

NEW PATIENT UPDATE

DR: _____

DATE: _____

PATIENT ACCOUNT #: _____

Patients Legal Name:

(First) _____ (Middle) _____ (Last) _____ Sex: M F

Social Sec. # _____ DOB: _____ Age: _____ Marital Status: M S W D

Address: _____ City, State and Zip: _____

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

Employer: _____ Occupation: _____

School Name (if student): _____

Religious Preference: _____

Primary Physician Name and Phone: _____

EMERGENCY CONTACT

Name _____ Phone# _____ Relationship _____

RESPONSIBLE PARTY If the patient is a minor, person responsible for billing account

Name: _____ Relationship to patient: _____ Sex: M F

Address: _____ DOB: _____

City, State and Zip: _____ Social Security # _____

Phone: _____ Employer: _____

PRIMARY INSURANCE

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

SECONDARY INSURANCE/ WC/ MVA

Insurance Company: _____ Primary Insured Person: _____

Claim Address: _____ Insured Address: _____

Group #: _____ Insured Phone #: _____

Member I.D. #: _____ Social Security #: _____

Effective Date: _____ DOB: _____ Sex: M F

DOI: _____

THIRD INSURANCE/ OTHER

How were you referred to us?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Referring Physician | <input type="checkbox"/> Employer | <input type="checkbox"/> Seminar/Screening | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Friend/Relative/Former Patient
(circle one) | <input type="checkbox"/> Hospital | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other |
| <input type="checkbox"/> HMO/PPO | <input type="checkbox"/> Case Manager | <input type="checkbox"/> Television | <input type="checkbox"/> Workers Compensation |
| | <input type="checkbox"/> School | <input type="checkbox"/> Radio | |

Name	Address	Phone
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PLEASE READ:

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

SIGNED (Patient or Guardian) _____ DATE _____

AUTHORIZATION AND ASSIGNMENT

I authorize The Orthopedic Center to release information regarding my treatment to my insurance company, to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work-related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served with a Subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

SIGNED (Patient or Guardian) _____ DATE _____



David M. Brown, M.D.
Matthew F. Gornet, M.D.
Lyndon B. Gross, M.D., Ph.D.
John O. Krause, M.D.
Paul S. Lux, M.D.

Mark D. Miller, M.D.
Michael J. Milne, M.D.
George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Consent to Release Information

I, _____, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends or legal counsel that we are allowed to discuss your treatment or billing issues with.)

_____ Relation: _____

_____ Relation: _____

_____ Relation: _____

Patient Signature: _____ Date: _____

(Parent or Guardian Signature if a minor)



David M. Brown, M.D.
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George A. Paletta, Jr., M.D.
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Brett A. Taylor, M.D.

Dear Friends and Patients,

Welcome. Thank you for choosing **the Orthopedic Center of St. Louis**.

The Orthopedic Center of St. Louis constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 10 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital xrays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the 1st floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1st floor
- Electrodiagnostic testing on the 3rd floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3rd floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and the **Corner Pharmacy** delivers medications to each of the following surgical facilities to save you a trip to the drugstore after surgery.

If surgery is required, **Timberlake Surgery Center** is located on the 1st floor. The **St. Louis Spine and Orthopedic Surgery Center** and **Advanced Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

Some of the individual physicians at the Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website www.TOC-STL.com

We appreciate the opportunity to serve you and your family.

Signed: _____

Date: _____

Printed Name: _____

TOC: _____

**The Orthopedic Center of St. Louis
Notice of Health Information Practices**

This notice describes how your medical information may be used or disclosed and how you can access this information. Please review it carefully.

Uses and Disclosures:

We will use and disclose elements of your protected health information (PHI) in the following ways.

