Name:
Chart:
Date:

Welcome to Our Practice

Your Appointment is: ____________________

Provider: ____________________

In order to efficiently and effectively provide you with quality care, please complete the enclosed forms and be sure to bring this information to your appointment.

Additionally, we ask that you:

- Arrive 20 minutes before your appointment time.
- Bring any x-rays, MRIs, CT scans, EMGS or other related tests, along with the written reports. If your studies were done at Meadville Medical Center, you do not need to bring them.
- Bring your insurance card(s) and photo ID, such as a driver's license.
- Bring the co-pay amount required by your insurance plan; this will be due at the time of service.
- Self pay patients must pay for their services at the time of the office visit.
  We accept cash, personal checks, debit cards, Visa, MasterCard, American Express and Discover.
- Contact your PCP to obtain a referral if you have Gateway, AmeriHealth Caritas, Coventry Cares or UPMC for You.
- Please check with your health insurance plan to be sure that Orthopedic Associates of Meadville, PC is in network. Or call our office with any questions.

If you cannot keep your appointment for any reason, please call our office at (814) 724-1252 to cancel. There is a $25 No-Show Fee for failure to cancel your appointment at least one business day in advance or $50 for an EMG appointment with Dr. Wheeling.

Minors must be accompanied by a parent, legal guardian or custodian.

Thank you for choosing Orthopedic Associates of Meadville, P.C.

Name:
Chart:
Date:

PLEASE COMPLETE ALL SECTIONS

Patient Information

NAME: LAST FIRST MIDDLE SOCIAL SECURITY #

BIRTHDATE AGE SEX LANGUAGE: ☐ English ☐ Spanish / ____________

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

STREET ADDRESS RACE: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Native American ☐ Unknown

CITY STATE ZIP CODE

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

EMPLOYER EMPLOYER ADDRESS

*If you have been a patient in the past under a different name, please enter that name: ____________

Emergency Contact

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Financially Responsible Party if other than Patient

NAME RELATIONSHIP

ADDRESS

HOME PHONE# CELL PHONE# WORK/DAYTIME PHONE#

Primary Care Physician

NAME PHONE#

ADDRESS

Insurance

Primary Insurance Information
NAME OF INSURANCE ID#

Secondary Insurance Information
NAME OF INSURANCE ID#

Workers Compensation ☐ YES ☐ NO -OR- Auto Accident ☐ YES ☐ NO
NAME OF INSURANCE

CLAIM # ____________ DATE OF INJURY / ACCIDENT ____________

MEDICARE I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits assigned to OAM.

OTHER I authorize OAM to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in OAM all payments for medical services rendered to myself or my dependents.

I also understand that I am responsible for any amount not covered by my insurance. Initials: ____________

Signature ____________

Name:
Chart:
Date:

PATIENT MEDICAL HISTORY

Name: ______________________ DOB: __________
Referring Physician: ______________________ PCP: __________
Reason for visit: ______________________
Cause of problem: ____ Car accident ____ Work Accident ____ Other __________
Date of onset: __________ Current symptoms: __________

Occupation: ______________________
Are you currently disabled from work? YES / NO
The date you last worked: __________
Any work restrictions? Lifting, time, etc. please explain: __________
Marital status: __________ Children: __________
Do you smoke: YES / NO How many packs/day? __________ How long? __________
When did you quit? __________
Do you drink alcohol? YES / NO If yes, DAILY / WEEKLY / MONTHLY / RARELY
Any history of drug use? YES / NO
Do you live alone? YES / NO If no, who lives with you? __________
Do you need to go up and down stairs? YES / NO How many? Do you have railings? YES / NO
Is your bedroom on 1st floor? YES / NO Is your bathroom on 1st floor? YES / NO
Do you have throw rugs? YES / NO / NA Night lights? YES / NO / NA
Do you have grab bars? YES / NO / NA
Do you have adaptive equipment?
____ Cane ____ walker ____ wheelchair ____ beside commode ____ raised toilet ____ reacher ____ braces

MEDICAL INFORMATION

Please list current medications and dosages; prescription and over the counter: __________

Any allergies to medications? YES / NO List the medications and reaction: __________

Please circle any problems you have currently or had in the past:

