Name:
Chart: DOB:
Date:

PATIENT INFORMATION

Last Name ______ Legal First Name ______ Middle Initial ______
Sex ______ Social Security # ______ Birth date ______
Street Address ______ City, State, Zip ______ OK To Leave Msg ___
Home Phone: ______ Work Phone: ______ Cell: ______
Email Address ______ @ ______ Prefers To Be Called ______

Race Choices: ☐ White ☐ American Indian ☐ Black ☐ Asian ☐ Type-Unknown______
Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type-Unknown______
Language Choices: ☐ English ☐ Chinese ☐ French ☐ Hebrew ☐ Hindi ☐ Japanese ☐ Portuguese
☐ Russian ☐ Yiddish ☐ Type - Unknown______

SPOUSE INFORMATION

First Name______ Last Name______ Date of Birth ______
Work Phone ______ Emergency Contact Person ☐ Same as Spouse
☐ Other ☐ Relationship ______

WHO REFERRED YOU TO THE OFFICE?

Dr. Name ______ Phone ______ Hospital______
Other______

PRIMARY CARE PHYSICIAN: ______
Phone Number______ Fax Number ______
Address ______
______

RESPONSIBLE PARTY INFORMATION (PERSON'S NAME WHO APPEARS ON YOUR INSURANCE CARD)

NOTE: If your name is not the primary name on the insurance card, you are NOT the responsible party
Name on Card: ______ Date of Birth ______ SSN# ______
Address:______ City ______ State ____ Zip ______
Employer Name ______ Occupation ______
Work Phone ______ Relationship ______

Attention Parents: It is the policy of this office that the parent who requests treatment for his/her child is responsible for all fees for service.

INSURANCE INFORMATION

PRIMARY INSURANCE
☐ **Blue Cross Blue Shield** ☐ **Medicare**
☐ **Medicaid** ☐ **Workers Comp**
☐ **Auto** ☐ **Other** ______
☐ **HAP**

SECONDARY INSURANCE:
☐ **Blue Cross Blue Shield** ☐ **Medicare**
☐ **Medicaid** ☐ **Workers Comp**
☐ **Auto** ☐ **Other** ______
☐ **HAP**

Name:

Chart: DOB:

Date:

HISTORY OF CURRENT CONDITION

What are you being seen for today? ______________________________ ☐ Right ☐ Left

____

How long have symptoms been present? ______________________________

Is this condition related to an injury? ☐ Yes ☐ No

IF INJURY RELATED, PLEASE COMPLETE THE REMAINDER OF THIS FORM

Date of Injury ____________________

Describe Injury ____

____

Where did the injury occur? ______________________________________

How did the injury occur? _______________________________________

____

Have you been seen by a doctor for this condition? ☐ Yes ☐ No

If so, who? ____

Are you being seen for a	Work related injury?	☐ Yes	☐ No
	Motor vehicle injury?	☐ Yes	☐ No
	Other injury?	☐ Yes	☐ No

Are you filing a claim with	Automobile insurance?	☐ Yes	☐ No
	Worker's Comp?	☐ Yes	☐ No

Name:

Chart: DOB:

Date:

PLEASE FILL OUT THIS FORM COMPLETELY

REVIEW OF SYSTEMS: Have you ever had any problems or conditions involving the following areas:

1)	Constitutional symptoms (e.g. fever, chills)	☐ YES	☐ NO
2)	Eyes (e.g. blurred, double vision)	☐ YES	☐ NO
3)	Ears, Nose, Throat	☐ YES	☐ NO
4)	Cardiovascular (Heart, Blood Vessels)	☐ YES	☐ NO
5)	Respiratory (Lungs)	☐ YES	☐ NO
6)	Gastrointestinal (stomach, intestines)	☐ YES	☐ NO
7)	Musculoskeletal (Other than today's problem)	☐ YES	☐ NO
8)	Skin/Breasts	☐ YES	☐ NO
9)	Nervous System	☐ YES	☐ NO
10)	Psychiatric (e g. Depression)	☐ YES	☐ NO
11)	Endocrine (Hormones)	☐ YES	☐ NO
12)	Hematologic/Lymphatic (Blood/Lymph System)	☐ YES	☐ NO
13)	Allergic Reactions/Immunologic	☐ YES	☐ NO

