Name:
Chart:
Date:

TOS Health Questionnaire

Name _____ Date of Birth _____

Referring Physician _____ Family Physician _____

Main Reason for Medical Evaluation _____

Date of Injury/Length of symptoms: _____ Where did injury occur? _____

Is this a *work related* problem? Y N Are you right or left handed? _____

Occupation _____ Employer _____

What treatment have you received for this problem? _____

1. Medications: _____ 2. Physical Therapy (**location**): _____
3. Injections (**when**): _____ 4. Surgery: _____
4. X-rays (**where & when**): _____ 6. MRI (**where & when**): _____
7. Brace/Walking Aids: _____ 8. Other: _____

Have you ever been diagnosed with any of the following conditions: Check all that apply.

☐ Alcoholism	☐ Colitis	☐ Kidney Disease	☐ Sleep Apnea
☐ Asthma	☐ Diabetes	☐ Lung Disease	☐ Stomach Ulcers
☐ Anemia	☐ Epilepsy	☐ Migraines	☐ Stroke
☐ Anesthesia Problems	☐ GI Bleeding	☐ Osteoarthritis	☐ Thyroid Disease
☐ Bleeding Tendencies	☐ Heart Disease	☐ Osteoporosis	☐ Tuberculosis
☐ Blood Clots	☐ Hepatitis	☐ Rheumatoid Arthritis	☐
☐ Cancer	☐ High Blood Pressure	☐ Sickle Cell Disease	☐ Other _____

Are any other physicians treating you for ANY health problems? _____

If yes, whom? _____

Have you had any heart testing? Y N if yes, when and where? _____

Have you ever had **Blood Clots**? _____

Did you have any adverse reaction to anesthesia? _____

Smoking Status? ☐ Never smoker ☐ Current everyday smoker: _____ Year started smoking
☐ Current some day smoker: _____ Year started ☐ Former smoker: _____ Year started _____ Year quit

Do you drink alcohol: ☐ None ☐ Beer ☐ Liquor ☐ Wine Amount: _____

Marital status: S M D W Hobbies: _____

Have you recently had any of the following problems/symptoms: Check any which apply.

☐ Abdominal pain	☐ Easy bruising	☐ Lumps/Masses
☐ Alcohol addiction	☐ Excessive thirst	☐ Nausea or vomiting
☐ Balance problems	☐ Fainting spells	☐ Numbness/Tingling/Weakness
☐ Blood in stool	☐ Fever or chills	☐ Other joint symptoms
☐ Blood in urine	☐ Gait disturbance/Walking changes	☐ Pain burning with urination
☐ Breathing difficulties	☐ Headaches/Migraines	☐ Palpitations
☐ Chest pain	☐ Hearing Loss	☐ Rectal bleeding
☐ Chronic cough	☐ Heartburn	☐ Sexual dysfunction
☐ Constipation	☐ Hoarseness	☐ Shortness of breath
☐ Depression	☐ Hot or cold intolerance	☐ Skin rashes or sores
☐ Dizziness	☐ Loss of appetite	☐ Trouble swallowing
☐ Drug addiction	☐ Loss of control of bladder	☐ Unexplained weight loss
☐ Easy bleeding	☐ Loss of control of bowels	☐ Vision Problems
☐ Other: _____		

Name:

Chart:

Date:

TOS Health Questionnaire

Family History:	Father	Mother	Sibling		Father	Mother	Sibling
High Blood Pressure:	☐	☐	☐	Diabetes:	☐	☐	☐
Heart Disease:	☐	☐	☐	Bleeding Problems:	☐	☐	☐
Cancer:	☐	☐	☐	Lung Disease:	☐	☐	☐
Arthritis:	☐	☐	☐	Reaction to Anesthesia:	☐	☐	☐
Blood Clots:	☐	☐	☐	Other: _____	☐	☐	☐

Do you have issues with activities of daily living? Check all that apply.

- ☐ Getting in and out of bed
- ☐ Getting dressed
- ☐ Putting on shoes
- ☐ Getting in and out of the car
- ☐ Getting in and out of the tub/shower
- ☐ Other: _____

Please list any current prescriptions and non-prescription medication and dosages:

Please list any allergies:

Please list any surgeries you have had and dates:

Patient Signature _____ Date _____

Physician Review _____ Date _____

Name:

Chart:

Date:

Toledo Orthopaedic Surgeons Patient Data Sheet

Patient Name _____ Today's Date _____

SS# _____ Sex _____ Date of Birth _____

Address _____ Phone _____

(Street)

_____ Cell Phone _____

(City) (State) (Zip Code)

Race: American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ White ☐ Other ☐ Unknown ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Preferred Language _____

Employer _____ Work Phone _____

Referring MD _____ Primary Care MD _____

Address _____ Phone _____

Guarantor's Name and Address (if different from patient's) _____

_____

(City) (State) (Zip Code)

Emergency Contact (other than spouse) _____

Phone _____ Relationship to Patient _____

INSURANCE INFORMATION (*We will ask to make a copy of your card*)

Primary Insurance Carrier _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Identification Number _____

Policy Holder's SS# _____ Employer _____

Secondary Insurance Carrier _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

Policy Holder's Identification Number _____

Policy Holder's SS# _____ Employer _____

Consent to Release Medical Information / Assignment of Benefits

****SIGNATURE REQUIRED****

I hereby consent to the use and disclosure by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, inc. of medical information to carry out medical treatment, payment, and health care operations as defined by applicable law. **Medical treatment** includes the provision, coordination, and management of my health care and related services, including treatment by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc. and other physicians, hospitals, and providers of medical services and/or their agents to whom I may be referred (and any referring and primary care/family physicians which have been or may be involved in my care and treatment). **Payment** includes all activities relating to the determination of coverage and reimbursement for the provision of health care services, and related claims management and review activities. **Health care operations** include activities of Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. relating to medical care and treatment and related assessment, quality improvement, and management activities.

I agree that Toledo Orthopaedic Surgeons may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I authorize my insurance benefits to be paid directly to TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans. Unpaid accounts sent to collection agency will incur a fee.

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account.

X _____ _____

PATIENT'S (OR RESPONSIBLE PARTY'S) SIGNATURE DATE

****MEDICARE PATIENT'S ONLY****

I request that payment of authorized Medicare benefits be made to me or on my behalf to the physicians of TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., for any service furnished to me by the physicians. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine the payments for related services.

X _____ _____

SIGNATURE OF BENEFICIARY DATE

Name:
Chart:
Date:

Ashok Biyani, MD
Spine
Toledo Orthopaedic Surgeons

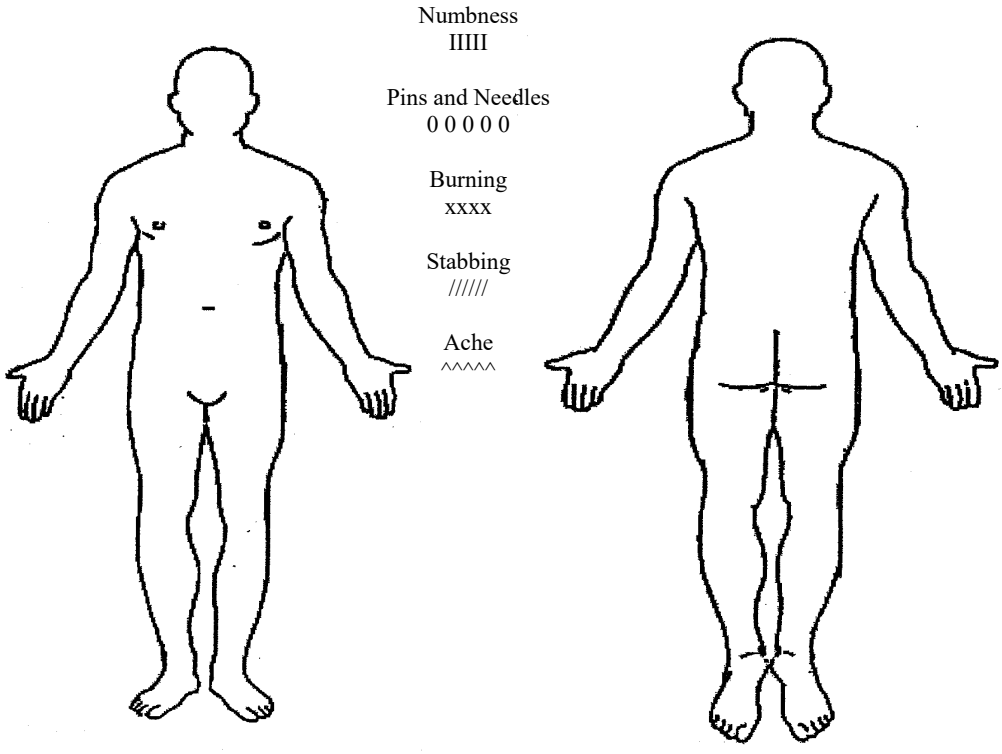
Patient questionnaire

Please answer all questions as directed to help us evaluate and treat your problem.

Name _____ Date of birth _____

Height _____ Weight _____

Mark these drawings according to where you hurt (if the back of your neck, 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. Include all affected areas.



Name:
Chart:
Date:

When did your pain start? _____

How did your pain start? (check appropriate box)

☐ Suddenly ☐ Gradually
☐ Pulling ☐ Lifting ☐ Twisting ☐ Fall ☐ Bending
☐ Injured at work ☐ Injured in auto accident ☐ Injured during sports
☐ No apparent cause

Back pain _____ **Neck pain** _____

Severity of pain at its worst_____ at its best_____ (1-10, 10 being the worst)

Progress: ☐ Improving ☐ Same ☐ Getting worse
Nature: ☐ Sharp ☐ Dull ☐ Burning ☐ Numbness ☐ Pins and needles

What affects your pain?

Worse with ☐ standing ☐ walking ☐ sitting ☐ laying ☐ no difference
Better with ☐ standing ☐ walking ☐ sitting ☐ laying ☐ no difference
Worse with ☐ coughing ☐ sneezing
Worse in the ☐ morning ☐ afternoon ☐ evening ☐ in bed

Pain in the leg R / L / both Pain in the arm R / L / both
Severity of pain at its worst _____ at its best _____ (1-10, 10 being the worst)

Radiation
Leg pain ☐ to the hips/thighs ☐ below the knees ☐ toes
Arm pain ☐ to the shoulder ☐ elbow ☐ fingers

Weakness in legs / arms _____

How far can you walk? _____ block(s), _____ mile(s)

Can you sleep well at night? _____

Bowel or bladder problems _____

Have you had back or neck pain in the past? Yes / No. When _____

Have you had any treatment so far? ☐ Yes ☐ No If yes, answer the following:

☐ physical therapy ☐ pain management ☐ aqua therapy
☐ chiropractic

Any prior spine surgery _____ When and by whom _____

If female over 67 years old - Have you had a bone density study (DEXA)? ☐ Yes ☐ No

Are you taking any medications for osteoporosis? ☐ Yes ☐ No

Previous studies

☐ X-rays ☐ Nerve conduction / EMG ☐ MRI / CT scan / myelogram

_____

Name and signature of person completing the form Date

Name:
Chart:
Date:

A. Biyani, MD
Scoliosis
Toledo Orthopaedic Surgeons

Patient questionnaire

Please answer all questions as directed to help us evaluate and treat your problem.

Name _____ Date of birth _____

Please list the name and address of the referring doctor who you would like us to send the letter to. _____

When were you diagnosed as having scoliosis or kyphosis? _____

Have you seen any physicians in the past for your spine? _____

Brace/ surgery advised? _____

Do you have any back pain? (Please circle one)

None, occasionally / at night / with activities / always / other

Radiation of pain to the legs yes / no Weakness or numbness in legs yes / no

Bowel or bladder problems yes / no

Any other medical problems or previous surgeries _____

Allergies _____

Current medications _____

Birth and developmental history

Born at full term/ ____ weeks early/ late

Any problems at birth _____

Needed ICU/ more than 3 day hospital stay

Started sitting at ____ months, walking at _____ months.

Periods (girls) started ___ months/years ago, not yet started

Family history:

Anybody else in the family has scoliosis or other orthopedic conditions

_____

Siblings, their ages and height _____

Mother's height _____ Father's height _____

Which grade in school? _____

Sports you like to participate in _____

Height _____ Weight _____

Name:
Chart:
Date:

Toledo Orthopaedic Surgeons

Preferred Pharmacy Information

In an effort to serve you better, we are now able to send prescriptions electronically. This process will help reduce medication errors and reduce the time you have to wait for a prescription to be filled. In order to do this efficiently, please complete the information below. Please know that this form does not obligate you to use this pharmacy; it simply allows us to prepare your chart so that your information is readily available to your physician.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

Name:
Chart:
Date:

Toledo Orthopaedic Surgeons Division

Patient Name: _____ DOB: _____

I wish to be contacted in the following manner (check all that apply):

Oral Communication:

- ❑ Home telephone
- ❑ O.K. to leave message with detailed information.
- ❑ Leave message with call-back number only.
- ❑ Work telephone
- ❑ O.K. to leave message with detailed information.
- ❑ Leave message with call-back number only.
- ❑ Other _____

Written Communication:

- ❑ O.K. to mail to my home address
- ❑ O.K. to mail to my work/office address
- ❑ O.K. to fax to this number _____
- ❑ Other _____

Email Communication:

My email address is: _____

❑ **I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:**

- ❑ Spouse's name: _____ Phone: _____
- ❑ Adult child(ren) name: _____ Phone: _____
- ❑ My parent(s) name: _____ Phone: _____
- ❑ Personal representative name: _____ Phone: _____

❑ **If checked, the following additional instructions apply:**

_____

_____

_____ _____

Patient signature Date

If signed by patient's authorized representative, describe the representative's authority:

- ❑ Patient is a minor; I am the patient's parent and natural guardian.
- ❑ Patient is a minor; I am the patient's guardian, appointed by the _____ County Juvenile Court.
- ❑ Patient is a ward; I am the patient's guardian, appointed by the _____ County Probate Court.
- ❑ The patient is deceased. I am the patient's surviving spouse.
- ❑ The patient is deceased. I am the executor or administrator of the patient's estate, appointed by the _____ County Probate Court.
- ❑ I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- ❑ Other (describe) _____

Name:
Chart:
Date:

Toledo Orthopaedic Surgeons

Bureau of Worker's Compensation Declaration
NON-Work Related Injuries

PLEASE READ CAREFULLY. By signing below, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon physician is treating you ***is <u>not</u> a work related injury, and that it did not occur while you were on the job or executing a work related activity.***

Further, you understand that we will not support this injury or disease as a work related injury.

Patient signature _____ Date _____

Bureau of Worker's Compensation Declaration
Work Related Injuries

PLEASE READ CAREFULLY: By signing this form, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon is treating you ***is a work related injury, and that it occurred while you were on the job or executing a work related activity.***

I hereby declare that my injury is work related and I authorize Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. to submit a claim with complete information to my Workers' Compensation insurance carrier for covered services rendered by my physician at Toledo Orthopaedic Surgeons. I authorize my Workers' Compensation insurance to issue payment directly to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all payable services. I understand that I am financially responsible to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all charges to the extent they are not covered by insurance, unless otherwise prohibited by applicable State of Ohio law.

Patient Signature _____ Date _____

Patient Name _____

Claim Number _____ Date of Injury _____

Employer at Time of Injury _____

Address of Employer _____

Is your employer disputing your claim? _____ Is your claim in litigation? _____

Description of how injury occurred _____

_____

_____

Is this a **possible** worker's comp claim? _____ Are you filing a claim? _____

*****Please Note*** We will need to make a copy of your black and white identification card from BWC, <u>*as well as your health insurance card.*</u> In the event your claim is disallowed, your health insurance will be billed. Please remember you are ultimately responsible for all payment of all charges.**

Name:
Chart:
Date:

CONTRACT FOR CONTROLLED-SUBSTANCE PRESCRIPTIONS

When used appropriately, controlled substances, such as narcotics and tranquilizers, are safe and useful medications. These drugs can control pain and improve function. In many cases, they allow people to resume fairly normal lives. However, these drugs are frequently abused in our society. In order for Toledo Orthopaedic Surgeons to comply with State and Federal regulations, it is necessary to ask you to agree to the following conditions before any of these types of medications can be prescribed for you.

1. I am responsible for my controlled-substance medication. If the prescription or medication is lost or stolen, or if I use it up sooner than prescribed, I understand that it will NOT be replaced. I am responsible to take the medication as prescribed and keep track of the number of doses remaining.

2. I will not request or accept controlled-substance medications from any other physician while I am receiving such medication from any physician of Toledo Orthopaedic Surgeons. The only exception is if a controlled substance is given while I am admitted to a hospital.

3. I can request refills for my controlled-substance medication ONLY DURING REGULAR OFFICE HOURS. I understand that refills WILL NOT BE AVAILABLE AT NIGHT, ON WEEKENDS, OR ON HOLIDAYS, AS THE ON-CALL PHYSICIAN DOES NOT HAVE ACCESS TO MY MEDICAL RECORDS.

4. I understand that I must select and use one pharmacy where I will have my prescriptions filled. If I move or my insurance changes that would require a change in pharmacy, I will notify the staff of Toledo Orthopaedic Surgeons of the reason for the change should it happen.

