

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?

- |   |                                       |  |   |
|---|---------------------------------------|--|---|
| <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<br>(circle one) | <input type="checkbox"/> Hospital     | <input type="checkbox"/> Yellow Pages      | <input type="checkbox"/> Other                |
| <input type="checkbox"/> HMO/PPO  | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Television        | <input type="checkbox"/> Workers Compensation |
|   | <input type="checkbox"/> School       | <input type="checkbox"/> Radio             |   |

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.

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## 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)



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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 1<sup>st</sup> floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1<sup>st</sup> floor
- Electrodiagnostic testing on the 3<sup>rd</sup> floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3<sup>rd</sup> 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 1<sup>st</sup> 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](http://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.

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**Acknowledgement:**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print the name of the Patient: \_\_\_\_\_

If you are signing as the patient's representative:

Print your name: \_\_\_\_\_

Describe your authority: \_\_\_\_\_

# Medical History Form

Please fill out completely due to this being a part of your permanent medical record.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please Circle: Mr. Mrs. Ms. Dr. Rev. Sr. Pregnant: Y / N Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Right / Left Handed: \_\_\_\_\_ Date of Accident/Injury: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Telephone Numbers: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_

Drug Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Please describe the recent events of this current orthopedic problem. Answer how long it has been a problem, what makes it worse, and what makes it better:

\_\_\_\_\_  
\_\_\_\_\_

Please list all Current Medications:

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Past Surgeries: Please list in chronological order from oldest to newest and year of surgery.

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

List any diagnostic studies you have had for this condition along with date and place the study was performed. (MRI, CAT Scan, X-rays, EMG, NCV etc.):

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

Family Medical History: List medical illnesses affecting your immediate family, i.e., parents/siblings.

Disease	Family Member	Disease	Family Member
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Social History: Check and fill in the blanks.

\_\_\_\_ Married    \_\_\_\_ Single    \_\_\_\_ Divorced    \_\_\_\_ Live alone    # \_\_\_\_ Children    # \_\_\_\_ Pets  
\_\_\_\_ Alcohol    \_\_\_\_ Occasional    \_\_\_\_ Moderate    \_\_\_\_ Heavy    \_\_\_\_ History of Abuse  
\_\_\_\_ Tobacco    \_\_\_\_ Years used    \_\_\_\_ Packs per day    \_\_\_\_ Recreational drugs    \_\_\_\_ Yrs used

General History: Please check if any apply

General

- \_\_\_\_ 1. Weight change
- \_\_\_\_ 2. Fever or chills
- \_\_\_\_ 3. Night sweats
- \_\_\_\_ 4. Urinary frequency
- \_\_\_\_ 5. Bleeding
- \_\_\_\_ 6. Lumps or masses
- \_\_\_\_ 7. Dizziness or fainting
- \_\_\_\_ 8. Itching or rash
- \_\_\_\_ 9. Diabetes mellitus
- \_\_\_\_ 10. Thyroid problem
- \_\_\_\_ 11. Cancer

Ear-Nose-Throat-Eye

- \_\_\_\_ 1. Visual change
- \_\_\_\_ 2. Hearing change
- \_\_\_\_ 3. Tinnitus
- \_\_\_\_ 4. Dentures
- \_\_\_\_ 5. Bleeding gums
- \_\_\_\_ 6. Hoarseness

Gastrointestinal

- \_\_\_\_ 1. Dysphagia  
(difficulty swallowing)
- \_\_\_\_ 2. Nausea & vomiting
- \_\_\_\_ 3. Jaundice
- \_\_\_\_ 4. Hepatitis

Cardiovascular

- \_\_\_\_ 1. Heart dx/pain
- \_\_\_\_ 2. Hypertension
- \_\_\_\_ 3. Mitral valve prolapse
- \_\_\_\_ 4. Thrombophlebitis

Respiratory

- \_\_\_\_ 1. Cough/sputum
- \_\_\_\_ 2. Rheumatic fever
- \_\_\_\_ 3. Tuberculosis
- \_\_\_\_ 4. Pleurisy/pneumonia
- \_\_\_\_ 5. Shortness of breath
- \_\_\_\_ 6. Asthma

Genitourinary

- \_\_\_\_ 1. Urinary tract infections
- \_\_\_\_ 2. Incontinence
- \_\_\_\_ 3. Venereal diseases
- \_\_\_\_ 4. Menopause

Neurologic

- \_\_\_\_ 1. Seizures
- \_\_\_\_ 2. Paralysis
- \_\_\_\_ 3. Numbness
- \_\_\_\_ 4. Weakness

Musculoskeletal

- \_\_\_\_ 1. Backache
- \_\_\_\_ 2. Joint pain
- \_\_\_\_ 3. Joint swelling

Breast

- \_\_\_\_ 1. Lumps, pain, discharge

Other medical conditions not listed above:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

Description of current employment/Occupation:

\_\_\_\_\_

Is injury work related?    \_\_\_\_ Yes    \_\_\_\_ No

Who referred you to our office?

\_\_\_\_\_

Name of Primary Care Physician:

\_\_\_\_\_