GENERAL: fever, weight loss, fatigue, night sweats	CURRENT	/	PAST
EYES: injuries, glaucoma, cataracts, macular degeneration	CURRENT	/	PAST
EAR, NOSE, THROAT, MOUTH: hearing loss, hearing aides, ear pain, ringing in the ears, vertigo, nosebleeds, nasal congestion, inability to smell, sinus problems, sore throat, mouth sores, Meniere's disease, tonsillectomy	CURRENT	/	PAST
CARDIOVASCULAR: heart attack, angina, heart murmur, irregular pulse high cholesterol, bypass surgery - heart or legs, leg pain while walking, swelling, congestive heart failure, high blood pressure, DVD, pulmonary embolism	CURRENT	/	PAST
RESPIRATORY: asthma, COPD, emphysema, cough, shortness of breath, pneumonia, lung cancer	CURRENT	/	PAST
GASTROINTESTINAL: reflux, indigestion, ulcers, colon cancer, abdominal pain, liver disease, jaundice, bowel problems	CURRENT	/	PAST
GENITOURINARY: kidney stones, bladder infections, urinary incontinence, prostate cancer, endometriosis, cervical or uterine cancer, breast cancer/surgeries	CURRENT	/	PAST
MUSCULOSKELETAL: Neck pain, low back pain, arthritis, joint replacement, weakness, joint pain, fractures, Lyme disease, rheumatoid arthritis	CURRENT	/	PAST
NEUROLOGICAL: headaches, dizziness, numbness or tingling hands/feet, weakness, balance problems, memory problems, spinal cord injury, head/brain injury, stroke, MS, seizure, fainting/passing out, coordination issues, speech, arm/leg pain or burning	CURRENT	/	PAST
SKIN: cancer/eczema/psoriasis/pressure sores	CURRENT	/	PAST
ENDOCRINE: diabetes/thyroid	CURRENT	/	PAST
PSYCHIATRIC depression/anxiety/bipolar/other	CURRENT	/	PAST
PAST SURGERIES: please list type and year if known __________	CURRENT	/	PAST

(for office use) Height______ Weight______ B/P______ BMI______ Age______

Patient Signature: ______________________ Date: __________

Physician Signature: ______________________ Date: __________

Name:
Chart:
Date:

Patient Name ______________________

Date of Birth ______________________

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Orthopedic Associates of Meadville, P.C. has the right to change it's privacy practices from time to time and I may contact Orthopedic Associates of Meadville, P.C. to obtain a current copy of the brochure.
I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: ______________________ **Signature:**______________ Date: ________

MEDICAL RELEASE (including minors)

I hereby authorize Orthopedic Associates of Meadville, P.C. to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing, I also understand that by law OAM may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name ______________ Relationship ____________ Phone ____________
Name ______________ Relationship ____________ Phone ____________
Name ______________ Relationship ____________ Phone ____________

Further, I hereby authorize and give my consent to Orthopedic Associates of Meadville, P.C. to leave messages on my answering machine/voicemail system for the following:

______ Appointment reminders (including return telephone calls)
______ Prescription Refills
______ Test Results
______ **Do not leave message**
______ Permission to fax work status reports to employer
______ Permission to fax gym/school excuses to school

Signature ______________________________ Date ____________

Student Resident Consent

The physicians at Orthopedic Associates of Meadville are proud to play an integral role in the teaching of residents from Lake Erie College of Osteopathic Medicine (LECOM) and the training of student interns.

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature ______________________________ Date ____________

Name:
Chart:
Date:

ORTHOPEDIC ASSOCIATES OF MEADVILLE, P.C.

11277 VERNON PLACE, SUITE 200 • MEADVILLE, PENNSYLVANIA 16335 • 814/724-1252
FAX 814/337-6043

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **7 day notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday - Friday. No refills on the weekends or holidays. The "on-call" physicians will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of medication. Do not give your medications to other people and do not take medication from others.
8. Preferred Pharmacy & Location: ______________________________
(This pharmacy will be used for your refills unless otherwise specified.)
9. Orthopedic Associates of Meadville may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree and will comply with the above guidelines.

Print Patient Name: ______________________ DOB: ________________

Signature: ____________________________ Date: ________________
(Patient, Parent or Guardian)