Name:
Chart:
Date:

Welcome to Our Practice

Your Appointment is: _____

Provider: _____

In order to efficiently and effectively provide you with quality care, please complete the enclosed forms and be sure to bring this information to your appointment.

Additionally, we ask that you:

- Arrive 20 minutes before your appointment time.
- Bring any x-rays, MRIs, CT scans, EMGS or other related tests, along with the written reports. If your studies were done at Meadville Medical Center, you do not need to bring them.
- Bring your insurance card(s) and photo ID, such as a driver's license.
- Bring the co-pay amount required by your insurance plan; this will be due at the time of service.
- Self pay patients must pay for their services at the time of the office visit.
  We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Discover.
- Contact your PCP to obtain a referral if you have Gateway, AmeriHealth Caritas, Coventry Cares or UPMC for You.
- Please check with your health insurance plan to be sure that Orthopedic Associates of Meadville, PC is in network. Or call our office with any questions.

If you cannot keep your appointment for any reason, please call our office at (814) 724-1252 to cancel. There is a $25 No-Show Fee for failure to cancel your appointment at least one business day in advance or $50 for an EMG appointment with Dr. Wheeling.

Minors must be accompanied by a parent, legal guardian or custodian.

Thank you for choosing Orthopedic Associates of Meadville, P.C.

Name:
Chart:
Date:

INITIAL PAST MEDICAL HISTORY

Name _____ Date _____
Date of Birth _____ Date of injury _____

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR
__Heart attack
__Angina or chest pain
__High blood pressure
__Palpitation/heart skipping
__Heart murmur
__Stroke
__Edema - ankle swelling
__Varicose veins
__Phlebitis or blood clots
__Other heart-circulation problems
__Sleep apnea

LUNGS
__Bronchitis
__Emphysema
__Asthma
__Tuberculosis
__Sinusitis
__Hay-fever
__Respiratory infections
__Shortness of breath
__Black lung
__Other lung problems
_____

OTHER SYSTEMS
__Diabetes - Insulin/Non
__Thyroid problems
__Kidney/bladder problems
__Stomach or duodenal ulcer
__Heartburn or burping
__Convulsions - epilepsy
__Dizzy or fainting spells
__Hepatitis/jaundice/liver
__Pregnant Y / N
__HIV/AIDS
__Depression / Anxiety

__Arthritis/rheumatism
__Glaucoma
__Bleeding problems/anemia
__Psychiatric problems
__Back problems
__Alcoholism
__Drug Addiction
__Cancer - type _____
__Bone disorders
__Fibromyalgia
__Other _____

2. Please list prior surgeries and dates _____
_____

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.
Drug Name Strength Dosage
_____
_____
_____

4. Do you have any allergies to medications? If so, please list medication and reaction
_____

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.)
_____

6. Do any medical problems run in your family? _____DVT/Blood Clots _____Other
_____Hypertension _____Diabetes _____Heart Disease _____Rheumatic arthritis. _____Cancer

7. Do you smoke cigarettes, cigars or a pipe?
If so, how many per day? _____, for how many years? _____

8. Do you drink alcohol? Yes No If yes, how much per week _____

9. Tattoo within the past 6 months? _____

10. Do you live in a _____one story home, _____two story home or other? _____

11. Who lives at home with you? _____

12. Do you typically use a walker/cane/wheelchair? _____

13. What is your occupation? _____

14. Are you able to operate a vehicle? _____

15. Who is your primary care physician? _____

(for office use) Height _____ Weight _____ B/P _____ Age _____ BMI _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date _____

Physician/PA Signature _____ Date _____

Name:
Chart:
Date:

HIP and LOW BACK HISTORY

Name: _____ DOB: _____

1. Reason for visit (include left or right) _____
2. Date of onset (beginning) of complaint/injury _____
3. What activity were you engaged in and where did it happen? _____
   _____
4. Describe complaint (ache, pain, throb, lump, etc.) _____
5. Is there associated pain elsewhere? If so, describe _____
   _____
6. What is the effect of activity? Does it make the pain better or worse? _____
   _____
7. Do you use _____ cane, _____ walker, _____ crutches? If yes, how often? _____
8. Do you use _____ furniture _____ shopping carts for support?
9. What is the effect of weather changes? _____
10. Any numbness or tingling in your arm or leg? _____
11. Any fever, chills, appetite lose, unexpected weight loss? _____
12. Does Aspirin/Tylenol/Advil, etc. help? _____
13. Does the pain awaken you from sleep? _____
14. Are there other symptoms? If so, describe _____
15. Describe any similar episodes in the past _____
16. Current treatment _____
17. Other physicians consulted for this problem? _____
18. Status now compared to onset? Better/worse/same _____
19. If off work because of this problem, state date last worked _____

Have one or more of the below conservative treatments been tried?

- ☐ Anti-inflammatory medication:
  Name of medication : _____ Duration _____
- ☐ Pain Medicine:
  Name of medication : _____ Duration _____
- ☐ Home exercise : _____ Duration _____
- ☐ Physical therapy : _____ Duration _____
- ☐ Use of a cane or walker : _____ Duration _____
- ☐ Weight loss: _____ Duration _____
- ☐ Cortisone shot(s) : _____ Duration _____

Name:
Chart:
Date:

PLEASE COMPLETE ALL SECTIONS

Patient Information

NAME: LAST FIRST MIDDLE SOCIAL SECURITY #

BIRTHDATE AGE SEX LANGUAGE: ☐ English ☐ Spanish / _____
ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

STREET ADDRESS RACE: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Native American ☐ Unknown

CITY STATE ZIP CODE

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

EMPLOYER EMPLOYER ADDRESS

*If you have been a patient in the past under a different name, please enter that name: _____

Emergency Contact

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Financially Responsible Party if other than Patient

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Primary Care Physician

NAME PHONE#

ADDRESS

Insurance

Primary Insurance Information
NAME OF INSURANCE ID#

Secondary Insurance Information
NAME OF INSURANCE ID#

Workers Compensation ☐ YES ☐ NO -OR- Auto Accident ☐ YES ☐ NO
NAME OF INSURANCE

CLAIM # _____ DATE OF INJURY / ACCIDENT _____

MEDICARE I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits assigned to OAM.

OTHER I authorize OAM to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in OAM all payments for medical services rendered to myself or my dependents.

I also understand that I am responsible for any amount not covered by my insurance. Initials: _____

Signature _____

Name:
Chart:
Date:

Patient Name _____

Date of Birth _____

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change it's privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.
I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: _____ **Signature:** _____ Date: _____

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P.C. to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders (including return telephone calls)
_____ Prescription Refills
_____ Test Results
_____ **Do not leave message**

_____ Permission to fax work status reports to employer
_____ Permission to fax gym/school excuses to school

Signature _____ Date _____

Student Resident Consent

The physicians at Orthopedic Associates of Meadville are proud to play an integral role in the teaching of residents from Lake Erie College of Osteopathic Medicine (LECOM) and the training of student interns.

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature _____ Date _____

Name:
Chart:
Date:

ORTHOPEDIC ASSOCIATES OF MEADVILLE, P.C.

11277 VERNON PLACE, SUITE 200 • MEADVILLE, PENNSYLVANIA 16335 • 814/724-1252
FAX 814/337-6043

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **7 day notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday - Friday. No refills on the weekends or holidays. The "on-call" physicians will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of medication. Do not give your medications to other people and do not take medication from others.
8. Preferred Pharmacy & Location: _____
   (This pharmacy will be used for your refills unless otherwise specified.)
9. Orthopedic Associates of Meadville may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree and will comply with the above guidelines.

Print Patient Name: _____ DOB: _____

Signature: _____ Date: _____
(Patient, Parent or Guardian)