THE ORTHOPAEDIC INSTITUTE OF WESTERN KENTUCKY

PN: _____

Patient Demographics: Today's Date: __/___/_____

Last name: _____ First Name: _____ Middle: _____ Date of Birth: _____ Age: _____

Height: _____ Weight:_____ Sex: Male Female SSN: _____ Hand Dominance: Left Right

Address: _____ City: _____ State: _____ Zip: _____

Primary #/Cell #: _____ Secondary #:_____ Email: _____

Emergency Contact Name: _____ Emergency Contact #: _____

Who may we speak with regarding your care? _____

Primary Physician: _____ Referring Physician: _____

Have you seen any other physician regarding this condition prior to coming to OIWK: Yes No *(If yes, please complete below.)*

Physician Name: _____ When: _____ Treatment: _____ Results:_____

Social History:

Marital Status: Single Married Divorced Widowed Life Partner Other: _____ Number of children: _____

Occupation: _____ Employer: _____

Work Status: Working Unemployed Disabled Homemaker Laid off On Leave Retired Date of Retirement: _____

Have you been off work from this current injury? Yes No If yes, date last worked: _____

Is this a Workman's Compensation Claim: Yes No Liability Claim: Yes No Motor Vehicle Accident: Yes No

Have you ever used tobacco: No/Never Yes Type: Cigarettes Chew/Dip Cigar Other How often: _____ Quit/when:_____

Do you drink alcohol: Yes No Formerly Frequency: Daily Monthly Occasionally Rarely Socially Amount: _____

Recreational Drug Use: Yes No Type: _____ Frequency:_____

Chief Complaint/Details of Injury:

Chief Complaint: _____

Body Part: _____ Left Right Both

When did the symptoms begin/Date of onset: _____

Where did the injury happen: Home School Work MVA/Auto Sports Other:_____

How did the injury happen: _____

**If you are over 55, have you had an Osteoporosis Screening within the last 2 years? Yes No

History of Present Illness: *Circle when applicable* PN: _____

Previous similar problems or complaints: _____

Severity of Pain: 1 (mild) 2 3 4 5 6 7 8 9 10 (severe)

Character of Pain: Dull Sharp Achy Piercing Burning Stabbing Throbbing Other:_____

What makes your symptoms worse: Time of day Daily activity Driving Sitting Standing Lifting Other:_____

How long does the pain last: _____

Associated symptoms: Swelling Giving way Fatigue Numbness Radiating pain Joint pain Other: _____

What makes your symptoms better: No movement Heat Ice Sitting Standing Rest Other: _____

Previous treatment for the problem: Medications Therapy Injections Bracing Other: _____

Any special diagnostic tests or studies done: X-rays MRI NCS Labs Other: _____ Where: _____

Similar complaints on opposite side: _____

Past Medical History: *Applies to the patient*

- ☐ Arthritis – (Circle) Rheumatoid or Psoriatic
- ☐ High Blood Pressure
- ☐ Elevated Cholesterol
- ☐ Heart Disease – (Circle) CHF or CAD
- ☐ Thyroid Problem
- ☐ Kidney Disease
- ☐ Diabetes – (Circle) Type 1 or Type 2
- ☐ Liver Disease
- ☐ Sleep Apnea
- ☐ Cancer – Type? _____
- ☐ Ulcer Disease- (Circle) Peptic or GERD
- ☐ Stroke
- ☐ Hepatitis
- ☐ AIDS/HIV
- ☐ Fibromyalgia
- ☐ Blood Clots/Pulmonary Embolism
- ☐ Anxiety
- ☐ Obesity
- ☐ Osteoporosis/Osteopenia
- ☐ Chronic Migraines
- ☐ Gout
- ☐ Bone Density Test – When? _____
- ☐ Seizure Disorder
- ☐ Psoriasis
- ☐ Date of Menopause or LMP: _____
- ☐ Lung Disease (Circle) Asthma, COPD, Emphysema
- ☐ Other Medical Conditions: _____

Current Medications: ****Include ALL medications and dosage including over the counter drugs and supplements**

Medication & Dosage	Medication & Dosage

If taking, date you began using NSAIDS (Motrin, Ibuprofen, Naproxen)? _____

Preferred Pharmacy: _____ **Location:** _____

Allergies: ☐ ***NO KNOWN ALLERGIES*** PN: _____

Latex: Yes No Reaction: _____ **Metal:** Yes No Reaction: _____ **Food:** Yes No Reaction: _____

Medication Allergy (specify)	Adverse Reaction

Prior Surgeries: *Applies to the patient*

Do you have a Pacemaker or other implants? Yes No If yes, what type? _____

Prior transfusion? Yes No

Type of Surgery	Date	Provider/Where	Any Complications

Family History: *Do any of your immediate relatives (mother, father, brother, sister) have any of the following?*

☐ Cancer – Type? _____ ☐ Thyroid Disease

☐ Heart Disease ☐ Liver Disease

☐ Diabetes ☐ Kidney Disease

☐ High Blood Pressure ☐ Other: _____

Review of Systems: *Applies to patient for today's visit. Check all symptoms/conditions which apply or you are currently experiencing.*

