

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>MIDDLE INITIAL:</b>	
<b>GENDER:</b>		<b>DATE OF BIRTH:</b>		<b>SS#:</b>	
<b>MAILING ADDRESS:</b>			<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>
<b>HOME #:</b>		<b>MOBILE #:</b>		<b>WORK #:</b>	
		<b>CONSENT TO TEXT: YES or NO</b>			
<b>Email:</b> Consent to call: YES or NO			<b>Contact preference: (please circle)</b> Home # Cell # Work # Email Mail Portal		
<b>LANGUAGE:</b> DECLINE TO ANSWER <input type="checkbox"/>		<b>RACE:</b> DECLINE TO ANSWER		<b>ETHNICITY:</b> DECLINE TO ANSWER <input type="checkbox"/>	
<b>MARITAL STATUS:</b>	<b>Emergency Contact Name/Relationship:</b>			<b>Mobile #:</b>	<b>Home #:</b>
<b>PATIENT'S EMPLOYER:</b> <b>OCCUPATION:</b>			<b>Referring Doctor:</b> <input type="checkbox"/> Self referred		

***GUARANTOR - PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR OR STUDENT:***

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>RELATIONSHIP:</b>	
<b>MAILING ADDRESS:</b>			<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>
<b>DATE OF BIRTH:</b>	<b>SS#:</b>	<b>HOME #:</b>	<b>MOBILE #:</b>	<b>WORK #:</b>	

***INSURANCE INFORMATION \*COPIES OF YOUR INSURANCE CARDS ARE REQUIRED\****

<b>INSURANCE #1 (PRIMARY INSURANCE)</b>		<b>INSURANCE #2 (SECONDARY INSURANCE)</b>	
<b>INSURED'S NAME:</b>	<b>RELATIONSHIP TO PATIENT:</b>	<b>INSURED'S NAME:</b>	<b>RELATIONSHIP TO PATIENT:</b>
<b>SS# OF INSURED (IF DIFFERENT FROM PATIENT):</b> SAME AS ABOVE		<b>SS# OF INSURED (IF DIFFERENT FROM PATIENT):</b>	
<b>DATE OF BIRTH OF INSURED:</b> <input type="checkbox"/> SAME AS ABOVE		<b>DATE OF BIRTH OF INSURED:</b>	
<b>INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT):</b> <input type="checkbox"/>		<b>INSURED'S EMPLOYER (IF DIFFERENT FROM PATIENT):</b>	

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided in exchange for this information. I assign to Midlands Orthopaedics & Neurosurgery, PA, all health insurance benefits available for services provided to me. I understand that fees for services provided by Midlands Orthopaedics & Neurosurgery, PA, are my responsibility and I agree to pay any balance left unpaid by any insurance company or third party entity immediately upon notification of said balance. If I do not have insurance, I understand that I am responsible for any incurred expenses in their entirety.

Patient/Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

**MIDLANDS ORTHOPAEDICS & NEUROSURGERY (MON) AUTHORIZATIONS AND ACKNOWLEDGEMENTS**

1. **NOTICE OF PRIVACY POLICIES:** I have been offered a copy of the *MON Notice of Privacy Policies* detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law. I understand that MON is permitted to disclose my PHI without my authorization to facilitate treatment, payment and health care operations. This Notice is always available on the MON website ([www.midorthoneuro.com](http://www.midorthoneuro.com)) and at each office location upon request.
2. **FINANCIAL POLICY:** I have been offered a copy of the *MON Financial Policy* and acknowledge its requirements. This Notice is always available on the MON website ([www.midorthoneuro.com](http://www.midorthoneuro.com)) and at each office location upon request.
3. **ePrescribe:** I understand that MON utilizes electronic health record software which incorporates ePrescribing technology. I understand that MON may access and use my prescription history through ePrescribing software to facilitate appropriate treatment.
4. **PAPERLESS BILLING:** MON delivers paperless billing statements via our patient portal. I understand that I am automatically enrolled to receive paperless billing statements via the email address provided at registration. Changes to statement preferences may be made via the patient portal at anytime.
5. **PATIENT PORTAL:** The patient portal is the most efficient tool to securely request appointments and communicate with our staff members, allowing you to bypass our phone system completely. Registering by smartphone is fast and easy. Ask the front desk staff to send a text with the registration link. Use the link and temporary password to login. You may also follow the Patient Portal link on our website ([www.midorthoneuro.com](http://www.midorthoneuro.com)), and click "Sign Up Today." You will need to enter your name, date of birth and email address as they appear in your MidOrthoNeuro account.

***I acknowledge understanding of the items described on this Authorizations & Acknowledgements form.***

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*Patient/Guardian Signature*

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*Date*

**HIPAA PRIVACY AUTHORIZATION**

I hereby authorize Midlands Orthopaedics & Neurosurgery, PA, to use and/or disclose the protected health information below to: [Name of individual, Address, and Telephone Number] (i.e. Spouse, Family member, Doctor, etc)

NAME	CONTACT INFORMATION

**Authorization for Release of Information:**

-Covering the period of health care from:

Date: \_\_\_\_\_ to \_\_\_\_\_ **OR**  All past, present and future periods

-Covering the following protected health information:

I hereby authorize the release of my complete health record.

