

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
(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 _____
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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)



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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 to save you a trip to the drugstore after surgery.
- **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: _____

**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: _____

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 Synvisc Hyalgan Supartz Euflexxa

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?		Who?
<input type="checkbox"/> Bleeding Problems	_____	<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"/>	Ringling 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.

 Matthew C. Bayes M.D.

 Date