

The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION

150 Kingsley Lane
 Norfolk, VA 23505

NEW PATIENT MEDICAL HISTORY

Date _____

Chart # _____

Primary Care Physician _____

Ref Physician _____

Patient's Name _____

Date of Birth _____ Age _____ Weight _____ Height _____ Date of last tetanus _____

Problems with anesthesia? YES NO If yes, explain _____

Current Complaints _____

Do you have an allergy to chicken and/or eggs or ever been told you should not receive the flu vaccination? YES NO

Allergies/ Difficulty with Medications	Reaction <input type="checkbox"/> None	Current Medication	Dosage <input type="checkbox"/> None
1. _____	_____	1. _____	_____
2. _____	_____	2. _____	_____
3. _____	_____	3. _____	_____
4. _____	_____	4. _____	_____
5. _____	_____	5. _____	_____

Please Check All That Apply To You:

PERSONAL MEDICAL HISTORY			
<input type="checkbox"/> No Illnesses	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Bladder/ Kidney Infection	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Attack or Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Intestinal Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Mental or Nervous Disorder	<input type="checkbox"/> Angina
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Murmurs/Valve Problems
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Specify _____

SOCIAL HISTORY			
Do you smoke cigarettes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	How many packs per day?	_____
Do you drink alcohol?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Number of drinks per day	_____ per week
Do you take drugs?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Check all that apply:	<input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Others (specify) _____
Marital Status:	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> Number of Children	_____
Are you:	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed		
How many hours a day do you stand and/or walk while at work?	<input type="checkbox"/> 0-1 <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-8	While at home?	<input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-8
Employment: (Type)	_____		

FAMILY HISTORY (Siblings, parents and children)			REVIEW DATE	
<input type="checkbox"/> No Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other (specify) _____	Date	Initial
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	_____	_____	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	_____	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Excessive Bleeding	_____	_____	_____
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Problems with Anesthesia	_____	_____	_____

Physician's Signature _____

R. Michael Graham, MD, FAAOS

Previous Surgery None _____ Dates _____

1. _____

2. _____

3. _____

4. _____

5. _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): None

Chest X-ray Stress Test Blood Work EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)			
GENERAL: <input type="checkbox"/> None ___Fever ___Chills ___Night Sweats ___Weight Change	HEAD: <input type="checkbox"/> None ___Headaches ___Blackouts ___Seizures ___Dizziness ___Hearing Loss ___Double and/ or Blurred Vision ___Ringing Ears ___Sinusitis ___Post Nasal Drip ___Sore Throat ___Hoarseness ___Cold	CHEST: <input type="checkbox"/> None ___Cough ___Cold ___Sputum ___Coughing up Blood ___Wheezing ___Shortness of Breath ___Chest Pain ___Palpitations ___Heart Murmur ___Swelling of Feet ___Rheumatic Fever	
ABDOMEN: <input type="checkbox"/> None ___Nausea ___Vomiting ___Pain and/ or Difficulty Swallowing ___Gas ___Indigestion ___Abdominal Pain ___Bloating ___Constipation ___Diarrhea ___Hemorrhoids ___Blood Stools	URINARY: <input type="checkbox"/> None ___Blood in Urine ___Burning with Urination ___Bladder or Kidney Infection ___Frequency and/or Difficulty with Starting Urination ___Sense of Full Bladder ___Difficulty with Leaking Urine ___Getting Up at Night to Urine	NEUROMUSCULAR: <input type="checkbox"/> None ___Joint Stiffness ___Joint Pain ___Swelling ___Back Pain ___Varicose Veins ___Night Cramps ___Bursitis ___Tendonitis ___Raynaud's	
MUSCULOSKELETAL: <input type="checkbox"/> None ___Fracture ___Sprain ___Strains ___Dislocations	SKIN: <input type="checkbox"/> None ___Rash ___Itching ___Psoriasis ___Change in or Bleeding of Mole		

