

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)



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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: _____

YOUR APPOINTMENT _____ AT _____ AM/PM

PLEASE COMPLETE AND RETURN THIS FORM AT YOUR APPOINTMENT

HEALTH HISTORY
THE ORTHOPEDIC CENTER OF ST. LOUIS

NAME _____

DATE _____

VERY IMPORTANT
PLEASE BRING A LIST OF ALL MEDICATIONS
THAT YOU ARE NOW TAKING
WHEN YOU COME IN FOR YOUR FIRST VISIT

Do you have any allergies to medication? Yes No

Allergy	Reaction

Have you or anyone in your family ever had problems with anesthesia?

Yes No Explain: _____

Are you allergic to anything else? (Include sedatives, stimulants, diet pills, antacids, laxatives, cold tablets, foods, dyes, hay fever, milk products, tape, etc.)

Family History:

List any illnesses which run in your family:

If deceased, how and at what age did your parents die?

Mother _____

Father _____

Social History

Have you ever smoked regularly? ----- Yes No

Have you ever smoked in the past three years? ----- Yes No

If you have a history of smoking, how many years did you smoke? _____

If you have a history of smoking, how many packs per day did you average? _____

Do you drink alcoholic beverages? ----- Yes No

If so, how much do you average drinking per week? _____

Head and Neck

1. Do you have headaches more than once a week? ----- Yes No

2. Does quickly twisting your neck cause pain? ----- Yes No

3. Have you ever had lumps or swelling in your neck? ----- Yes No

Respiratory

4. Do you wheeze or have to gasp to breathe? ----- Yes No
5. Are you bothered by coughing spells? ----- Yes No
6. Do you cough up a lot of phlegm? ----- Yes No
What color is it? _____
7. Have you ever coughed up blood? ----- Yes No
8. Do you have chest colds more than once a month? ----- Yes No
9. Are you sweating more than usual or have night sweats? ----- Yes No

Cardiovascular

10. Have you ever been told that you have high blood pressure? ----- Yes No
11. Have you been bothered by a thumping or racing heart? ----- Yes No
When? _____
12. Do you ever get pains or tightness in your chest? ----- Yes No
13. Do you have trouble with dizziness or light-headedness? ----- Yes No
14. Have you ever fainted/blacked out? ----- Yes No
15. Are you ever short of breath? ----- Yes No
16. Have you ever had a heart attack? ----- Yes No
17. Do you wake up at night short of breath? ----- Yes No
18. Do you have trouble with swollen feet or ankles? ----- Yes No
19. Have you ever been told that you have a heart murmur? ----- Yes No
When? _____
20. Have you ever had a seizure (fit)? ----- Yes No

Digestive

21. Have you ever vomited blood? ----- Yes No
22. Is it difficult or painful for you to swallow? ----- Yes No
23. Are your bowel movements ever black or bloody? ----- Yes No
24. Are your bowel movements gray in color? ----- Yes No
25. Have you had any bleeding from your rectum? ----- Yes No
26. Do you routinely take laxatives? ----- Yes No

Urinary

27. Have you ever had burning or pains when you urinate? ----- Yes No
28. Has your urine ever been brown, black, or bloody? ----- Yes No
29. Do you have any difficulty starting your urine flow? ----- Yes No
30. Do you have a constant feeling that you have to urinate? ----- Yes No
- The following three questions pertain to men only:*
31. Is your urine stream very weak and slow? ----- Yes No
32. Do you ever have urinary hesitation? ----- Yes No
33. Has a doctor ever told you that you have prostate trouble? ----- Yes No

Skin

- 34. Do you have any skin problems? ----- Yes No
- 35. Do you have trouble stopping a small cut from bleeding? ----- Yes No
- 36. Do you bruise easily? ----- Yes No

Circulatory Status of Legs

- 37. Do you have, or have you ever had, blood clots in your legs? ----- Yes No
- 38. Have you ever had phlebitis? ----- Yes No
- 39. Do you have varicose veins? ----- Yes No
- 40. Do you have difficulty keeping your feet warm? ----- Yes No
- 41. Do you ever get leg cramps? ----- Yes No
- 42. Have you lost any hair over the skin of your ankle or feet? ----- Yes No
- 43. Do you ever have blue or pale-colored feet? ----- Yes No
- 44. Do you ever have burning in your feet? ----- Yes No

Describe any special problems or symptoms that you feel have not been covered by this questionnaire. _____

Have you had a recent evaluation of any of the conditions you indicated? Yes No
If so, what type, when, and by whom? _____

Please explain the orthopaedic problem that brings you to visit the doctor today.

Is this a work-related injury? ----- Yes No
If yes, please provide the date _____ and time _____ of the injury.

Was an automobile involved? ----- Yes No
If yes, please provide the date _____ and time _____ of the accident.

Please describe the accident or injury.

What was the first date of treatment for your injury? _____

What type of treatment have you received?

Are you currently disabled? ----- Yes No

If yes, please provide the date the disability began. _____

Primary care physician name: _____

Primary care physician phone number: _____

What was the date of your last visit? _____

Do you have a cardiologist? ----- Yes No

Cardiologist name: _____

Cardiologist phone number: _____

Signature _____ Date _____

(For Office Use Only)
UPDATE of Health History Form:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____