

PLEDGER ORTHOPEDIC & SPINE CENTER

PATIENT INFORMATION

Today's Date _____

Last Name _____ First _____ Middle _____

Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Social Security # _____ Date Birth _____ Age _____ Sex _____ Marital Status _____

Employer's Name _____ Work Phone _____

College Student? Y / N Full / Time School Name _____

Referred By _____ Spouse Name _____

Emergency Contact # _____

RESPONSIBLE PARTY

Check here if Self and move to next section

Spouse Mother Father Other

Name _____ First _____ Middle _____

Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Social Security # _____ Date Birth _____ Age _____ Sex _____ Marital Status _____

Employer's Name _____ Work Phone _____

INSURANCE INFORMATION

Primary Insurance Company _____ Group Identification # _____

Insurance Company Address _____

Insured Name _____ Date of Birth _____ SS# _____

Employer's Name _____ Work Phone _____

Secondary Insurance Company _____ Group Identification # _____

Insurance Address _____

Insured Name _____ Date of Birth _____ SS# _____

Employer's Name _____ Work Phone _____

AUTO w/ OTHER WORK RELATED ACCIDENT

Date of Injury _____

Insurance Company/Employer Handling Medical Bills _____

Insurance Company/Employer Address _____

Agent's Name _____ Work Phone _____

RELEASE OF INFORMATION

I authorize this physician office or its designate to release any medical information requested by representatives of local, state and federal agencies; insurance companies; my physicians or other organizations or entities as may be required by said representatives to assure continuity of care and billing. I understand that my medical records may be reviewed by a representative of my insurance company, and/or my referring physician. I authorize the Social Security Administration to release to this physician's office information regarding my Medicare entitlement.

Date _____ Signature _____

POSC6

PLEDGER ORTHOPEDIC & SPINE CENTER
NEW BACK/NECK PATIENTS
 Review of Systems/Past Personal, Family and Social History

Name: _____ Age _____ Sex _____ Height _____ Weight _____
 Occupation: _____ Family Physician: _____
 What physician referred you to this office: _____
 Reason for the appointment: _____
 Allergies: _____

Do you smoke? Yes No Amount: _____ How many years? _____

Do you drink alcohol? Yes No Amount: _____

Please List Current Medications and Dosages (include herbs, naturopathic meds or supplements):

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all surgical operations (Type and Date):

_____	_____
_____	_____
_____	_____

Do you have or have you had any of the following conditions?

- | | | | |
|-----------------------------|--|--------------------------|--|
| Anemia | Yes <input type="checkbox"/> No <input type="checkbox"/> | Fibromyalgia | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Angina | Yes <input type="checkbox"/> No <input type="checkbox"/> | Neuropathy | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cardiovascular Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Fear of tight spaces | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes | Yes <input type="checkbox"/> No <input type="checkbox"/> | Ulcers | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Elevated Cholesterol | Yes <input type="checkbox"/> No <input type="checkbox"/> | Heart Attacks | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Elevated Triglycerides | Yes <input type="checkbox"/> No <input type="checkbox"/> | Irregular Heartbeat | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| High Blood Pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | Congestive Heart Failure | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Lung Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Multiple Myeloma | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Peripheral Vascular Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Abnormal Bleeding | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Phlebitis | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pulmonary Embolism | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Stroke | Yes <input type="checkbox"/> No <input type="checkbox"/> | Anesthesia Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| History of Smoking | Yes <input type="checkbox"/> No <input type="checkbox"/> | Respiratory Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Coronary Artery Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatoid Arthritis | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Problems | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Drug Dependency | Yes <input type="checkbox"/> No <input type="checkbox"/> | Thyroid Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Drug Addiction | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Please List Any Other Serious Illness or Injury:

Do your Parents, Brothers or Sisters have a history of any of the following conditions? If the answer is yes, please list the family member and relationship:

Stroke: _____	Diabetes: _____
Arthritis: _____	Osteoporosis: _____
Hypertension: _____	Heart Disease: _____
Bleeding Problems: _____	Malignant Hyperthermia: _____
Cancer and type: _____	

REVIEW OF SYSTEMS

GENERAL:

Weight Gain:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Weight Loss:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excessive crying:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fever:	Yes <input type="checkbox"/> No <input type="checkbox"/>

SKIN:

Bruising:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hives:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Rash:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

HEENT:

Blurred vision:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headaches:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Double vision:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Visual loss:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Spinning sensation:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Voice changes:	Yes <input type="checkbox"/> No <input type="checkbox"/>

NECK:

Neck mass:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Neck pain:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neck stiffness:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swollen glands:	Yes <input type="checkbox"/> No <input type="checkbox"/>

CARDIOVASCULAR:

Chest Pain:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Calf cramps:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Claudication:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Edema:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Irregular Heartbeat:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Elevated Blood Pressure:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Leg Pain:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling extremities:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Phlebitis:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Shortness of Breath:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Difficulty breathing on exertions:	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Difficulty breathing lying down:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

