Name:
Chart:
Date:

Welcome to Our Practice

Your Appointment is: ____________________

Provider: ____________________________

In order to efficiently and effectively provide you with quality care, please complete the enclosed forms and be sure to bring this information to your appointment.

Additionally, we ask that you:

- Arrive 20 minutes before your appointment time.
- Bring any x-rays, MRIs, CT scans, EMGS or other related tests, along with the written reports. If your studies were done at Meadville Medical Center, you do not need to bring them.
- Bring your insurance card(s) and photo ID, such as a driver's license.
- Bring the co-pay amount required by your insurance plan; this will be due at the time of service.
- Self pay patients must pay for their services at the time of the office visit. ***We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Discover.***
- Contact your PCP to obtain a referral if you have Gateway, AmeriHealth Caritas, Coventry Cares or UPMC for You.
- Please check with your health insurance plan to be sure that Orthopedic Associates of Meadville, PC is in network. Or call our office with any questions.

If you cannot keep your appointment for any reason, please call our office at (814) 724-1252 to cancel. There is a $25 No-Show Fee for failure to cancel your appointment at least one business day in advance or $50 for an EMG appointment with Dr. Wheeling.

Minors must be accompanied by a parent, legal guardian or custodian.

Thank you for choosing Orthopedic Associates of Meadville, P.C.

Name:
Chart:
Date:

INITIAL PAST MEDICAL HISTORY

Name ______________________ Date ______________

Date of Birth ______________________ Date of injury ______________

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR
- __ Heart attack
- __ Angina or chest pain
- __ High blood pressure
- __ Palpitation/heart skipping
- __ Heart murmur
- __ Stroke
- __ Edema - ankle swelling
- __ Varicose veins
- __ Phlebitis or blood clots
- __ Other heart-circulation problems
- __ Sleep apnea

LUNGS
- __ Bronchitis
- __ Emphysema
- __ Asthma
- __ Tuberculosis
- __ Sinusitis
- __ Hay-fever
- __ Respiratory infections
- __ Shortness of breath
- __ Black lung
- __ Other lung problems ______________

OTHER SYSTEMS
- __ Diabetes - Insulin/Non
- __ Thyroid problems
- __ Kidney/bladder problems
- __ Stomach or duodenal ulcer
- __ Heartburn or burping
- __ Convulsions - epilepsy
- __ Dizzy or fainting spells
- __ Hepatitis/jaundice/liver
- __ Pregnant Y / N
- __ HIV/AIDS
- __ Depression / Anxiety
- __ Arthritis/rheumatism
- __ Glaucoma
- __ Bleeding problems/anemia
- __ Psychiatric problems
- __ Back problems
- __ Alcoholism
- __ Drug Addiction
- __ Cancer - type ______________
- __ Bone disorders
- __ Fibromyalgia
- __ Other ______________

2. Please list prior surgeries and dates ______________________

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.

Drug Name	Strength	Dosage

4. Do you have any allergies to medications? If so, please list medication and reaction ______________________

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.) ______________________

6. Do any medical problems run in your family? _____ DVT/Blood Clots _____ Other
_____ Hypertension _____ Diabetes _____ Heart Disease _____ Rheumatic arthritis. _____ Cancer

7. Do you smoke cigarettes, cigars or a pipe?
If so, how many per day? ______________, for how many years? ______________

8. Do you drink alcohol? Yes No If yes, how much per week ______________

9. Tattoo within the past 6 months? ______________

10. Do you live in a _____ one story home, _____ two story home or other? ______________

11. Who lives at home with you? ______________

12. Do you typically use a walker/cane/wheelchair? ______________

13. What is your occupation? ______________

14. Are you able to operate a vehicle? ______________

15. Who is your primary care physician? ______________

(for office use) Height _________ Weight _________ B/P _________ Age _________ BMI _________

The above information is true and complete to the best of my knowledge.

Patient Signature ______________________ Date ______________

Physician/PA Signature ______________________ Date ______________

Name:
Chart:
Date:

PLEASE COMPLETE ALL SECTIONS

Patient Information

NAME: LAST FIRST MIDDLE SOCIAL SECURITY #

BIRTHDATE AGE SEX LANGUAGE: ☐ English ☐ Spanish / ______
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

STREET ADDRESS RACE: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Native American ☐ Unknown

CITY STATE ZIP CODE

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

EMPLOYER EMPLOYER ADDRESS

*If you have been a patient in the past under a different name, please enter that name: ______

Emergency Contact

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Financially Responsible Party if other than Patient

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Primary Care Physician

NAME PHONE#

ADDRESS

Insurance

Primary Insurance Information
NAME OF INSURANCE ID#

Secondary Insurance Information
NAME OF INSURANCE ID#

Workers Compensation ☐ YES ☐ NO -OR- Auto Accident ☐ YES ☐ NO
NAME OF INSURANCE

CLAIM # ______ DATE OF INJURY / ACCIDENT ______

MEDICARE I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits assigned to OAM.

OTHER I authorize OAM to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in OAM all payments for medical services rendered to myself or my dependents.

