ORTHOMO

☐ NEW PATIENT ☐ UPDATE

**PATIENT'S LEGAL NAME:**

First: _____ Middle Initial: _____ Last: _____
DOB: _____ Sex: ☐ Male ☐ Female Social Sec. #: _____
Age: _____ Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced
Address: _____
City, State and Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____
***Pharmacy Name: _____ Phone#: _____**
**Primary Care provider: _____ Phone#: _____**
**Employer: _____**

**Emergency Contact:**
Name: _____ Phone: _____ Relationship: _____

**Responsible Party: (Please complete if a minor)**
Name: _____ Relation to Patient: _____ DOB: _____
Address: (if different from above) _____

**PRIMARY INSURANCE:**
INS Company: _____ Subscriber: _____ DOB: _____
ID#: _____ Group #: _____ Phone# _____

**SECONDARY INSURANCE:**
INS Company: _____ Subscriber: _____ DOB: _____
ID#: _____ Group #: _____ Phone# _____

**PLEASE READ:**
Some insurance companies will not pay your bill if you do not select one of their participating physicians. It is the patient's responsibility to determine if our physician participates in your insurance plan. Payment or copayment 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 OrthoMO to release information regarding my treatment to my insurance co., to health care providers who have referred me to OrthoMO 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 OrthoMO or the individual physicians. 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 OrthoMO is served with a subpoena for production of records, the undersigned authorizes OrthoMO 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 This above authorization can only be withdrawn or revoked by written notification to OrthoMO.

**SIGNED** (Patient or Guardian) _____ Date: _____

ORTHOMO

# Consent to Release Information

I, (patient name) _____, authorize OrthoMo staff to discuss my medical treatment and any billing issues with the following people:

Please list any family members, friends, or legal counsel with whom we are allowed to discuss your treatment or billing issues.

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Patient Signature: _____ Date: _____

(Parent or Guardian Signature if a minor)

11330 Olive Blvd., Suite 150 Creve Coeur MO 63141 Phone# 314-782-1994 Fax# 314-850-3761

ORTHOMO

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____
Print Full Name

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, may individual rights and the practice's legal duties with respect to my protected health information. This includes, but is not limited to:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of this notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to"
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communication of protected health information.
    - The right inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

*** The full HIPPA disclosure will be available upon request ***

# Medical History Form

Please fill out completely due to this being a part of your permanent medical record.

Name:_____ Nickname: _____ Date:_____

Please Circle: Mr. Mrs. Ms. Dr. Rev. Sr. Pregnant: ___Y ___N Age:_____ Birthdate:_____

____Right ____ Left Handed Name of Spouse: _____ Your City/State: _____

Best Phone Number: ( ) _____-_____ Best Email Address: _____

Drug *Allergies*:_____ Height: _____Weight:_____ Shoe Size:_____

Problem and side which you are seeing Dr. Gross: _____

When did this problem start? _____

How did this problem begin (specifically)?

_____

What treatments have you tried? □Physical Therapy □ Injections □ Rest □ Ice□ Anti-Inflammatory Medication □ Pain Medication
Other:

_____

What makes it worse, and what makes it
better:_____

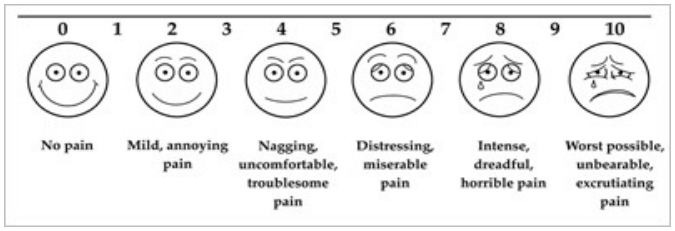
Have you seen another doctor for this problem? ___Y / ___N If yes, whom and when?

_____

Did this problem result from a work injury ___ Y/ ____N Occupation:

_____

Please rate your current pain level on the graph below by circling the appropriate number:




Please list all Current Medications:

1._____ 3._____
2._____ 4._____

Past Surgeries: Please list in chronological order from oldest to newest and year of surgery.

1._____ 3._____
2._____ 4._____

List any diagnostic studies you have had for this condition along with date and place the study was performed.
(MRI, CAT Scan, X-rays, EMG/NCV etc.):

1._____ 3._____
2._____ 4._____

Family Medical History: List medical illnesses affecting your immediate family, i.e., parents/siblings.

| Disease | Family Member | Disease | Family Member |
|---|---|---|---|
| 1. | | 3. | |
| 2. | | 4. | |

Social History: Check and fill in the blanks.

_____Married _____Single _____Divorced _____ Widowed _____Live alone #_____Children #_____Pets
_____Alcohol _____Occasional _____Moderate _____Heavy _____History of Abuse
_____Tobacco _____Years used _____Packs per day _____Recreational drugs _____Yrs used

Are you a student, where? _____ What grade? _____ Sports? _____

Coach/Athletic Trainer Name: _____ Phone, if known:_____

Physical/Recreational Hobbies: _____

General History: Please check if any apply

General
____1. Weight change
____2. Fever or chills
____3. Night sweats
____4. Urinary frequency
____5. Bleeding
____6. Lumps or masses
____7. Dizziness or fainting
____8. Itching or rash
____9. Diabetes mellitus
____10.Thyroid problem
____11.Cancer

Gastrointestinal
____1.Dysphagia (difficulty swallowing)
____2. Nausea & vomiting
____3. Jaunice
____4. Hepatitis

Genitourinary
___1. Urinary tract infections
___2. Incontinence
___3. Venereal diseases
____4. Menopause

Cardiovascular
____1. Heart diagnosis/pain
____2. Hypertension
____3. Mitral valve prolapse
____4. Thrombophlebitis

Neurologic
____1. Seizures
____2. Paralysis
____3. Numbness
____4. Weakness

Ear-Nose-Throat-Eye
____1. Visual change
____2. Hearing change
____3. Tinnitus
____4. Dentures
____5. Bleeding gums
____6. Hoarseness

Respiratory
____1. Cough/sputum
____2. Rheumatic fever
____3. Tuberculosis
____4. Pleurisy/pneumonia
____5. Shortness of breath
____6. Asthma

Musculoskeletal
____1. Backache
____2. Joint pain
____3. Joint swelling

Breast
____1. Lumps, pain, discharge

Other medical conditions not listed above:
1. _____
2. _____

Who referred you to our office? _____ Relationship to you?_____

Name of Primary Care Physician: _____

Phone#_____ City, State: _____

Is your doctor aware of the current problem for which you are seeing Dr. Gross: ___Yes ___ No