- Basis for planning your care and treatment
- Communication among the health professionals who may contribute to your care
- Legal document describing the care you receive
- Means that you, your insurance company or a third party payor can verify that services billed were actually provided
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Source we can assess our data to improve the care we render and the outcomes we achieve
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences
- To use an automated telephone system to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights:

- Request a restricted access to all or part of your private health information as provided by 45 CFR 164.522, if we are unable to abide by this request we will notify you
- Inspect or receive a copy of your medical record as provided by 45 CFR 164.524
- To get updates or reissue of this notice, at your request
- To request a list of disclosures of your medical records as provided by 45 CFR 164.528
- To receive correspondence of confidential information by alternate means or location as long as the request is reasonable
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our duties:

We are required by law to maintain the privacy of your private health information. We must abide by the terms of this notice or any update of this notice. If this notice is updated we will notify you by mail to the address you've supplied us.

To obtain more information or report problems please contact The Orthopedic Center of St. Louis's HIPAA Compliance Officer at 314-336-2555. **Full explanation of notice is posted in our waiting room. To request your own copy, please see our receptionist.**

If you believe your privacy rights have been violated, you can file a complaint with the administrator or operations manager. If, after contacting, The Orthopedic Center of St. Louis, you are not satisfied with the response you may contact the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date of this notice is April 14, 2003.

Acknowledgement:

Signature: _____ Date: _____

Print the name of the Patient: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____

Patient Health Questionnaire for Dr. Paletta's Office

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____ Gender: M F

Referring Physician: _____ Primary Care Physician: _____

Reason for today's visit? _____

When did problem begin? _____

How did the problem begin? _____

Have you seen a doctor for this problem? N Y If yes whom did you see? _____

Have you had any tests for this problem? N Y If yes please list below.

Date	Where test was done.	Results
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X-rays _____

MRI _____

CT Scan _____

Bone Scan _____

EMG _____

Other _____

What treatment(s) have you tried so far?

- | | | |
|---|---|--|
| <input type="checkbox"/> Rest/Activity Modification | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Pain Medication |
| <input type="checkbox"/> Physical Therapy/Exercises | <input type="checkbox"/> Massage | <input type="checkbox"/> Anti-inflammatories |
| <input type="checkbox"/> Immobilization (Cast, splint, sling) | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Steroid/Cortisone Injection |
| <input type="checkbox"/> Braces/Orthotics | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Tylenol |

Previous Surgery for this problem: _____

Medications you are currently taking for this problem? _____

Do you have any of the following conditions or illnesses?

High Blood Pressure	Heart Disease	Diabetes	Asthma/Lung Disease
Gastrointestinal/GI Diseases	Stomach Ulcers	Arthritis	Kidney Disease
Thyroid Disease	Cancer: _____		

Previous Surgery:

Procedure	Date	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Medications:

Drug Name	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently having problems with any of the following?

Eyes/vision	Ears/hearing	Nose/smelling	Throat/swallowing
Lungs/breathing	Shortness of breath	Chest Pain	Palpitations
Indigestion	Urinary Problems	Dizziness	Fainting
Seizures	Fever/Chills	Infections	Bleeding disorders
Ankle swelling	Numbness/tingling	Balance	Weight loss/gain

Other problems not listed above: _____

Family History:

<u>Family Member</u>	<u>Alive or Dead</u>	<u>Age</u>	<u>Illnesses or Cause of Death</u>
Grandmother (Mom's)	_____	_____	_____
Grandfather (Mom's)	_____	_____	_____
Grandmother (Dad's)	_____	_____	_____
Grandfather (Dad's)	_____	_____	_____
Mother	_____	_____	_____
Father	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____
Sister/Brother	_____	_____	_____

Social History:

Are you employed? Y N Occupation: _____ Student Retired

Marital Status: Single Married Divorced Widowed Children? N Y Number _____

Do you exercise? N Y How often? _____ What type? _____

Do you smoke? N Y Packs per day? _____ How many years? _____

Did you used to smoke? N Y If yes when did you quit? _____

Do you drink alcohol/beer/wine? N Y Daily . 1-2 times per week 1-2 times per month

Do you use other drugs? N Y If yes, what type? _____

Is this a work related injury? N Y Is there a lawsuit related to your injury? N Y

Patient Signature: _____

Parent or Guardian Signature (if patient < 18 yrs. old): _____

Physician Statement of Review: I have reviewed the above patient health history.

Physician Signature: _____