<u>I also understand that I am responsible for any amount not covered by my insurance.</u> Initials: ______

Signature ______

Name:
Chart:
Date:

Patient Name ______________________________

Date of Birth ______________________________

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change it's privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.
I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: ______________________________ **Signature:**____________________ Date: __________

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name ____________________ Relationship ________________ Phone ______________
Name ____________________ Relationship ________________ Phone ______________
Name ____________________ Relationship ________________ Phone ______________

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P.C. to leave messages on my answering machine/voicemail system for the following:

_______ Appointment reminders (including return telephone calls)
_______ Prescription Refills
_______ Test Results
_______ **Do not leave message**

_______ Permission to fax work status reports to employer
_______ Permission to fax gym/school excuses to school

Signature ____ Date ______________

Student Resident Consent

The physicians at Orthopedic Associates of Meadville are proud to play an integral role in the teaching of residents from Lake Erie College of Osteopathic Medicine (LECOM) and the training of student interns.

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intem or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature ____ Date ______________

Name:
Chart:
Date:

ORTHOPEDIC ASSOCIATES OF MEADVILLE, P.C.

11277 VERNON PLACE, SUITE 200 • MEADVILLE, PENNSYLVANIA 16335 • 814/724-1252
FAX 814/337-6043

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **7 day notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday - Friday. No refills on the weekends or holidays. The "on-call" physicians will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of medication. Do not give your medications to other people and do not take medication from others.
8. Preferred Pharmacy & Location: ______________________________
(This pharmacy will be used for your refills unless otherwise specified.)
9. Orthopedic Associates of Meadville may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree and will comply with the above guidelines.

Print Patient Name: ______________________ DOB: ________________

Signature: ______________________________ Date: ________________
(Patient, Parent or Guardian)

Name:
Chart:
Date:

BACK HISTORY

Name ______________________ Date of Birth ______________

Please answer each question as carefully as possible. This information will help your doctor to understand what is wrong with your back.

1. History of previous spine problems ______________________
2. Where did injury occur? ______________________
3. What activity were you engaged in? ______________________
4. Is pain better or worse than before? ______________________
5. Is pain daily? Yes No ______________________
6. Describe intensity of pain, is pain aching/sharp? ______________________
7. Does activity affect pain? ______________________
8. What aggravates it? ______________________
9. What makes it better? ______________________
10. Does the pain radiate or travel into your legs, especially below the knee? ______________________
11. Do you have any numbness or weakness? ______________________
12. Do you have loss of control - bladder or bowel function? ______________________
13. Does your back/neck hurt more than extremity? ______________________
14. What previous treatments have you had - medications, chiropractor, physical therapy, braces or injection. Please describe ______________________
15. Please describe your work history - date last worked, how long at this job, any previous job injuries, education level, work comp or social security? ______________________
16. Please list your past health problems ______________________
17. If you have had previous back surgery, please give date, type of surgery and result ______________________
18. Does pain wake you up at night? ______________________
19. What would you do if you didn't have the pain? ______________________
20. What would you like the Doctor to do for you? ______________________

Name:
Chart:
Date:

Mark these drawings according to where you hurt. (If the back of your neck hurts, mark the drawing on the back of the neck, etc.) If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram.

NUMBNESS
= = = =

PINS AND NEEDLES
O O O O

BURNING
X X X X

STABBING
/ / / /

ACHE
^ ^ ^ ^

Form #223

Name:
Chart:
Date:

ORTHOPEDIC ASSOCIATES OF MEADVILLE
CONTROLLED SUBSTANCE AGREEMENT

First Name MI Last name	Birth date
Doctor:	Pharmacy:

I understand that I have a condition which may require the use of a narcotic medication to control my pain. When a narcotic medication is prescribed the following information will apply:

1. **I understand that narcotic medications can be addictive.**
2. I will obtain prescriptions for narcotics and other controlled medicines only from my doctor (named above) at Orthopedic Associates of Meadville or his associates. The only exception is if it is prescribed while I am admitted in a hospital.
3. I will have prescriptions filled at only one pharmacy and notify my doctor (named above) of the name of that pharmacy.
4. I will take medication only as prescribed and will promptly notify my doctor (named above) if I do not.
5. I will meet regularly with my doctor (named above) to assess my progress.
6. I agree to random urine tests to assess my compliance. Illegal "street" drugs detected at that time may result in termination of prescriptions. Pill count may be required at any time upon 2 hr notice.
7. **I understand that lost, stolen or misplaced medicines will not be replaced and refills will not be given early FOR ANY REASON.**
8. I understand that decreased pain is only one factor. For the medicine to be continued I must show improvement in functioning and comply with the above measures.
9. **I understand that after my acute fracture or post surgical care my narcotics will be tapered and discontinued. Narcotics will not be continued for chronic pain. This is solely determined by the doctor.**
10. I understand that if I do not comply with the above measures, the medication will be discontinued. Furthermore, I understand that my doctor (named above) or his associates may discontinue the medication at any time.
11. I release my doctor (named above), and his staff and associates to communicate with pharmacies, police authorities and the Drug Enforcement Administration, as necessary, to confirm the accuracy of any prescriptions. This may include providing authorities with copies of written prescriptions and prescription logs.

Refills of controlled substance medication:

- Will not be made at night, on holidays or weekends
- Will not be made as an "emergency", such as Friday afternoon because "I realized I will run out tomorrow". I will call at least seven (7) days ahead if I need assistance with a controlled substance prescription.

Signature: ______________________ Date : ______________

Witness: ______________________ Date : ______________