

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): _____

Pharmacy Name: _____

Pharmacy Number: _____

Present Medications LIST ALL

Name	Dose	Frequency
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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

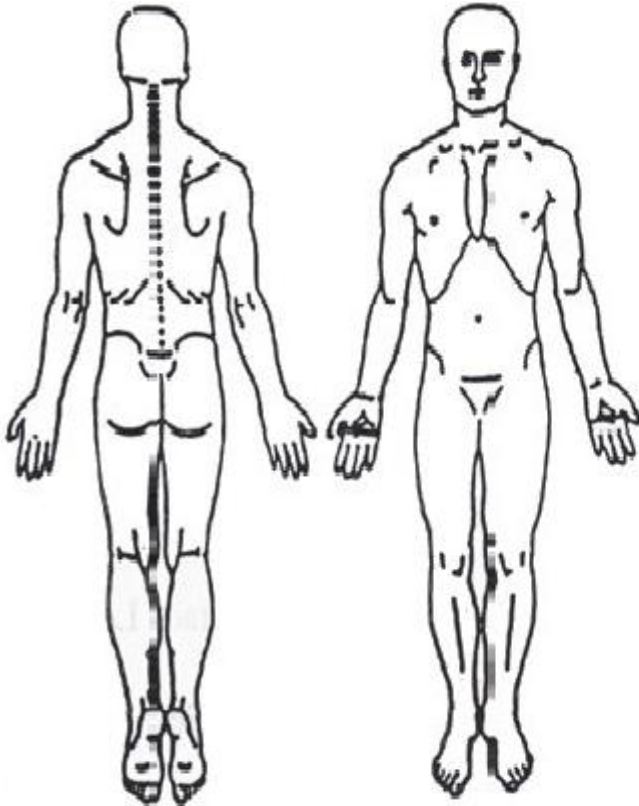
Unusual joint/muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Prior neck/back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

Virginia Spine & Sports Orthopaedics

ASSIGNMENT OF BENEFITS

As the patient whose name appears below, I hereby authorize Angela M. Santini, M.D., P.C./ Virginia Spine and 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 and 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., P.C./ Virginia Spine and 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 and 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 and Sports Orthopaedics will bill charges to the primary and/or secondary insurance carrier, and M. 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).

CANCELLATION POLICY (EFFECTIVE AUG 1ST, 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.

HIPAA

HIPAA regulations prohibit the disclosure of your health information/medical care to family members or friends without your permission. Please list below any person to whom you authorize our practice to speak to regarding your care. Please be advised, it is your responsibility to keep this information up to date (adding/removing names)

NAME:	RELATION TO PATIENT
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Receipt of Notice of Privacy Practices Acknowledgement

I have received a copy of Angela M. Santini, MD, PC's Notice of Privacy Practices and understand how my/ the patient's medical information may be used and how access to this information may be obtained. I have acknowledged I have an opportunity to ask questions about the information provided in the notice.

Signature

Date

Relation to patient if form is executed by someone other than patient

My signature above acknowledges agreement and understanding to all three areas above.