FEMALE PATIENTS

Do you take Birth Control Pills? YES NO
 If YES, type _____

Do you take PREMARIN or ESTROGEN or other hormone replacements? YES NO
 If YES, type _____

Is there any chance you are pregnant? YES NO

OFFICE USE ONLY

ACCOUNT # _____ DR. _____ NP WC UPDATE _____

PLEASE PRINT

PATIENT INFORMATION

PATIENT NAME LAST		FIRST		MIDDLE INIT.	SEX	BIRTHDATE	AGE	SOCIAL SECURITY #	
HOME ADDRESS: STREET			APT. NO.	CITY		STATE		ZIP CODE	
HOME PHONE ()		-WORK PHONE ()		MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED					
EMPLOYER NAME AND ADDRESS				WERE YOU REFERRED BY A PHYSICIAN <input type="checkbox"/> YES <input type="checkbox"/> NO IF SO WHO: _____					
CURRENT PROBLEM			HOW DID YOU HEAR ABOUT OUR PRACTICE?			PRIMARY CARE PHYSICIAN AND/OR REF. DR.			

REASON FOR VISIT

DATE OF INJURY/SYMPTOMS FOR THIS PROBLEM		WORK RELATED <input type="checkbox"/> YES <input type="checkbox"/> NO		AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	
WERE YOU TREATED FOR THIS PROBLEM AT A HOSPITAL <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF HOSPITAL		WERE X-RAYS TAKEN FOR THIS PROBLEM <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE _____	
DATE PHYSICIAN FIRST CONSULTED FOR THIS PROBLEM			NAME OF YOUR ATTORNEY - IF APPLICABLE		
IN CASE OF EMERGENCY CONTACT:			PHONE NUMBER(S)		

SPOUSE / GUARANTOR INFORMATION

SPOUSE/GUARANTOR (IF PATIENT IS A MINOR)		HOME PHONE ()		WORK PHONE ()	
HOME ADDRESS: STREET		APT. NO.	CITY		STATE ZIP CODE
PATIENT'S RELATIONSHIP TO GUARANTOR: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> OTHER _____		SOCIAL SECURITY #		BIRTHDATE	
EMPLOYER NAME AND ADDRESS					

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH
SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> OTHER _____		
INSURANCE ID NO. (Member / Certificate)	GROUP NO.	PLAN NO.	EFFECTIVE DATE FROM _____ TO _____

SECONDARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH
SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO SUBSCRIBER: <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD <input type="checkbox"/> OTHER _____		
INSURANCE ID NO. (Member / Certificate)	GROUP NO.	PLAN NO.	EFFECTIVE DATE FROM _____ TO _____

PATIENT/GUARANTOR SIGNATURE _____

WITNESS _____

DATE _____

The Orthopaedic Center for **FOOT AND ANKLE RECONSTRUCTION**

150 KINGSLEY LANE • NORFOLK, VIRGINIA 23505 • Phone: 757.889.6580 • Fax: 757.889.6583

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PHYSICIAN

I **HEREBY CONSENT TO TREATMENT** by the physicians of The Orthopaedic Center for Foot and Ankle Reconstruction, their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary.

I understand that payment (or co-payment) is expected at the time of service and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. I further understand if a balance exists on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid and paid in full at the time of settlement. **Should collection actions become necessary, I understand that I will be liable for any and all costs, including any attorney fees associated in collecting the unpaid balance owing on my account.**

I hereby authorize, the release of any information necessary for filing of any insurances and, direct payment to the physicians of The Orthopaedic Center for Foot and Ankle Reconstruction for any amounts due under my present policy(ies) or any policy that I may at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise The Orthopaedic Center for Foot and Ankle Reconstruction of any changes in insurance coverage.

