

NEW PATIENT UPDATE

DATE: _____

DR: _____

PATIENT ACCT. #: _____

PATIENT'S 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: _____

DATE OF INJURY: _____

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 Sec. #: _____

Phone #: _____ Employer: _____

PRIMARY INSURANCE:

Insurance Company: _____ Primary Insured's Name: _____

Insured's Group# _____ Insured's ID # _____

Insured's Phone #: _____ DOB: _____ Social Sec. #: _____

SECONDARY INSURANCE:

Insurance Company: _____ Primary Insured's Name: _____

Insured's Group# _____ Insured's ID # _____

Insured's Phone #: _____ DOB: _____ Social Sec. #: _____

HOW WERE YOU REFERRED TO US: _____

PLEASE READ: Some insurance companies will not pay your bill if you do not select one of their participating physicians. It is the patient's responsibility to determine if our physician participates in your insurance plan. Payment or copayment 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 co., 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 or the individual physicians. 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)



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Dear Friends and Patients,

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 x-rays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the first floor at **Imaging Partners of Missouri**
- **CT Partners & MRI Partners of Chesterfield** provides state of the art CT & MRI scanning on the first floor
- Electrodiagnostic testing on the third floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the third 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 and some of our Surgeons dispense medications in-house to save you a trip to the drugstore.
- **Pain & Rehabilitation Specialists of St. Louis** specializes in interventional pain management and non-operative spine treatment
- **Sports Medicine Institute** on the third floor provides non-surgical sports medicine care

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: _____

Matthew C. Bayes, M.D. F.A.A.P.
Sports Medicine Institute with The Orthopedic Center of St. Louis
14825 N. Outer Forty Road, Chesterfield, MO 63017
Telephone 314-336-2590 Fax 314-336-2571

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. Bayes and his staff 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: _____

Please Circle: Mr. Mrs. Ms. Dr. Rev. Sr. Jr. Spouse's Name: _____ Are you pregnant: Yes No

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Shoe Size: _____

Male Female

Right handed Left Handed

Best Phone Number: _____ Best Email Address: _____

Did this problem result from a WORK Injury Yes No Occupation: _____

Currently Working Yes No Full Duty Yes No Date Last Worked: _____

Who sent you to Dr. Bayes? _____ Relationship to you? _____

Primary Care Doctor's Name: _____ Phone #: _____

Address: _____ Fax (if known): _____

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

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

Would you like help in locating a primary care doctor for you or your family Yes No

Is there a lawsuit related to your injury? Yes No Name and address of your attorney: _____

Problem and side which you are seeing Dr. Bayes: _____

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

How did the problem begin (specifically)? _____

Have you seen another doctor for this problem? Yes No **If yes, whom and when?** _____

Rate your pain from 1 to 10 with 10 being the most painful, and 7 being tearful: Currently ____ **At its worse:** ____

Is the pain? Front Back Inside Outside Deep Superficial Radiating The whole area

Is the pain? Constant Dull Aching Intermittent Sharp Stabbing Shooting Throbbing

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

When do you experience it most? _____

What makes it better? _____

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

Chiropractic Acupuncture Massage Exercise Anti-inflammatory Medications Tylenol Pain

Medications Injections *What Type?* Cortisone Trigger Point Hyalgan Supartz Euflexxa

Synvisc (Date of last injection _____)

Has anything helped? Yes No **If yes, what?** _____

Previous Surgeries for this problem? _____

Medications you are currently taking for this problem? _____

Testing for this Problem

List all medical tests including X-rays, MRI, CT Scan, Bone Scan, Nerve Test (EMG/NCV), pertaining to this problem:

<i>Date</i>	<i>Test Performed</i>	<i>Result</i>	<i>Location/Site</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 Hernia Crohn's IBS Other: _____

Genitourinary: Kidney Disease Frequent Urinary Tract Infections Kidney Stones Other: _____

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

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

Neurologic: Strokes Seizure Disorder Diabetic Peripheral Neuropathy Other: _____

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

Have you ever tested positive for: Hepatitis Tuberculosis HIV/AIDS

Surgical/Medical History-Please list ALL previous Surgeries and Serious injuries, broken bones, Illnesses:

<i>Date</i>	<i>Surgery/Illness/Injury</i>
_____	_____
_____	_____
_____	_____
_____	_____

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>Times a day</i>	<i>How long?</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

Do you have any known medication allergies? Yes No

<i>Medication</i>	<i>Reaction (What Happened?)</i>
_____	_____

Are you allergic to LATEX? Yes No

Any other allergies? Yes No If yes, to what? _____

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

Who?	<input type="checkbox"/> Bleeding Problems _____	Who?	<input type="checkbox"/> Diabetes _____
	<input type="checkbox"/> Blood Clots _____		<input type="checkbox"/> Arthritis _____
	<input type="checkbox"/> Cancer _____		<input type="checkbox"/> Genetic Problems _____
	<input type="checkbox"/> Heart Problems _____		<input type="checkbox"/> Osteoporosis _____
	<input type="checkbox"/> Lung Problems _____		<input type="checkbox"/> 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 drink alcohol/beer/wine? Yes No How many per week? _____

Do you smoke? Yes No If yes, how many packs/day? _____ How many years? _____ Quit Date: _____

Marital Status: Single Married Separated Divorced Widowed Committed Relationship

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

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

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

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

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

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

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

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

Is there any other information that you think will be helpful in diagnosing and treating your problem Yes No

If yes, what? _____

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 HIPPA information. I give Dr. Bayes 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 electronic medical record. If no signature appears, I have reviewed and approved this document electronically on the date or dates this patient was seen by me.