Name:
Chart:
Date:

Midwest Orthopedic Specialists

SRS#:

PLEASE USE BLUE OR BLACK INK

Curtis D. Burton, M.D.
Richard L. Baumann, M.D.
Rahul Basho, M.D.
Daniel J. Samani, M.D.

1 PATIENT INFORMATION

Date _____

Legal Name _____
Last First Middle

Name you go by _____

Address _____

_____
City State Zip

Preferred Phone _____ Alternate Phone _____

Contact Preference: ☐ Call ☐ Text ☐ Email

Sex: _____ Age: _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Social Security # _____

Who lives in your home with you? _____

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Type-Unknown ☐ White

Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic ☐ Type-Unknown

Language: _____

Email Address: _____

Employer _____

Employer Address _____

Work Phone # _____

Job Duties _____

Parent/Guardian Name: _____

DOB _____ Employer _____

Spouse's Name _____ D.O.B. _____

Spouse's SSN # _____

Spouse's Employer _____

Employer Address _____

Spouse's Work Phone # _____ Spouse's Cell Ph. # _____

2 EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Ph. _____ Work Ph. _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Midwest Orthopedic Specialists for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are determined by the Medicare carrier.

_____ _____
Signature Date

ASSIGNMENT AND RELEASE

I, the undersigned, hereby AUTHORIZE Midwest Orthopedic Specialists to furnish information to insurance carriers and/or healthcare facilities concerning my illness or treatments. I also assign any benefits to Midwest Orthopedic Specialists for services rendered by the physician(s). I understand that I am responsible for any amount not covered by insurance. I understand that payment in full is due upon the rendering of services, If the account becomes delinquent and is referred to a collection agency and/or attorney, the undersigned agrees to pay all collection agency fees, attorney's fees, and expenses. If a suit is filed to enforce collection, it may be filed in the county where this Agreement is being signed and entered into.

_____ _____
Signature Date

3 ACCIDENT DETAILS

Date, Time & Place of Accident _____

Is this a Work Related Injury? _____ Auto? _____ Other? _____

Details of Accident _____

_____

Please note if any Liability Insurance involved (Auto, Homeowners, Liability) _____

Name, Address & Phone Number of Attorney (if one is representing you in this accident) _____

_____

Do we have authorization to release information to the above listed attorney? ☐ Yes ☐ No

Signature _____ **Date** _____

Name:
DOB:
Chart:
Age:
Date:

Patient History Form

Midwest Orthopedic Specialists

PATIENT INFORMATION

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____

HISTORY OF CHIEF COMPLAINT

What body part are you seeing the doctor for today? ☐ Rt ☐ Lt ☐ Bil _____

Explain your symptoms leading to today's visit:_____

How long have you had this problem?_____ ☐ Recurrent ☐ New ☐ Chronic

Describe your discomfort: ☐ Sharp ☐ Dull ☐ Numb ☐ Aching ☐ Other_____

Pain Scale (0=no pain, 10=worst pain): 0 1 2 3 4 5 6 7 8 9 10 Does the joint ☐ Give way ☐ Catch

Tried to relieve symptoms with: ☐ medication ☐ therapy ☐ heat/ice ☐ braces ☐ injections ☐ home exercise

☐ Other_____How long have you tried these for relief?_____

What makes your pain better?_____ What makes your pain worse?_____

Have you had any x-rays, MRI, CT for this problem? ☐ Yes ☐ No If yes, When?_____ Where?_____

Is this problem a result of an injury/accident? ☐ Yes ☐ No

PROVIDERS

Primary Care: _____ Referred By: _____

Specialty Providers: _____

PHARMACY

Preferred Pharmacy: _____ Location: _____

SURGICAL HISTORY

Please check if you have had any of these surgeries in the past: ☐ No Surgical History