I also authorize The Orthopaedic Center for Foot and Ankle Reconstruction to speak with and exchange information with other medical professionals regarding my medical condition. These medical professionals include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physician's assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practitioners.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Signed: _____
Patient or Responsible Party Date Witness

I understand that as a condition of my treatment at The Orthopaedic Center for Foot and Ankle Reconstruction, in the event litigation is required in this case, neither the physician nor the office staff will be available to appear in court. Conferences and/or depositions are scheduled.

Signed: _____
Patient or Responsible Party Date Witness

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I request that payment of authorized Medicare benefits be made either to me or on my behalf to The Orthopaedic Center for Foot and Ankle Reconstruction for any services furnished to me by The Orthopaedic Center for Foot and Ankle Reconstruction. I authorize any holder of medical information about me be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits or the benefits payable for related services.

Signed: _____
Patient or Responsible Party Date Witness

The Orthopaedic Center for Foot and Ankle Reconstruction files your insurance as a courtesy to you. If a co-payment or co-insurance is due from you, your insurance company, HMO, or managed care company requires us to collect this payment at the time of service. We accept cash, check, MasterCard, Visa and Visa debit cards.

**ORTHOPAEDIC CENTER FOR FOOT AND ANKLE RECONSTRUCTION
AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION**

****Please Note: All of the following information must be completed in order to process this request.**

Print patient's full name

Birth date (Mo/Day/Yr)

Street address

Social security number

City, State, Zip code

Phone (Home) include area code

I, _____, authorize the facility name below,

to release my medical records as marked below, dates of service ALL, to:

**Orthopaedic Center for Foot and Ankle Reconstruction
150 Kingsley Lane
Norfolk, VA 23505
Phone: (757) 889-6580/ Fax: (757) 889-6583**

___ All clinical notes, except _____ All medical reports, except _____

___ All information, including attorney correspondence and financial, except _____

Purpose of Disclosure: ___ medical treatment / continuing care

___ Other (please list) _____

I _____, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification, but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons, or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

Signature of individual or guardian or
Personal representative of patient's estate

Date

The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals, team coaches, immediate family members include spouse, parents, adult children, guardians and insurance companies for the purpose of treatment, payment or healthcare operations. (example)

“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.”

“It is our policy to provide a substitute health care provider, authorized by The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. to provide assessment and/ or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”

Workers’ Compensation

We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to : preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership

In the event that The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have the right to request that The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. amend your protected health information. Please be advised, however, that The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
 - You have the right to receive an accounting of disclosures of your protected health information made by The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.
 - You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is required by law to comply with this Notice.

The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice, or if you want more information about your privacy rights, please contact: Mark Judd by calling this office at 757-889-6580. If Mark Judd is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days (Mon.-Thurs.).

Complaints

Complaints about your Privacy rights, or how The Orthopaedic Center for Foot and Ankle Reconstruction, P.C. has handled your health information should be directed to Mark Judd by calling this office at 757-889-6580. If Mark Judd is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days (Mon.-Thurs.).

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 01-17-05

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

The Orthopaedic Center for **FOOT AND ANKLE RECONSTRUCTION**

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.**'s "NOTICE OF PRIVACY PRACTICES," revision date 17 January 2005.

As required by the Privacy Regulations, **The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.** has provided a copy of the "NOTICE OF PRIVACY PRACTICES" of which I understand.

As required by the Privacy Regulations, I am aware that **The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that maintains.

I authorize **The Orthopaedic Center for Foot and Ankle Reconstruction, P.C.** to release or obtain any information needed from insurance companies in regards to the treatment and or payment for services provided by them.

I understand that this office is not required to honor any changes to the "NOTICE OF PRIVACY PRACTICES."

Signature

Date

Print Name

(OFFICE USE ONLY)

Signed form received by: _____ Date: _____

Good faith effort to obtain receipt: (Describe) _____

Optional Requests:

- I wish to file a "Request for Restriction" of my Protected Health Information.
- I wish to file a "Request for Alternative Communications" of my Protected Health Information.
- I wish to object to the following in the "Notice of Privacy Practices:"

