem that you are being seen for? ______________________

What company were you working for when you developed this problem? ______________________

When did you first start working for this company? ______________________

If you are no longer working for this company, when did you last work for this company? ______________________

Hour many hours a day do you (or did you) work? ______________________

Hour many hours a week do you (or did you) work? ______________________

Describe your job in detail (the job you were working when you developed your problem)(what do you do with your hands and arms at work, how often do you do these activities, how much do you lift and how often, if you do data entry how many hours a day, is it continuous or intermittent? if you do something repetitive how many times an hour do you do it?):

____

Do you have a second job? ☐ Yes ☐ No

If yes, please describe what you do and how many hour a day and week you work there:

____

Past Work History

Please list the type of work you did before you worked for the company you working for when you developed this problem; where did you worked; how long did you worked there (from when to when), and what did you do?

____

Are you currently working your regular job? Or are you on light duty? Or are you not currently working?

____

If you are on light duty what are your work restrictions?

____

Signature: ______________________ **Date:** ______________________