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
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: _____

Review of Systems for the last 12 months
Page 2

Name: _____
Date: _____

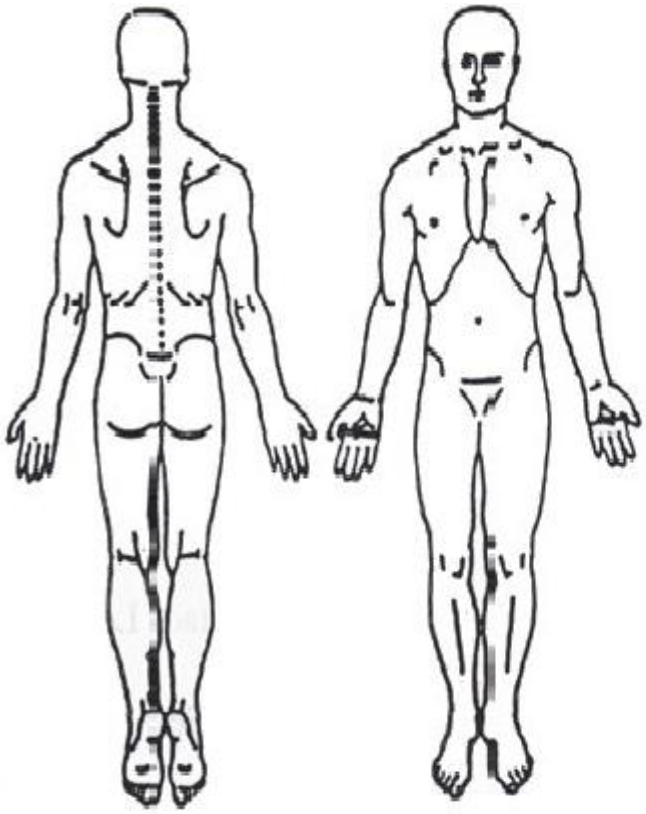
General	Yes	No
Loss of energy	☐	☐
Unusual chills	☐	☐
Night sweats	☐	☐
Unusual fever	☐	☐
Weight gain (unintentional)	☐	☐
Weight loss (unintentional)	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Memory loss/Dementia	☐	☐
Sleep Disturbance	☐	☐
Personality Change	☐	☐
Poor attention/attention deficit	☐	☐
Ophthalmic- Eyes		
Blurred vision	☐	☐
Wear glasses/contacts	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Macular degeneration	☐	☐
Ear, Nose, Throat		
Hearing problems	☐	☐
Hoarseness	☐	☐
Swallowing difficulty	☐	☐
Ear pain	☐	☐
Tooth pain	☐	☐
Allergy/Immunology		
Seasonal allergy/hay fever	☐	☐
Shellfish allergy	☐	☐
Hematology/Lymphatic		
Anemia	☐	☐
Bruise easily	☐	☐
Excessive bleeding	☐	☐
History of blood transfusion	☐	☐
Dermatological		
Bruise easily	☐	☐
Masses/cysts	☐	☐
Melanoma	☐	☐
Skin lesions	☐	☐
acne	☐	☐

Endocrine		Yes	No
Diabetes controlled by:	Insulin	☐	☐
	Oral Meds	☐	☐
	Diet	☐	☐
Thyroid Disease		☐	☐
Cardiovascular			
Chest Pain		☐	☐
Palpitation/irregular heartbeat		☐	☐
Hypertension		☐	☐
Heart attack or heart failure		☐	☐
Stroke		☐	☐
High Cholesterol		☐	☐
Respiratory			
Shortness of breath		☐	☐
Asthma		☐	☐
Unusual cough		☐	☐
Emphysema/COPD		☐	☐
Gastrointestinal			
Abdominal pains		☐	☐
Ulcers		☐	☐
Acid reflux		☐	☐
Change in bowel habits		☐	☐
Hepatitis		☐	☐
Genitourinary			
Pain with urination		☐	☐
Blood in urine		☐	☐
Kidney stones/disease		☐	☐
Weak urinary stream		☐	☐
Incontinence		☐	☐
Urinary retention		☐	☐
Musculoskeletal			
Unusual joint/muscle pain		☐	☐
Degenerative Arthritis		☐	☐
Rheumatoid Arthritis		☐	☐
Osteoporosis/osteopenia		☐	☐
Prior neck/back pain		☐	☐
Neurological			
Dizziness		☐	☐
Headaches		☐	☐
Epilepsy/seizures		☐	☐
Numbness/tingling in extremities		☐	☐

Sign: _____ Date: _____

VIRGINIA
SPINE & SPORTS ORTHOPAEDICS

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: _____

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 patent 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 $75.00 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.