GASTROINTESTINAL:

Abdominal Pain:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipation:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Difficulty Swallowing:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heartburn:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Indigestion:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vomiting:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

MUSCULOSKELETAL:

Leg cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint stiffness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Backache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle cramps	Yes <input type="checkbox"/> No <input type="checkbox"/>
Back pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
Claudication	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle weakness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Decrease Range of Motion	Yes <input type="checkbox"/> No <input type="checkbox"/>	Myalgia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Disuse atrophy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Swelling of extremities	Yes <input type="checkbox"/> No <input type="checkbox"/>
Fasciculation's	Yes <input type="checkbox"/> No <input type="checkbox"/>	Fibromyalgia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Joint pain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Joint replacements	Yes <input type="checkbox"/> No <input type="checkbox"/>
Joint redness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Deformity (legs, feet, arms, back)	Yes <input type="checkbox"/> No <input type="checkbox"/>

NEUROLOGICAL:

Dizziness:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stroke:	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Weakness in arms/legs:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Numbness:	Yes <input type="checkbox"/> No <input type="checkbox"/>

PSYCHIATRIC:

Anxiety:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Depression:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Insomnia:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Panic Attacks:	Yes <input type="checkbox"/> No <input type="checkbox"/>

ENDOCRINE:

Excessive thirst:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Excessive urination:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Thyroid Problems:	Yes <input type="checkbox"/> No <input type="checkbox"/>		

HEMATOLOGY:

Anemia:	Yes <input type="checkbox"/> No <input type="checkbox"/>
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PLEDGER ORTHOPAEDIC & SPINE CENTER

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

I do hereby and herewith freely and voluntarily agree and consent to and authorize the administration and performance of all medical treatment and procedures, the administration of any lawful drug or therapeutic agent and professional and medical judgement of my physician or associates and assistants of his/her choice, that may be considered medically necessary, advisable or otherwise appropriate. I further authorize the personnel of this physician's office to take samples, specimens and cultures, perform medically accepted diagnostic tests and procedures, and to take such precautions as may be necessary for my treatment and safety and the safety of others.

I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the outcome of my medical or surgical treatment or examination. I understand that there may be risks from radiation (x-rays) and some medicines if I am pregnant. I know that it is my responsibility to discuss a possible pregnancy with my physician and to advise the technician before an exam.

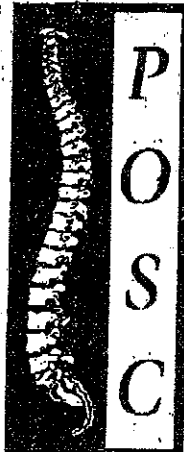
I understand that if I leave the physician's office against his/her advice or refuse treatment or medication, that he/she is not responsible for any ill effect my decision may cause. I am aware that I can revoke my consent at anytime and that this decision is mine alone. This consent shall remain in full force and effect until revoked in writing.

I understand that payment for services is due at the time services are rendered. I hereby authorize payment directly to this physician's office or their designate of all insurance benefits, otherwise payable to me. I understand that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to this physician's office.

I hereby acknowledge the disclosure of the above information. All questions that I have asked have been answered in a satisfactory manner. I certify that I understand all of the above statements and that the information provided on this form is true and accurate to the best of my knowledge. I will notify you of any future changes in this information.

Signature of Responsible Party

Date



PLEDGER ORTHOPAEDIC & SPINE CENTER

STEPHEN R. PLEDGER, M.D.

Orthopaedic Surgeon Specializing in Spine

- 1) CO-PAYS ARE REQUIRED AT THE TIME OF VISIT. IF WE HAVE TO BILL YOU FOR YOUR CO-PAY, THERE WILL BE AN ADDITIONAL \$10.00 CHARGE.
- 2) YOU MUST PRESENT YOUR INSURANCE CARD OR BWC CARD OR ANY OTHER AUTHORIZING INFORMATION AT THE TIME OF YOUR VISIT. WE WILL ALSO NEED TO MAKE A COPY OF YOUR DRIVERS LICENSE OR A PHOTO ID.
- 3) CANCELLATIONS MUST BE MADE 24 HOURS PRIOR TO YOUR APPOINTMENT. SHOULD YOU "NO-SHOW", THERE WILL BE A \$50 CHARGE, PAYABLE BEFORE OR AT THE TIME OF YOUR NEXT SCHEDULED APPOINTMENT.
- 4) WE WILL NOT BE RESPONSIBLE FOR PRESCRIBING YOUR MEDICATIONS UNTIL THE TIME WE HAVE EITHER SCHEDULED A PROCEDURE OR A SURGERY FOR YOU. YOU MUST CONTINUE TO CONSULT YOUR FAMILY PHYSICIAN FOR YOUR PRESENT MEDICATIONS.

I have read the policies listed above and accept full responsibility for following them as written.

PATIENT NAME

DATE

1044 Summit Drive • Middletown, OH 45042

513/420/3773 • Fax 513/420/3795