☐ Chills	☐ Hearing Loss	☐ Leg Swelling	☐ Hematuria (Blood in Urine)	☐ Insomnia
☐ Fever	☐ Vertigo	☐ Irregular Heartbeat/Palpitations	☐ Cold Intolerant	☐ Contact Allergy
☐ Night Sweats	☐ Ear Drainage	☐ Abdominal Pain	☐ Hair Loss	☐ Rash
☐ Weight Gain (Last 6 Months)	☐ Hoarseness	☐ Diarrhea	☐ Heat Intolerant	☐ Skin Lesion
☐ Weight Loss (Last 6 Months)	☐ Vision Loss	☐ Loss of Appetite	☐ Difficulty Walking	☐ Itchy Skin
☐ Fatigue	☐ Chest Pain	☐ Constipation	☐ Memory Loss	☐ Skin Infections
☐ Weakness	☐ Dyspnea (Shortness of Breath)	☐ Heartburn	☐ Seizures	☐ Bleeding
☐ Malaise (Discomfort)	☐ Known TB Exposure	☐ Nausea	☐ Dizziness	☐ Bruising
☐ Blurred Vision	☐ Cough	☐ Black Tarry Stools	☐ Muscle Weakness	☐ Asthma
☐ Fascial Pain	☐ Wheezing	☐ Jaundice	☐ Tremors	☐ Contact Dermatitis
☐ Nasal Congestion	☐ Recent Infections	☐ Vomiting	☐ Poor Coordination	☐ Food Allergies
☐ Double Vision	☐ Heart Murmur	☐ Dysuria (Painful Urination)	☐ Paresthesia (Pins & Needles)	☐ Bee Sting Allergies
☐ Headache	☐ Syncope	☐ Urge Incontinence	☐ Anxiety	☐ Environmental Allergies
☐ Ringing Ears	☐ Cyanosis (Bluish)	☐ Frequent Urination	☐ Depression	☐ Seasonal Allergies
☐ Dysphagia (Difficulty Swallowing)		☐ Urinary Incontinence		

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PN: _____

Billing Information, Financial Policy, Information Release

Billing Information

An insurance claim for fracture care will typically appear as follow, as it is considered surgery:

1. Exam at the documented level for diagnosis/decisions about the best treatment options.
2. An x-ray is often used to diagnose the fracture and/or a post fracture treatment x-ray to ensure proper alignment.
3. A Fracture Code will be assigned based on the site, type of fracture, and whether the treatment is *closed* or *open*. Open treatment is most often performed in an operating room at a surgery center or hospital. Closed treatment is often done at the emergency room of in the office. However, all fracture treatment is considered "Major Surgery" and will often be reported as surgery on your insurance company's Explanation of Benefits (EOB).
4. The Cast Application for the initial work of applying the cast is included in the above Fracture Code at no charge. Subsequent applications are separately reported and billable.
5. Cast Supplies are reported separately and billable.
6. Subsequent Fracture Care: Most "routine" fractures will require several post operative visits which are included in the fracture fee. There are special rules our office requires to use to report those services.

This office is required by Federal Compliance Law to report the services provided based on the documentation in the medical record. As a matter of policy, we cannot improperly alter a claim with the purpose of obtaining payment. If you discover a bone fide billing error, duplicate charge, or other posting error, we would greatly appreciate you bringing the matter to the attention of our business office staff for further investigation, upon which further, corrective action may be taken. If you receive a questionnaire from your insurance asking how your injury occurred, please complete the form, and return to them promptly. Your insurance company will not pay until the form is returned to them.

Insurance coverage and payment amounts vary greatly by payer. If you have any questions about your coverage, it is best to inquire with your insurance company's representative. Our business office staff is happy to assist in the claims filing process for prompt adjudication and payment of your insurance claim.

Financial Policy

No Surprises Act: The Orthopaedic Institute of Western Kentucky follows the guidelines put in place by the Centers for Medicare and Medicaid Services (CMS) and the State of Kentucky for "out of network" and "self-pay" patients. You will receive a notice explaining your rights as a patient and a "Good Faith Estimate" (GFE).

Contracted Insurances: The Orthopaedic Institute of Western Kentucky is contracted with all major insurance companies. Any co-pays assigned by your specific insurance company is due at the time of service. We accept payment via cash, check, VISA, Mastercard, or Discover.

Workers' Compensation: Charges will be submitted for you **IF** all information has been fully furnished and agreed to by your employer. You are required to provide us the claim number, name, address, and contact information of your compensation carrier. **IF** all information is not provided, we assume and expect payment from you.

"I authorize any treating physician or provider to communicate orally, or in writing, with my employer or its insurance company, claims administrator, medical management consultant, case manager, field nurse case manager, and/or attorneys as to the treatment provided associated with my assumed work-related injury, and do hereby waive my physician-patient privilege."

Authorization: "I authorize Drs. T. DeWeese, S. Patel, B. Kern, B. Strenge, W. Adams, S. Romine, R. Beck, and/or J. Patton to release records pertaining to my health to insurance companies, referring physicians, attorneys, employer, employer's insurance company, case manager, field nurse case manager, claims administrator, and/or my other responsible party. I authorize release of my x-rays to above said persons. I request payment under the medical insurance program to be made directly to the appropriate above said physicians. Should my account become delinquent and referred to collection, I shall pay all reasonable collection expenses, court costs, and attorney fees associated."

"I have read and understand the billing information, financial policy, and information release, and agree to the contents."

Patient Signature: _____ Date: _____

Signature of other Responsible Party: _____ Date: _____

Notice of Privacy Practices

I, _____, have read the notice of privacy practices, and authorize The Orthopaedic Institute of Western Kentucky to disclose the identified information to the persons and for the purpose described herein. I understand that by signing this document, I release The Orthopaedic Institute of Western Kentucky harmless of any release made pursuant to this authorization.

_____ Date: _____

Signature of Patient or Legal Representative

_____

Description of Legal Representative's Authority