I hereby authorize the release of my complete health record with the exception of the following Information:

\_\_\_\_\_

\_\_\_\_\_

- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned upon signing this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient

GENERAL MEDICAL INFORMATION

Reason for your visit today? \_\_\_\_\_

<b>Primary Physician Information</b> Name:		<b>Other Specialist Involved in care?:</b>	
<i>Please provide your preferred pharmacy information.</i>			
<b>Preferred Pharmacy:</b> Name:  Address:  Phone:		<b>Mail-In Pharmacy:</b> Name:  Address:  Phone:	

CURRENT Height: \_\_\_\_\_ Weight: \_\_\_\_\_

ALLERGIES AND REACTIONS (list allergies to Medications, Metals or Latex)	
Name of Allergy :	Reaction:

FAMILY HISTORY please check any that have occurred with a blood relative			
	Relationship		Relationship
Blood Clots in Legs or Lungs		Heart Disease	
Bleeding Disorder		Aneurysm	
Osteoporosis		High blood pressure	
Osteoarthritis		Diabetes	
Rheumatoid arthritis		Nerve Disease	
Muscle or Bone Disease		Depression	
Cancer		Lupus	
Thyroid disease		Malignant Hypothermia	

PAIN SCORE (please circle what applies to you)	
<b>Current Pain score:</b>	<b>0 1 2 3 4 5 6 7 8 9 10</b>
<b>Pain score at worst:</b>	<b>0 1 2 3 4 5 6 7 8 9 10</b>
<b>Pain score at best:</b>	<b>0 1 2 3 4 5 6 7 8 9 10</b>
<b>Average pain score:</b>	<b>0 1 2 3 4 5 6 7 8 9 10</b>

<b>Social History:</b> <i>(please circle what applies to you)</i>		
Are you a: Current Smoker   Nonsmoker   Former Smoker		
Tobacco-years of use (current and former smokers):		
If current smoker, how often do you smoke cigarettes? Every Day   Some Days		
If current smoker, how much do you smoke per day? ¼ PD   ½ PD   1 PD   1 ½ PD   2PD   3PD		
Cigar/pipe Use: Yes   No		
Chewing Tobacco: 1/day   2-4/day   5/day		
Alcohol: None   Occasional   Moderate   Heavy		
Number of Children?		
Marital Status: Married   Single   Divorced   Separated   Widowed   DomesticPartner		
Diet: Regular   Vegetarian   Vegan   Gluten free   Carbohydrate (limited)   Cardiac   Diabetic		
Work History: Disabled   Student   Homemaker   Retired		
Are you currently employed? Yes   No                      Are you currently working? Yes   No		
Occupation:		
If employed, what type of work do you do?		
Are you currently involved in a lawsuit/pending lawsuit?		
Are you on disability?		
How much does your pain interfere with your ability to work/daily activities? <input type="checkbox"/> No Interference <input type="checkbox"/> Moderate Interference <input type="checkbox"/> Extreme Interference		
<b>SOCIAL/PSYCHOLOGICAL HISTORY</b>	<b>Yes</b>	<b>No</b>
Do you have a personal history of alcohol abuse?		
Do you have a personal history of illegal drug use?		
Do you have a personal history of prescription drug abuse?		
Do you have a personal history of preadolescent sexual abuse?		
Do you have a history of ADD/ADHD, OCD, bipolar, or schizophrenia?		
Do you have a history of depression?		
Have you ever received outpatient psychiatric treatment or counselling?		
Have you ever been hospitalized for a psychiatric reason?		
Have you ever used prescription medications inappropriately?		
Do you use street drugs?		
Do you ever have nightmares or flashbacks about traumatic experiences? Do you smoke? If so, how many packs per day and for how long?		
Are you currently taking any narcotic/opioid medications?		

**Diagnostic Tests:** Please circle all that apply

X-Rays    MRI    CT Scan    Myelogram    Discogram    Bone Scan    EMG/NCS

Other: \_\_\_\_\_

**Procedures Tried:** Please circle all that apply

Trigger point injection

Epidural Steroid Injection

Spinal Cord Stimulator

Sympathetic nerve block

Vertebroplasty/kyphoplasty

Intrathecal pump

Facet joint injection

Medical branch block

Radiofrequency ablation

Shoulder injection

Hip injection

Knee injection

Sacroiliac joint injection

Genicular nerve block/ablation

Piriformis injection

**Surgical History/Broken Bones/Recent Hospitalizations:**

**ALL Medications that you take every day & as needed**

**Mark "X" on the picture where you are having discomfort.**

If your pain radiates, please indicate with a line.