☐ Ankle surgery	☐ Elbow surgery	☐ Hip surgery	☐ Shoulder Replacement
☐ Appendectomy	☐ Gallbladder surgery	☐ Hysterectomy	☐ Shoulder surgery
☐ Back surgery	☐ Gastric bypass	☐ Knee replacement	☐ Thyroidectomy
☐ Breast surgery	☐ Hand surgery	☐ Knee surgery	☐ Tonsillectomy
☐ CABG	☐ Heart surgery	☐ Neck surgery	☐ Tubal ligation
☐ Carpal Tunnel Release	☐ Hernia repair	☐ ORIF of_____	☐ Transplant
☐ Defibrillator	☐ Hip replacement	☐ Pacemaker	Other: _____

Describe any problems with anesthesia: _____

ALLERGIES

List Allergies and Reactions: ☐ NONE ☐ Latex ☐ Tape ☐ Iodine ☐ Chicken/Egg ☐ Metal ☐ Medication

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

MEDICATIONS

List all medications and dosage you are currently taking, including over the counter medications.

☐ NONE ☐ chemotherapy ☐ immunotherapy ☐ blood thinners ☐ See Med List

Name:
DOB:
Chart:
Age:
Date:

MEDICAL HISTORY

Check symptoms/conditions you currently have or had in the PAST YEAR:

GENERAL
- ☐ Dizziness/Fainting
- ☐ Headache/Migraine
- ☐ Loss of weight
- ☐ Sweats/Fever
- ☐ Bleeding Disorder
- ☐ HIV

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Hepatitis ____
- ☐ Rectal bleeding
- ☐ Vomiting blood
- ☐ Ulcers
- ☐ Liver Failure

HEENT
- ☐ Blurred Vision
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Sinus issues
- ☐ Glaucoma

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid problems

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety/Nervous
- ☐ Bipolar

MUSCLE/JOINT/BONE
- ☐ Gout
- ☐ Rheumatoid Disease
- ☐ Osteogenesis imperfection
- ☐ Osteoporosis

Pain/weakness/numbness of:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Hypertension
- ☐ Hypotension
- ☐ Cardiac Arrhythmia
- ☐ Ankle swelling
- ☐ Blood Clot
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Stent Year placed:_____

SKIN
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Thick scars
- ☐ Persistent sores

PULMONARY
- ☐ Tuberculosis
- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Sleep Apnea

CANCER
- ☐ Thyroid ☐ Prostate
- ☐ Myeloma ☐ Breast
- ☐ Leukemia ☐ Kidney
- ☐ Lung ☐ Skin
- ☐ Bone ☐ Colon

NEUROLOGICAL
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Neuropathy
- ☐ Multiple Sclerosis
- ☐ Polo

GENITOURINARY
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Prostate problems
- ☐ Renal Failure

Females:
Type of birth control
_____
☐ None used

Currently pregnant?
☐ Yes ☐ No ☐ Unsure

Are there other medical problems/symptoms not listed above?_____
Have you tested positive for **MRSA**? ☐Yes ☐No ☐Unknown

FAMILY HISTORY

Check illnesses which have occurred in your immediate family:

☐ Arthritis Type:_____ ☐ Anxiety/Nervous Illness Other:_____
☐ Bleeding frequency ☐ Heart Disease
☐ Diabetes ☐ Stroke

Mother: ☐ Alive ☐ Deceased Cause of Death:_____
Father: ☐ Alive ☐ Deceased Cause of Death:_____
Siblings: ☐ Alive ☐ Deceased Cause of Death:_____

SOCIAL HISTORY

Occupation: _____ Currently Employed: ☐ Yes ☐ No
Smoker: ☐ Current Packs/day _____ Year started _____
☐ Former Year started _____ Year stopped _____
Chewing Tobacco: ☐ Current Packs/day _____ Year started _____
☐ Former Year started _____ Year stopped _____
Alcohol Intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

I certify the above information is correct to the best of my knowledge. I will not hold Midwest Orthopedic Specialists, Inc. or any member(s) of the staff responsible for errors or omissions I may have made.

Signature: _____ Date _____

Name:
Chart:
Date:

Midwest Orthopedic Specialists

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P.O. Box 935 Hannibal, Missouri 63401 Phone: 573/248-1010 Fax: 573/248-0536

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Personal Representative Signature

Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: