VIRGINIA
SPINE & SPORTS ORTHOPAEDICS

DATE_____ CO-PAY_____

NAME_____ SEX: M_____ F_____

ADDRESS_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____/_____/_____ AGE:_____ SS#:_____-_____-_____

MARITAL STATUS: _____

HOME PHONE #:_____ WORK #:_____ CELL#:_____

OCCUPATION: _____ EMPLOYER:_____

PARENT NAME (IF PATIENT IS A MINOR):_____

PHONE NUMBER:_____ SS#_____-_____-_____

EMERGENCY CONTACT:_____

PHONE NUMBER:_____

PRIMARY INSURANCE COMPANY:_____

NAME OF SUBSCRIBER:_____SUBSCRIBER'S DOB:_____

SUBSCRIBER'S SS#_____-_____-_____

MEMBER ID #:_____ GROUP# _____

INSURANCE CO. ADDRESS: _____

_____

INSURANCE CO. PHONE #: (___)_____

SECONDARY INSURANCE COMPANY:_____

NAME OF SUBSCRIBER:_____ SS#:_____-_____-_____

ID#:_____ SUBSCRIBER' DATE OF BIRTH:_____

INSURANCE CO. ADDRESS: _____

_____

INSURANCE CO. PHONE #:_____

FOR WORK RELATED INJURIES (must be filled out **completely** prior to being seen)

DATE OF INJURY:_____ REPORTED TO SUPERVISOR ☐ YES ☐ NO

NAME OF SUPERVISOR:_____ PHONE #:_____

NAME OF INSURANCE COMPANY:_____

CLAIMS MAILING ADDRESS: _____

_____

CLAIM #:_____ CASE MANAGER'S NAME:_____

PHONE:_____ FAX:_____

VIRGINIA
SPINE & 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 preferred to be left on my cell phone

___ Messages preferred to be left on my home phone

_____ _____
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.

VIRGINIA
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ASSIGNMENT OF BENEFITS

As the patient whose name appears below, I hereby authorize Virginia Spine & Sports Orthopaedics A Division of Centers for Advances Orthopaedics, LLC, to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Virginia Spine & Sports Orthopaedics, A Division of Centers for Advances Orthopaedics, LLC 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 Virginia Spine & Sports Orthopaedics, A Division of Centers for Advances Orthopaedics, LLC for all co-insurance, co-pays and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Virginia Spine & Sports Orthopaedics, A Division of Centers for Advances Orthopaedics, LLC. 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. Virginia Spine & Sports Orthopaedics, A Division of Centers for Advances Orthopaedics, LLC, will bill charges to the primary and/or secondary insurance carrier, and Virginia Spine & Sports Orthopaedics ,A Division of Centers for Advances Orthopaedics, LLC 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 for collection/and or an attorney for payment due, the patient and/or guarantor shall pay any collection costs and/or reasonable attorney fees. The staff will gladly assist you with any aspect of this policy.

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

RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge receiving a copy of Virginia Spine & Sports Orthopaedics, A Division of Centers for Advances Orthopaedics, LLC Notice of Privacy Practices.

_____ _____

Patient Signature Date

VIRGINIA SPINE & SPORTS ORTHOPAEDICS

Patient History Form 1

Please answer **ALL** questions

Name:_____
(First, Middle, & Last)

Age:_____Birth date:_____

Height:_____Weight:_____

☐ Male ☐ Female

Marital Status:_____

Occupation:_____

☐ Right handed ☐ Left handed

Allergies: ☐ None

_____

_____

_____

Specific reason for seeing Orthopaedic Surgeon:

_____

_____

Symptoms began/Date of injury:

_____

_____

Current/Past Medical History: ☐ None

****(List all medical problems)****

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

Previous Surgical History: ☐ None

Procedure Date Complications

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

Date:_____

How did you hear about this practice?