**Please circle the best description of your pain.**

Aching            Stiffness            Please describe if not listed:

Burning            Throbbing

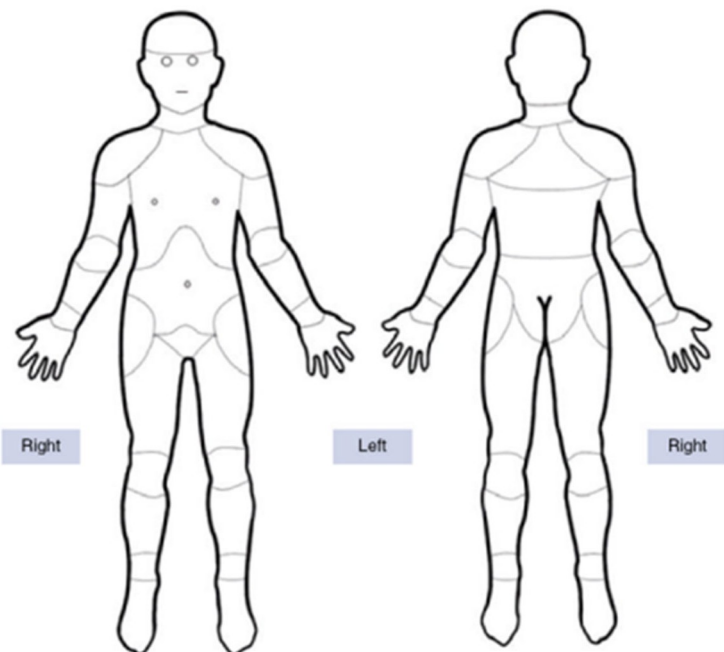
Cramps            Tingling

Dull                Pins & Needles

Numbness        Pounding

Sharp             Cold

Shooting        Heaviness



**Past Medical History:** *(please circle all that apply to you)*

Blood Clots in legs or lungs	Diabetes	Bronchitis
High Blood Pressure	Lupus	Skin Disorder
Congestive Heart Failure	Parkinson's Disease	Enlarged prostate
Heart Disease	Multiple Sclerosis	Bladder disease
Mitral Valve Prolapse	Hepatitis B or C	Kidney disease
Heart Attack	Stomach Ulcers	Seizure disorder
Irregular Heart Beat	Irritable Bowel	Thyroid Disorder
Congenital Heart Defect	Heartburn	Cancer
High Cholesterol	Liver Disease	Glaucoma
Stroke	Pneumonia	Osteoarthritis
Circulation problems	Tuberculosis	Rheumatoid Arthritis
Bleeding disorder	Emphysema	Restless legs
Gout	Infectious Blood Disease	Pregnancy (current or recent)

**Do you have sleep apnea?** Yes or No

If yes, do you use C-PAP or Bi-PAP? Yes or No

**Do you have cardiac stents, pacemaker or AICD:** If yes, please list date(s):

**Do you have any implantable devices:** If yes, please list device and date(s):

**History of Present Illness:**

**When and how did your pain start?**

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**What makes your pain better?**

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**What makes your pain worse?**

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**Since you were last seen, has your pain:**  Increased  Decreased  Remained the same

**What best describes your pain:**  Constant  Intermittent

**When is your pain worst:**  Morning  Daytime  Evening  Night

**In the past 3 months, have you developed any of the following** *(Circle all that apply)*

- |                    |                      |                    |              |
|--------------------|----------------------|--------------------|--------------|
| Balance Problems   | Groin numbness       | Difficulty walking | New weakness |
| Bowel Incontinence | Bladder Incontinence | New numbness       |              |

**Review of Systems: (Please circle all that apply to you)**

<p><b>Constitution</b></p> <p>Fever/chills Weight loss Malaise/fatigue Night sweats Weakness Swollen lymph nodes</p>	<p><b>Eyes</b></p> <p>Blurred/changes to vision Light sensitivity Eye pain Eye discharge Dry eyes</p>	<p><b>Gastrointestinal</b></p> <p>Heartburn Nausea/Vomiting Abdominal pain Diarrhea Constipation Incontinence of stool</p>	<p><b>Hematology</b></p> <p>Easy bruising Easy bleeding Blood clots</p>
<p><b>Skin</b></p> <p>Rash Itching Hair loss Fingers turn white with cold</p>	<p><b>Cardiovascular</b></p> <p>Chest pain Palpitations Difficulty breathing when lying flat Ankle/leg swelling</p>	<p><b>Genitourinary</b></p> <p>Painful urination Blood urine Flank pain Incontinence of urine</p>	<p><b>Neurological</b></p> <p>Dizziness Lightheadedness Headaches Tingling Tremor Sensory change Seizures</p>
<p><b>Ears/Nose/Throat</b></p> <p>Hearing loss Ear pain Sinus pain Sore throat Swollen lymph nodes Dry mouth Nose bleeds</p>	<p><b>Respiratory</b></p> <p>Cough/cold Sputum production Shortness of breath Wheezing</p>	<p><b>Musculoskeletal</b></p> <p>Muscle pains Neck pain Back pain Joint pain Recent falls Loss of height</p>	<p><b>Psychiatric</b></p> <p>Depression Suicidal thoughts Hallucinations Anxiety Difficulty sleeping Memory loss</p>

**Any additional Information you would like to share:**