



PLEASE READ CAREFULLY

The staff at Wooster Orthopaedic & Sports Medicine Center strives for excellence in patient care from your initial contact with our office to your final appointment. Please help us serve you more efficiently by notifying us if your coverage changes or if you are issued a new insurance card for any reason.

We have enclosed an appointment card with your scheduled appointment. All papers enclosed **must** be filled out and returned at the time of your appointment. Insurance regulations specify we must have this information. If you cannot keep this appointment, please cancel as soon as possible.

You will need to bring all current insurance cards, papers, your driver's license, and all of your pill bottles of medications that you are taking at the current time, or we may ask you to sign a waiver of responsibility, or reschedule your appointment. You will be expected to make your insurance co-pay at the time of your visit. Medicaid patients **must** present the current months care to receive medical treatment. If not presented, you will be asked to reschedule. Please bring any recent X-Ray or MRI films with you to your appointment.

If you are a patient under the age of 18 and this is your initial appointment, you **must be accompanied by a parent or an authorized adult**, in order to be seen.

Also, enclosed is a brochure outlining the general practices and policies of our office. Please take a few minutes to read over the brochures prior to your appointment. If you have questions, please call our office.

If you are being seen for a knee, back or hip problem, we ask that you bring a pair of shorts or skirt with an elastic waist (no metal zipper or buttons) to the appointment.

As a courtesy to you, we will submit a claim to your insurance carriers for our services upon receipt of accurate insurance information. **IT IS IMPORTANT FOR YOU TO UNDERSTAND YOUR COVERAGE AND BENEFITS.** There are hundreds of health plans with various deductibles for payment of services rendered to you and/or your dependents. We urge you to contact your insurance carrier to be apprised of your coverage and benefits. It is also your responsibility to get a referral from your Primary Care Physician if it is required for your insurance.

If you have secondary insurance coverage, please be sure we have all pertinent information. We will submit a claim to that secondary insurance after your primary insurance company has paid its portion of your charges. After your secondary insurance carrier submits payment, we will bill you for any remaining balance for which you are responsible. Prompt payment is appreciated.

WE HOPE YOUR EXPERIENCE WITH US IS A GREAT ONE!

PATIENT REGISTRATION

Patient Soc. Sec. # _____ Male _____ Female _____
 S M W D
 Marital Status (circle)

 Last First MI DOB

 Street City State Zip Length of time at current address

 Phone Employer Employer Address Employer Phone

Spouse Soc. Sec. # _____

 Name DOB Contact Phone

 Street City State Zip

 Employer Employer Phone Employer Address

Father (if patient is a minor) Soc. Sec. # _____

 Name DOB Contact Phone

 Street City State Zip

 Employer Employer Phone Employer Address

Mother (if patient is a minor) Soc. Sec. # _____

 Name DOB Contact Phone

 Street City State Zip

 Employer Employer Phone Employer Address

Insurance (circle) YES NO If none, how do you intend to pay? (circle) **CASH CHECK CREDIT CARD**

Workers Compensation Claim (circle) YES NO

 Claim Number Date of injury

 Business Where Injury Occurred Employer Phone Employer Address

Are you currently Employed there? (circle) YES NO If not, last date worked _____

Emergency Contact

 Name of nearest relative not residing with you Relationship Phone

 Street City State Zip

Primary Care Physician

 Name Phone Practice

 Street City State Zip

Physician requesting consultation (if different than above)

 Name Phone Practice

 Street City State Zip

I consent to treatment necessary for the care of the above named patient.
 I authorize the release of all medical records to the referring and family physicians and to my insurance, if applicable.
 I acknowledge full financial responsibility for services rendered by the treating physician of record. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
 I further authorize and request that insurance payments be made directly to the treating physician of record should they elect to receive such payment.
 I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.
 I swear that the information I have given above is true and current to the best of my knowledge.