Please explain your "YES" answers

Name:
Chart: DOB:
Date:

SOCIAL HISTORY: ☐ Occupation ______________________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Not Employed ☐ Disabled

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered

How many children? ______________

Do you drink Alcohol? ☐ Yes ☐ No How many drinks per week? _______

Exercise Regimen: ______________________

Do you use tobacco? ☐ Yes ☐ No If not currently did you ever use tobacco? ☐ Yes ☐ No

☐ Cigarettes - __________ pks./day

☐ Chew - __________ /day

☐ Cigars - __________ /day

Or year quit __________

PAST HISTORY:

(What medical conditions have you been treated for or are currently being treated for (e.g. High Blood Pressure, Diabetes, Kidney Disease, Heart Disease, Cancer, Ulcers, Blood Clots ?)

What surgeries have you had and approximately when ?

Current Prescription Medications and Over the Counter Medications

Medication Allergies

FAMILY HISTORY: Describe any family history of diseases or conditions (e.g. Rheumatoid Arthritis, Diabetes ?)

SIGNATURE: ______________________ Date: __________

Name:

Chart: DOB:

Date:

CENTER FOR ADVANCED ORTHOPEDICS AND SPORTS MEDICINE FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Payment of your bill is part of this treatment and care. Your coverage by your health insurance carrier is unique to your policy. It is your responsibility to know and understand what your insurance plan will cover and pay.

We accept payment by cash, check, VISA, MasterCard, American Express and Discover. Care Credit is available and information is available. A $30.00 fee will be charged for non-sufficient funds.

When you register for the first time at our office you will be asked for some form of picture identification as well as your current insurance cards. We apologize for any inconvenience, but we have to ask for this information to protect you against insurance identify theft.

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, your appointment will be rescheduled.

If you are a patient presenting with back pain, your insurance company may require a separate spine care referral. Currently, Priority Health and Blue Care Network require specific spine care referrals. If you require further information regarding the spine care referral program, please ask to speak with one of our billing specialists.

Co-Payments are due on the day of visit. We are bound by contracts that we have signed with the insurance companies and waiving of any co-pays and/or deductibles is forbidden.

If your physician recommends surgery, you will be escorted to his Surgery Scheduler. She will answer specific questions about the surgery scheduling process, discuss the paperwork and tests involved and complete all pre-certification/authorization if your insurance company requires it. The Surgery Scheduler will request a pre-surgical deposit If you do not have health insurance to cover your surgery charges.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Center for Advanced Orthopedics and Sports Medicine. I authorize Center for Advanced Orthopedics and Sports Medicine to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date Signature Printed Name

Name:

Chart: DOB:

Date:

Mykola J. Bartkiw, D.O.
Michael P. Donahue, D.O.
Christopher R. Nicholas, D.O.
John R. Olenyn, M.D.
Allen R. Prince, D.O.
Paul J. Siatczynski, M.D.
Sara Wierzbicki, PA-C

CENTER FOR **Advanced Orthopedics** AND SPORTS MEDICINE

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, , understand that as part of my health care, CAO originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, 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 billed 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 Information Practices* (located in the waiting room) 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 object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that CAO 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 as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CAO reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should CAO change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I understand that as part of this organization's 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, including disclosures via fax.

E-PRESCRIPTION CONSENT

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011. ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information. ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

I agree that Center for Advanced Orthopedics and Sports Medicine, P.C. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

At what number can you be reached? ______________________________

May we leave a message on your voice mail/answering machine? ☐ Yes ☐ No

______________________ Patient's Signature

__________ Date