

Date: _____ Email address: _____

Name: _____ Date of Birth: ____/____/____ AGE: _____

Address: _____

Home Phone #: _____ Cell #: _____ Work#: _____

Sex: M / F Marital Status: _____ SS#: _____ - _____ - _____

Occupation: _____ Place of Employment: _____

Parent Name (If patient is a minor): _____ Phone#: _____

Emergency Contact: _____ Phone #: _____

PRIMARY INSURANCE COMPANY: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____ Subscriber's SS# _____ - _____ - _____

Member ID #: _____ Group# _____

Claims Address : _____ Phone #: _____

SECONDARY INSURANCE COMPANY: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____ Subscriber's SS# _____ - _____ - _____

Member ID #: _____ Group# _____

Claims Address : _____ Phone #: _____

FOR WORK RELATED INJURIES:

Date of Injury: _____ Claim #: _____ Reported to supervisor: YES NO

Work Comp Company: _____

Claims Mailing Address: _____

Case Manager Name: _____ Phone#: _____

Fax: _____

Name of Employer: _____ Employer Phone #: _____

Supervisor Name: _____

Virginia Spine and Sports Orthopaedics

Dear Patient,

HIPAA regulations prohibit your physician from sharing information regarding your medical care with other family members or friends unless prior authorization by the patient is given.

I, _____ authorize Dr. Angela Santini and her staff to disclose my medical information to the following family members or close friends who assist in my care.

NAME:

RELATIONSHIP:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Please check all that apply for calls are made to you from Dr. Santini or staff:

Messages may be left on my cell phone

Messages may be left on my home phone

Do not leave messages on any phone number

Patient signature

date

Please be advised, it is your responsibility to keep this information up to date regarding adding or removing names from your disclosure list.

ASSIGNMENT OF BENEFITS

As the patient whose name appears below, I hereby authorize Angela M. Santini, M.D., P.C./Virginia Spine & Sports Orthopaedics to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Angela M. Santini, M.D., P.C./Virginia Spine & Sports Orthopaedics for application on the patient's bill. I certify that the information reported with regard to my insurance coverage and medical history is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Angela M. Santini, M.D./Virginia Spine & Sports Orthopaedics, for all co-insurance, co-pays and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Angela M. Santini, M.D., P.C./Virginia Spine & Sports Orthopaedics. Further, I will be responsible for payment of charges not covered by my insurance plan.

Payment is requested at the time the services are rendered. If expensive or extended treatment is anticipated, arrangement may be made for payment plan. All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of insurance carrier. Angela M. Santini, M.D., P.C./Virginia Spine & Sports Orthopaedics will bill charges to the primary and/or secondary insurance carrier, and Angela Santini M.D., P.C. will bill the remaining amount to the patient. Any balance due, for whatever reason, i.e. co-payments, failure to have proper referral, denial of worker's compensation benefits, is the patients' responsibility. Payment for charges which are the patient's responsibility are to be paid within 30 days. The patient/guarantor signing below accepts responsibility for payment.

Should the patient's account be turned over to our attorney and/or collection agency for payment due, the patient and/or guarantor shall pay any collection costs (25% of outstanding balance) and/or attorney fees (33% of outstanding balance plus court fees).

INTEREST RATE's: Interest fees of 25% annum will be charged to any outstanding balance that has not been paid within 30 days the 4th statement sent. All patients receive 4 statements total and partial payments are accepted interest free when paid within the above said time frame of 30 days following the 4th statement.

CANCELLATION POLICY (EFFECTIVE AUG 1, 2008)

If you are unable to keep your appointment, we require 24 hours notice, to avoid a \$50.00 FEE. This fee must be paid at the time of, or before your next office visit.

Patient Signature

Date

Please answer ALL questions

Name: _____

Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Male Female

Hand Dominance: Right Left

Occupation: _____

Marital Status: _____

Medication Allergies NKDA

SPECIFIC reason for seeing Orthopaedic Surgeon:

Symptoms began/ Date of injury:

Past Medical History None

*** (List ALL medical problems)***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Previous Surgical History None

Procedure Date Complications?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Date: _____

How did you hear of our practice?

