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:
Chart:
Date:

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

6. The information will be used for the following purpose (check as many as applicable):

- ☐ My personal records
- ☐ Disability Claim
- ☐ Social Service Agency
- ☐ Second opinion (as recommended by my physician)
- ☐ Referred to specialist
- ☐ Other (please describe) _____
- ☐ Attorney
- ☐ Insurance Company
- ☐ Relocation of self of family
- ☐ Second opinion (as preferred by patient)
- ☐ Transfer of care

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire (insert date or event): _____.
If I fail to specify an expiration date/event, this authorization will expire 1 year from the date it was signed.

9. I understand that once the information is disclosed, it may be re-disclosed by the recipient, and federal privacy laws or regulations may not protect the information.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative (must be 18 or older) Date

If signed by legal representative, relationship to patient _____

_____ _____
Signature of Witness Date

****

OFFICE USE ONLY:

Chart # _____ Date Rec'd _____ Date Sent _____ By (staff) _____

Copy of form provided to patient? ☐ Y ☐ N

Name:
DOB:
Chart:
Age:
Date:

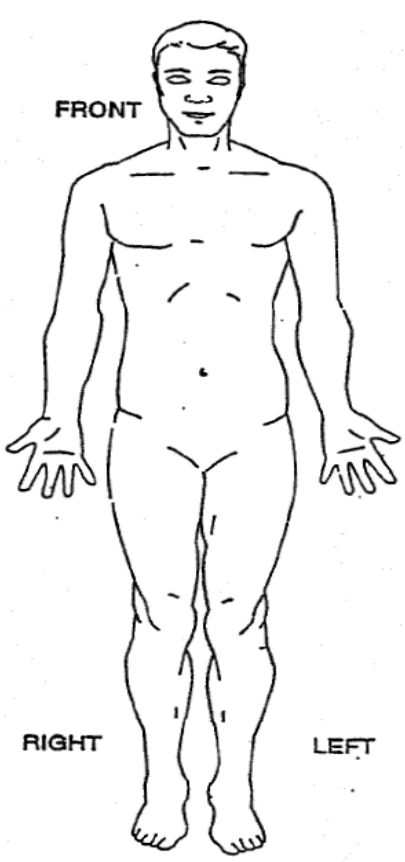
LOW BACK/LEG PAIN
INTAKE QUESTIONNAIRE

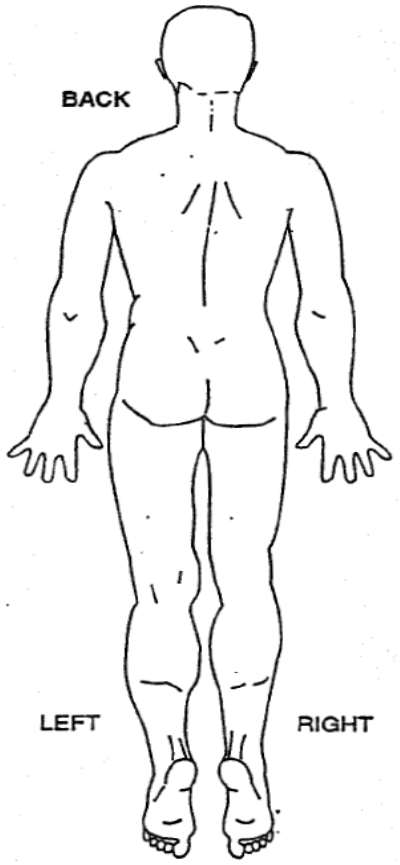
PART I

PAIN DIAGRAM

Please note the orientation of the diagrams below and mark on them the exact spots where you are experiencing any of the following sensations on your own body (please use only the symbols listed):

========== Numbness
xxxxxxxxxxx Pain
•••••••••••••••• Other, explain _____





Which condition best describes the percentage of pain in your back vs. in your legs:

- ☐ 100% back / 0% legs
- ☐ 75% back / 25% legs
- ☐ 50% back / 50% legs
- ☐ 25% back / 75% legs
- ☐ 0% back / 100% legs

Please further define your **LEG PAIN:**

My leg pain is _____ % right sided
_____ % left sided
(These two should add up to a total of a 100%.)

Name:
DOB:
Chart:
Age:
Date:

LOW BACK/LEG PAIN
INTAKE QUESTIONNAIRE
PART II

SOCIAL HISTORY AND HABITS

1. Work status: ☐ Homemaker ☐ Working ☐ Retired ☐ Disabled ☐ On leave
2. Occupation (current or most recent): _____
3. Date last worked: _____
4. If not currently working, reason stopped: _____
5. Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ cohabiting
6. Number of children: _____
7. I live: ☐ alone ☐ with: _____
8. Tobacco use: ☐ never ☐ cigar ☐ chew ☐ pipe
   ☐ cigarettes _____ packs/day for _____ years Start Date: _____
   ☐ quit year started _____ year quit _____
9. Alcohol:
   ☐ never or rare ☐ social ☐ frequently drunk (more than twice a week)
   ☐ alcoholic ☐ recovering alcoholic, number of years sober _____
10. Drug use: ☐ never ☐ in the past ☐ current ☐ IV drugs

REVIEW OF MEDICAL PROBLEMS

Check all that apply: ☐ None apply

- ☐ Reading glasses
- ☐ Change of vision
- ☐ Loss of hearing
- ☐ Ear Pain
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Difficulty swallowing
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Fever or chills
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Swollen ankles
- ☐ Calf cramps w/ walking
- ☐ Poor appetite
- ☐ Toothache
- ☐ Gum trouble
- ☐ Nausea or vomiting
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Frequent belching
- ☐ Frequent diarrhea
- ☐ Frequent constipation
- ☐ Hemorrhoids
- ☐ Frequent urination
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Get out more than once every night to urinate
- ☐ Frequent headaches
- ☐ Blackouts
- ☐ Seizures
- ☐ Frequent rash
- ☐ Hot or cold spells
- ☐ Recent weight change
- ☐ Nervous exhaustion

Other: _____

Name:
DOB:
Chart:
Age:
Date:

Height: _____ **Weight:** _____

E. MEDICAL HISTORY: Check all that apply:

☐ None apply

☐ Heart attack
☐ Heart failure
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Ankylosing Spondylitis
☐ Gout
☐ Osteoporosis
☐ Diabetes
☐ Stroke
☐ Seizures
☐ Mental illness
☐ Kidney stones
☐ Kidney failure
☐ Cancer
☐ Alcoholism
☐ Lung disease

☐ AIDS
☐ Tuberculosis
☐ Asthma
☐ Blood clot in leg
☐ Blood clot in lung
☐ Stomach ulcers
☐ Liver trouble
☐ Hepatitis
☐ Thyroid trouble
☐ Bleeding disorders
☐ Anemia
☐ Serious injuries (explain): _____

Other: _____

How long has the pain (your problem) been present? _____

What treatment have you had? _____

Please provide dates or time frame of treatment: _____

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: