MEADVILLE MEDICAL CENTER | MORE THAN A HOSPITAL
1034 Grove Street
751 Liberty Street
Meadville, PA 16335
(814) 333-5000
www.mmchs.org

O.A.M.
Orthopedic Associates of Meadville
11277 Vernon Place, Suite 200
Meadville, PA 16335
Phone: (814) 724-1252
Fax: (814) 337-6043

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: _____

   * How long have you had back/neck pain? _____ List any prior spine surgeries and dates: _____

   _____

2. If injury, where did it occur and what activity were you engaged in? _____

3. Is pain getting better or worse? _____ Is pain daily? Yes No

4. Rate your pain(circle one): 1 2 3 4 5 6 7 8 9 10 Is pain aching or sharp? _____

5. Does activity affect pain? Yes No How many minutes can you stand before you feel pain? _____

   * How far can you walk before you feel pain? _____ Do you have pain at night or during sleep? _____

6. What aggravates your pain? _____

7. What makes your pain better? _____

8. Does the pain radiate or travel into your legs, especially below the knee? _____

   _____

9. Do you have any numbness or weakness? _____

10. Do you have a loss of control of your bladder or bowel functions? _____

11. Does your back/neck hurt more than your leg/arm? _____

12. Please describe your work history - date last worked, how long at this job, any previous job injuries, education level, work comp or social security? _____

    _____

13. Please list any major medical problems including heart/lung and bleeding issues: _____

    _____

14. What previous treatments have you had?:

    ☐ Chiropractor Did this offer relief? Yes No

    ☐ Braces Did these offer relief? Yes No

    ☐ Physical Therapy When: _____ Relief? Yes No

    ☐ Injections When: _____ Where: _____ Relief? Yes No

    ☐ Medications _____ Did these offer relief? Yes No

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Name: _____
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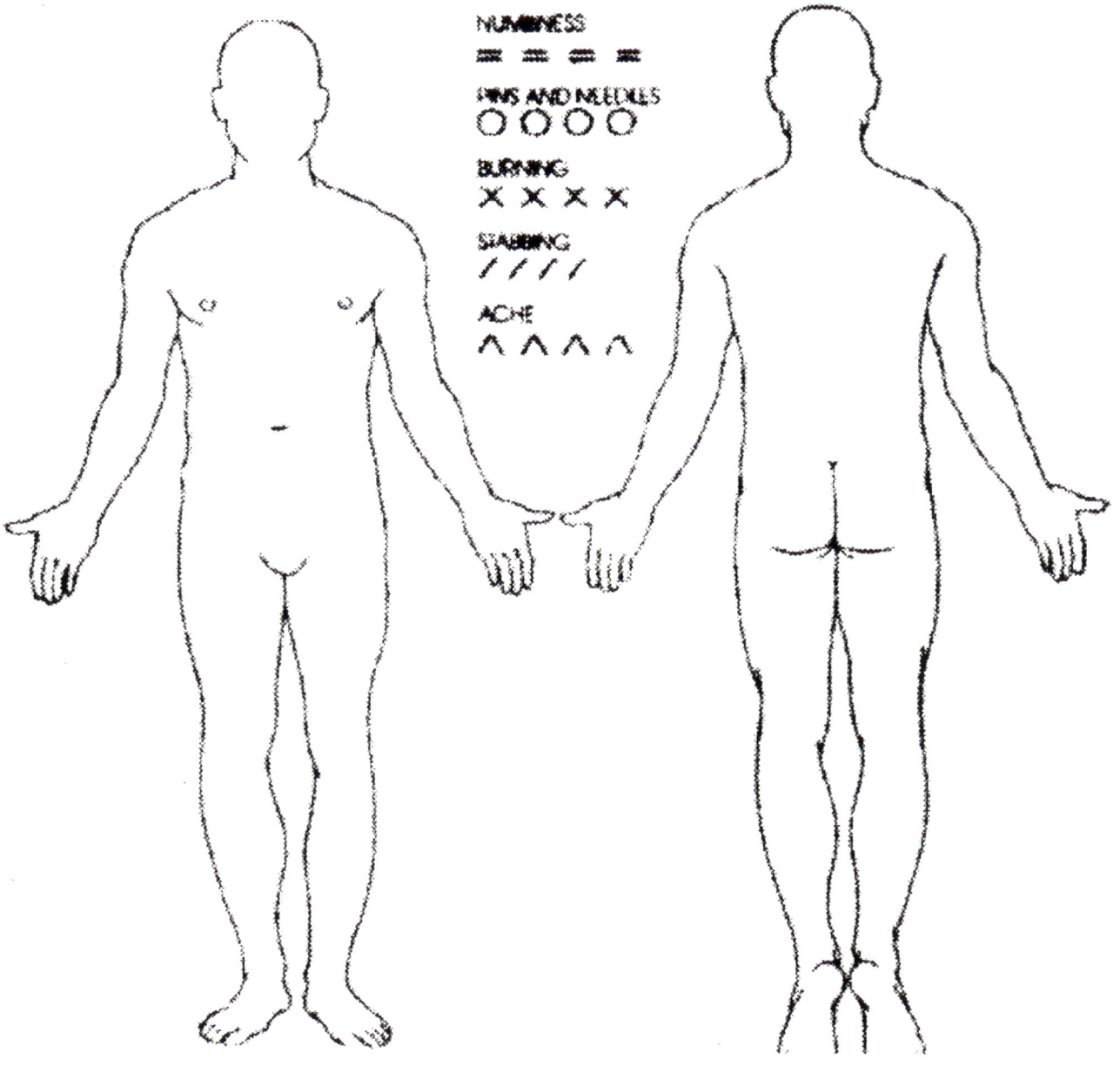
Show me where it hurts

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.



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A M B O A M N E W P T

OAM HIPAA Form

Form #90439
Rev 01/22

Name: _____
Medical Record#: _____
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 its 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 _____

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, intern 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 _____