_____

Family Physician:_____

Present Medications: (LIST ALL) ☐ None

Name Dose Frequency

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

Social History: ☐ Not Applicable

Do you smoke? ☐ YES ☐ NO

If yes, how much:_____

Do you consume alcohol? ☐ YES ☐ NO

☐ social ☐ moderate ☐ heavy

Do you use drugs? ☐ YES ☐ NO

If yes, name of substance:_____

Family History:	YES	NO
Heart Disease	☐	☐
Diabetes	☐	☐
Anesthetic Reaction	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Scoliosis	☐	☐

Other:_____

_____

_____

Patient History Form 2

Review of Systems for the last 12 months

Date:

Name:

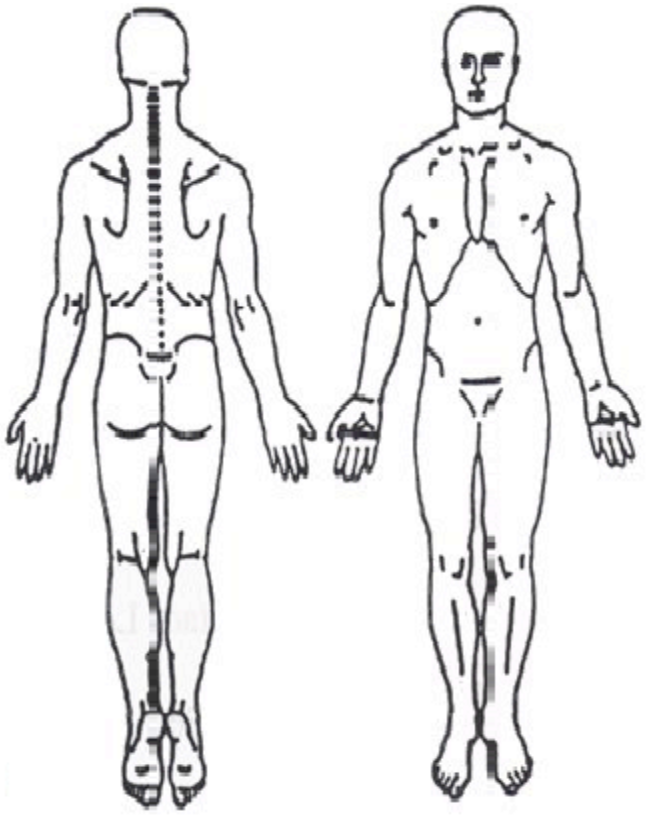
General	**Yes**	**No**
loss of energy	X	X
unusual chills	X	X
night sweats	X	X
unusual fever	X	X
weight gain (unintentional)	X	X
weight loss (unintentional)	X	X
Phychiatric		
Anxiety	X	X
Depression	X	X
Memory loss/Dementia	X	X
Sleep disturbance	X	X
personality change	X	X
poor attention/ attention deficit	X	X
Ophthalmic - Eyes		
blurred vision	X	X
wear glasses/contacts	X	X
cataracts	X	X
galucoma	X	X
macular degeneration	X	X
Ears, Nose, Throat		
hearing problems	X	X
hoarseness	X	X
swallowing difficulty	X	X
ear pain	X	X
tooth pain	X	X
Allergy/Immunology		
seasonal allergy/hay fever	X	X
shellfish allergy	X	X
Hematology/lymphatic		
anemia	X	X
bruise easily	X	X
excessive bleeding	X	X
History of blood transfusion	X	X
Dermatological		
Bruise easily	X	X
Masses/cysts	X	X
melanoma	X	X
skin lesions	X	X
Acne	X	X

Endocrine		**Yes**	**No**
Diabetes controlled by:	Insulin	X	X
	Oral meds	X	
	Diet	X	
Thyroid Disease		X	X
Cardiovascular			
Chest Pain		X	X
Palpitation/irregular heartbeat		X	X
Hypertension		X	X
Heart attack or heart failure		X	X
Stroke		X	X
High Cholesterol		X	X
Respiratory		X	X
Shortness of breath		X	X
Asthma		X	X
Unusual cough		X	X
Emphysema/COPD		X	X
Gastrointestinal			
Abdominal pains		X	X
Ulcers		X	X
Acid Reflux		X	X
Change in bowel habits		X	X
Hepatitis		X	X
Genitourinary			
Pain with Urination		X	X
Blood in Urine		X	X
Kidney Stones/Disease		X	X
Weak Urinary stream		X	X
Incontinence		X	X
Urinary retention		X	X
Musculoskeletal			
Unusual Joint/Muscle pain		X	X
Degenerative Arthritis		X	X
Rheumatoid Arthritis		X	X
Osteoporosis / osteopenia		X	X
Prior neck/back pain		X	X
Neurological			
dizziness		X	X
headaches		X	X
epilepsy/seizures		X	X
numbness/tingling in extremities		X	X

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: _____