 Patient signature Relationship to Patient Date

MEDICAL HISTORY

M F

Name _____

Age _____

Family Doctor _____

Please check ALL boxes below indicating your current conditions

MEDICAL PROBLEMS	YES	NO
Arthritis		
Fibromyalgia		
Gout		
High blood pressure		
Coronary artery disease		
Heart attack		
Congestive heart failure		
History of phlebitis/Blood clot		
Stroke		
Pacemaker		
Asthma		
Emphysema		
Pulmonary embolism		
Ulcers		
Hepatitis		
Kidney disease/Renal failure		
Kidney stones		
Diabetes		
Thyroid disease		
Psoriasis		
Seizure disorder		
Cancer		
Other:		

ORTHO HISTORY	Year	Hospital	Doctor
Arthroscopy			
Bunion			
Carpal tunnel			
Cervical fusion			
Hip replacement			
Knee replacement			
Laminectomy			
Other:			

ASSISTIVE AIDS

Circle Answer

Glasses	Dentures	Hearing Aid	Cane	Walker	Brace

FAMILY HISTORY

Number of children					
Circle Answer that applies to each:	F - Father, M - Mother, G - Grandparent, B - Brother, S - Sister				
Anemia	F	M	G	B	S
Arthritis	F	M	G	B	S
Bleeding disorder	F	M	G	B	S
Cancer	F	M	G	B	S
Diabetes	F	M	G	B	S
Heart disease	F	M	G	B	S
High blood pressure	F	M	G	B	S
Stroke	F	M	G	B	S
Anesthesia Complications	F	M	G	B	S

SURGICAL HISTORY

SURGICAL HISTORY	Year	Hospital
Anesthesia complications		
Appendectomy		
Colon resection		
Gallbladder		
Heart bypass (CABG)		
Heart valve replacement		
Hernia repair		
Hysterectomy		
Kidney stones		
Mastectomy		
Tonsillectomy		
Tubal ligation		
Other:		

SOCIAL HISTORY

Circle Answer

Marital Status:	S	M	D	W
Hand Dominance:	R L Both			
Work Status:	Student	Housewife	Not Working	Working
	Retired	Disabled	Injured	
	Off work since:		Disabled since:	
Occupation:				
Employer:				
Tobacco use:	Never	Former	Current	___ packs/day ___ yrs.
Alcohol use:	Never	Former	Current	Daily Weekly Occasional
Drug abuse:	Never	Former	Current	
	Heroin	Cocaine	Marijuana	Other_____
Exercise:	Never	1-3x/month	1-3x/week	Daily

REVIEW OF SYSTEMS

GENERAL YES NO

Anorexia		
Anxiety		
Appetite changes		
Fever		
Hard of hearing/deaf		
Vision problems/blind		
Weight changes		

CARDIO

Chest pain		
Heart murmur		
Irregular heartbeat		
Poor circulation/Peripheral vascular disease		

RESPIRATORY

Asthma		
Cough		
Pneumonia		
Sleep apnea		
Shortness of breath		
Tuberculosis		
Wheezing		

GI

Constipation		
Diarrhea		
Difficulty swallowing		
Heartburn		
Nausea		
Bloody Stool		
Vomiting		

GU

Incontinence		
Menstrual irregularities		
More than 3 mo. without period		
Pregnant		

MUSCULO/EXT

Difficulty walking		
Leg swelling		
Limp		
Weakness		

SKIN YES NO

Raynaud's		
Shingles		
Tattoo		

NERVE

Balance problems		
Dizziness		
Numbness/Tingling		
Tremor		

PSYCH

Anxiety		
Depression		
Insomnia		
Mental illness		
Stress		

HEMATOLOGIC

Anemia		
Bleeding/Bruising tendency		
Past transfusion		

ACCIDENTS/INJURIES (if yes, provide details)

Fractures
Details:
Auto accident
Details:
Sports injury
Details:
Other
Details:

SIGNATURES

Patient Signature

Date _____

Physician Signature

Date _____