Family Doctor (PCP): _____

Present Medications LIST ALL

Name	Dose	Frequency
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		

Social History:

Current Smoker Yes No

If yes, how much: _____

If past smoker, when did you quit: _____

Alcohol Consumption: Social Moderate
 Heavy None

Do you use drugs : Yes No

If yes, name substance: _____

Family History: Yes No

Heart Disease

Diabetes

Anesthetic Reaction

Cancer

Arthritis

Scoliosis

Other: _____

General

	Yes	No
Loss of energy	<input type="checkbox"/>	<input type="checkbox"/>
Unusual chills	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fever	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain (unintentional)	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss (unintentional)	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric

Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss/Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>
Personality Change	<input type="checkbox"/>	<input type="checkbox"/>
Poor attention/attention deficit	<input type="checkbox"/>	<input type="checkbox"/>

Ophthalmic- Eyes

Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>

Ear, Nose, Throat

Hearing problems	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>
Tooth pain	<input type="checkbox"/>	<input type="checkbox"/>

Allergy/Immunology

Seasonal allergy/hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Shellfish allergy	<input type="checkbox"/>	<input type="checkbox"/>

Hematology/Lymphatic

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding	<input type="checkbox"/>	<input type="checkbox"/>
History of blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>

Dermatological

Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Masses/cysts	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Skin lesions	<input type="checkbox"/>	<input type="checkbox"/>
acne	<input type="checkbox"/>	<input type="checkbox"/>

Endocrine

	Yes	No
Diabetes controlled by: Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Oral Meds	<input type="checkbox"/>	<input type="checkbox"/>
Diet	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular

Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Palpitation/irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack or heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory

Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Unusual cough	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema/COPD	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal

Abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary

Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones/disease	<input type="checkbox"/>	<input type="checkbox"/>
Weak urinary stream	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Urinary retention	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

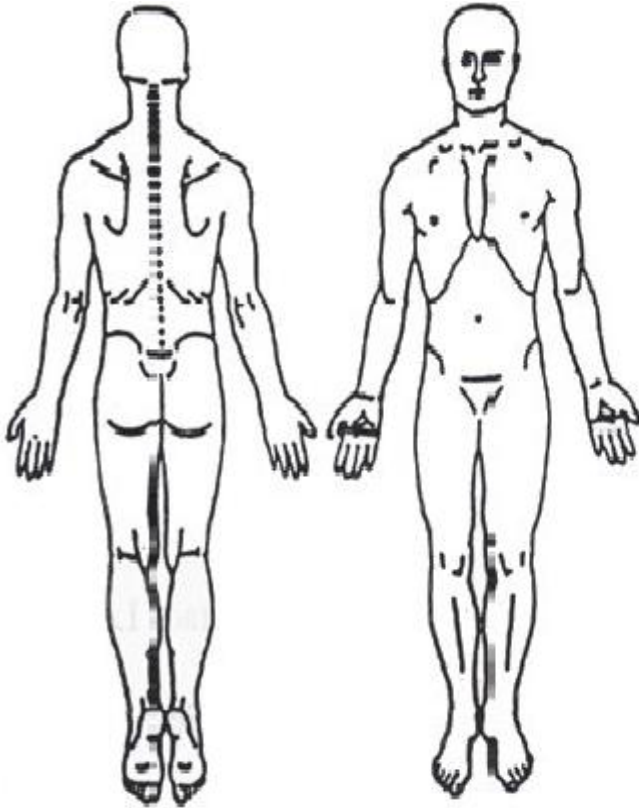
Unusual joint/muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Prior neck/back pain	<input type="checkbox"/>	<input type="checkbox"/>

Neurological

Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>
Numbness/tingling in extremities	<input type="checkbox"/>	<input type="checkbox"/>

Patient name: _____

Date: _____



Location and type of pain:
Please mark diagram below

Numbness:

Pins/needles:
 x x x x x x x x
 x x x x x x x x

Burning:
 // // // // // // //
 // // // // // // //

Pain:
 o o o o o
 o o o o o

Stabbing:
 + + + + +
 + + + + +

How often is your pain? Constantly Intermittently : Onset? Sudden Gradual

Please rate your pain score (using a scale of 0 to 10, 0 = no pain and 10 =unbearable pain)
 _____ Pain scale _____ Without Activity _____ With Activity

What makes the pain better? (e.g. heat, cold, sitting, laying down, meds)

What makes the pain worse? (e.g. bending, lifting, standing)

Have you taken part in any conservative treatment for current problem?

Physical Therapy Chiropractor Meds Injections Massage

Did conservative measures help Yes No

Please list any health care professionals who have treated you for this specific problem in the past: _____