5. IN THE EVENT THAT WE DISCOVER THAT YOU ARE RECEIVING PRESCRIPTIONS FOR PAIN MEDICATIONS FROM OTHER PHYSICIANS, OUR OFFICE WILL IMMEDIATELY DISCONTINUE ANY FUTURE PRESCRIBING OF ANY MEDICATIONS.

6. I understand that refills for any medication require a 48-hour notice. I understand that requests for “emergency” refills, such as on a Friday afternoon when I suddenly realize that I will “run out tomorrow”, will most likely not be honored.

7. I understand that refills for any type of pain medication will only be considered for patients who are under “current treatment”. Each prescription will be for a fixed amount of medication sufficient to last until the next visit and this WILL NOT be increased.

I UNDERSTAND THAT IF I VIOLATE ANY OF THESE CONDITIONS, MY CONTROLLED SUBSTANCE PRESCRIPTIONS MAY BE ENDED IMMEDIATELY.

I have read and understand the above policy and agree to abide by these conditions.

Signature _____ Date _____

Name:

Chart:

Date:

Toledo Orthopaedic Surgeons Division

Notice of Privacy Practices

THIS NOTICE, WHICH IS EFFECTIVE AS OF April 14, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The doctors and staff here at **Toledo Orthopaedic Surgeons Division** believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes your rights concerning our use of your health information.

We will use and disclose your health information for purposes of treatment, payment and/or health care operations.

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** includes certain activities of the practice, as well as activites of an organized health care arrangement in which we participate, including; quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and busines management and planning. *For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary for the reviewer to randomly select and examine patients' medical records.*

We are permitted or required to disclose limited health information about you, *without your authorization,* in the following circumstances:

1. **As required by law** so long as it is limited to the relevant requirements of such law.
2. **For public health activities,** including the prevention and control of disease, vital statistics, and public health investigations.
3. For purposes of making required reports about **victims of abuse, neglect or domestic violence.**
4. **Health oversight activities,** including audits, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. **Judicial and administrative proceedings,** in response to court orders.
6. **Law enforcement purposes** (i.e., reports of gunshot wounds; grand jury subpoenas; and information regarding victims of crime).
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. **For organ and tissue donation,** consistent with applicable laws.
9. **Research**, provided the federal regulations governing research activities that insure the privacy of your health information are met.
10. **To avert serious threats to health or safety.**
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposes, and inmates.
12. **Workers' compensation** to the extent necessary to comply with applicable laws.
13. **Marketing,** for purposes of appointemnt reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

Any uses or disclosures other than those noted above require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.

(*over*)

Name:

Chart:

Date:

You have the following rights with respect to your health information:

1. The right to request restrictions on certain uses of your health information, **however we are not required to agree to your request.**
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e., fax, e-mail, voice mail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect you health information (you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal, or administrative action or proceeding).
4. In limited circumstances, the right to ask us to amend your health information, **however we reserve the right to deny your request.** If your request to amend is denied, we will provide you with information about the basis of our denial and your right to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures made for national security purposes or to correctional institutions or law enforcement officials, or disclosures that were made prior to the compliance date.
6. The right to receive a copy of this Notice in writing.

We have the following obligations:

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide the terms of the notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available on request.

Complaints

If you believe we have violated your privacy rights, you may file a written complaint to our Privacy Officer and/or to the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

If you want more information or you believe your rights have been violated, you can contact Our Privacy Officer at the following address: Toledo Orthopaedic Surgeons Division. 2865 N. Reynolds Rd., Building A. Toledo. Ohio 43615-2100. Attention Privacy Officer. Our telephone number is 419-578-7200. Alternatively, you may wish to contact the federal agency in charge of enforcing patients' privacy rights. That address is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHS Building. Washington, D.C. 20201.

Acknowledgment

I have read the foregoing Notice of Privacy Practices provided to me by Toledo Orthopaedic Surgeons Division, and I have been given the opportunity to discuss the privacy practices at Toledo Orthopaedic Surgeons Division. I understand that the practice may, at its discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same.

Signature _____ Date _____

Print name _____ Staff initials _____

If signed by patient's authorized representative, describe the representative's authority:

❑ Parent of minor child ❑ Guardian ❑ Agent (Health Care Power of Attorney) ❑ Other (describe)

The Notice of Privacy Practices was provided to _____, however he/she did not acknowledge receipt for the following reason: ❑ Refused ❑ Did not understand ❑ Other

Staff Signature _____ Date _____