

ASSOCIATES IN ORTHOPEDICS, PC
HEALTH ASSESSMENT QUESTIONNAIRE & REVIEW OF SYSTEMS

Date _____
 Patient Name _____ Date of Birth _____ Age _____
 Primary Care Physicians Name _____ Male _____ Female _____
 Current Medications _____

Allergies to Medications _____
 Occupation _____ Right Hand Dominance _____ Left Hand Dominance _____
CHIEF COMPLAINT _____ Duration of Symptoms _____

Patients please complete the following:

MEDICAL HISTORY (Patient) If YES to any of the following, please explain:
 Diabetes Yes ___ No ___ _____
 Cancer Yes ___ No ___ _____
 Arthritis Yes ___ No ___ _____
 Gout Yes ___ No ___ _____
 Convulsions/-strokes Yes ___ No ___ _____
 Bleeding Tendency/Blood Clots Yes ___ No ___ _____
 Ulcers/Colitis/Acid Reflux/GERD Yes ___ No ___ _____
 Cardiac Problems Yes ___ No ___ _____
 Infectious Disease(s) Yes ___ No ___ _____
 Previous Hospitalization(s) Yes ___ No ___ _____
 Previous Surgery(s) Yes ___ No ___ _____
 Previous Injury(s) Yes ___ No ___ _____

FAMILY HISTORY (Diseases – from list above; Age; If Deceased; Cause of Death)
 Mother: _____
 Father: _____
 Siblings: _____
 Children: _____

SOCIAL HISTORY Marital Status: Single _____ Married _____ Divorced _____ Widowed _____
 Alcohol Use: Yes ___ No ___ If yes, daily use (#) _____
 Tobacco Use: Yes ___ No ___ Previous/#years _____ Packs per Day _____
 Drug Use: Yes ___ No ___ Type/Frequency _____

Tech's complete the following RVS:

REVIEW OF SYSTEMS
 Constitutional Y/N Fever _____ Chills _____ Dizziness _____ Malaise _____ Night Sweats _____
 Eyes Y/N History of Glaucoma _____ Double Vision _____ Cataracts/Glasses _____
 Ears/Nose/Mouth/Throat Y/N Pain _____ Pressure _____ Deafness _____ Hoarseness _____
 Cardiovascular Y/N History of Heart Attack _____ Heart Failure _____ Chest Pain _____ Edema _____
 Cold Extremity _____ High Blood Pressure _____ Low Blood Pressure _____
 Respiratory Y/N Asthma _____ Chronic Obstructive Pulmonary Disease (COPD) _____
 Gastrointestinal Y/N Hepatitis _____ Ulcer _____ Pain _____ Vomiting _____
 Genitourinary Y/N Urinary Tract Infections _____ Kidney Stones _____
 Dermatologic Y/N Scars _____ Hair & Nails _____
 Musculoskeletal Y/N Pain _____ Weakness _____
 Joint Swelling _____ Stiffness _____
 Neurological Y/N Weakness _____ Numbness _____ Speech _____ Memory _____ Gait _____
 Psychiatric Y/N Depression _____ Anxiety _____ Other _____
 Endocrine Y/N Diabetes _____ Thyroid _____ Adrenal _____
 Hematology/Lymphatic Y/N Bruise Easy _____ Anemia _____
 (Female Only) Last Menstrual Period (Date) _____ Menopausal _____

VITALS Height _____ Weight _____ Pulse _____ Blood Pressure _____

Have you ever had a Bone Density Test (the test for osteoporosis)? Yes ___ No ___
 If yes, when did you have the test? Month _____ Year _____
 If yes, was the test? Normal ___ Low Bone Density ___ Body ___ Finger ___ Wrist ___
 Where was the test done? _____ Who ordered the test (Physician) _____

DATE REV: _____ PHY SIGN: _____ DATE REV: _____ PHY SIGN: _____
 DATE REV: _____ PHY SIGN: _____ DATE REV: _____ PHY SIGN: _____

PATIENT INFORMATION

PATIENT NAME:	DATE:	SS#:
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME TELEPHONE:		
M / F	DOB#	
WORK TELEPHONE:	CELL PHONE:	
MARRIED:	SINGLE:	OTHER:

HEALTH INSURANCE INFORMATION

INSURANCE:	CERT#:	GROUP#:
ADDRESS		
CITY	STATE:	ZIP CODE:
EMPLOYER:		
SUBSCRIBER:	RELATION TO PATIENT:	
SS# OF SUBSCRIBER:	DOB:	

SECOND INSURANCE INFORMATION

INSURANCE:	CERT#:	GROUP#:
EMPLOYER:		
BILLING ADDRESS:		
CITY:	STATE:	ZIP CODE:
SUBSCRIBER:	RELATION TO PATIENT:	
SS# OF SUBSCRIBER:	DOB:	

EMERGENCY CONTACT INFORMATION

NAME:	TELEPHONE#:
PARENT'S NAME (MINOR CHILD)	
MOTHER'S NAME:	DOB:
FATHER'S NAME:	DOB:

CONSENT TO DISCUSS/PICK UP PATIENT INFORMATION

NAME:	TELEPHONE #
RELATIONSHIP TO PATIENT:	DATES OF CONSENT:

ASSOCIATES IN ORTHOPEDICS, PC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you, the patient, may be used and disclosed, and how you can get access to this information. Please review it carefully.

You will be asked by this Practice to sign a Patient Confidentiality Agreement. Your signed consent will allow your protected health information to be used and disclosed for the following purposes:

To allow your physician, office staff and other health care providers to use and disclose this information for the purpose of providing health care services.

To provide health information to obtain payment for your health care services.

To disclose your health information in order to support the business activities of your physician. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, use of a sign-in sheet at the front desk and use of your health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information only with third party "business associates" that perform various activities (e.g. billing, transcription services) for the Practice. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

DISCLOSURE THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may disclose protected health information to a health agency for activities authorized by law, such as audits, investigations, and inspections.

We may disclose your protected information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the entity or agency authorized to receive such information.

We may disclose protected health information in the course of judicial or administrative proceedings, in response to an order of a Court (to the extent such disclosure is expressly authorized), in response to a subpoena, discovery request or other lawful process.

We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

YOUR RIGHTS

You have the right to obtain a copy of your protected health information. This consists of your medical office notes and any other medical information that your physician and the Practice uses for making decisions about you.

You have the right to request a restriction of your protected health information. This means you may ask your health care provider not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. This request must be in writing.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. This request must be made in writing.

You have the right to request an amendment be added to your protected health information. In the event we deny your request for an amendment, you have the right to file a Statement of Disagreement with this Practice. In the event we prepare a rebuttal to your Statement, you will be provided with a copy of such rebuttal.

You have the right to complain to us, or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by this Practice. You may contact our Office Administrator for further information about our complaint process.

This Privacy Notice became effective August 20, 2002.

ASSOCIATES IN ORTHOPEDICS, PC

Patient Confidentiality Agreement

I, _____, understand that as part of my health care, Associates In Orthopedics, PC originates and maintains health records describing my health history, symptoms, examination and tests results, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to request restrictions as how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that Associates in Orthopedics, PC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me.

I further understand that Associates in Orthopedics, PC reserves the right to change their notice and practices, and prior to implementation will send a copy of any revised notice to the address I've provided.

I understand that as part of Associates in Orthopedics, PC treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses. I also understand that it is the policy of Associates in Orthopedics, PC to call patients regarding their appointments and to leave messages on patients' answering machines. I agree to this form of communication, unless stated above.

I understand and accept / decline the terms of this consent.
I have read the Notice of Privacy Practices.

Patient/Guardian Signature

Date