Dayton Orthopaedic & Sports Medicine 5491 Far Hills Ave. Dayton, Ohio 45429

*****How did you hear about Dayton Orthopaedics?*_____

Patient Information: Date:_____

Name:_____ DOB:_____ Age:_____

SS#_____ ☐ married ☐ single ☐ widowed ☐ divorced

Address:_____ Sex:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Family Physician:_____

Address/Phone:_____

Patients E-Mail Address: _____

Employment Information:

Employer:_____ Telephone:_____

Address:_____ Contact Person:_____

Job Title/Type of Work:_____

Spouse Information: (if patient is a minor, please fill in responsible party information)

Name:_____ DOB:_____ Age:_____

SS#_____ Sex:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ (please indicate home/cell/work)

Employment:_____ Relationship to patient:_____

937-436-5763/937-436-7399 fax

West Chester Office
7760 West VOA Park Suite G
West Chester, Ohio 45069

Springfield Office
2419 East High St
Springfield, Ohio 45503

North Dayton Office
MED CTR at ELIZABETH PL
1 Elizabeth Pl, 4th floor
Dayton, OH 45408

DAYTON ORTHOPAEDIC
SURGERY AND SPORTS MEDICINE CENTER

PATIENT INSURANCE INFORMATION

PLEASE GIVE INSURANCE CARD(S) TO FRONT DESK TO COPY

NAME OF PRIVATE INSURANCE: _____

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

EMPLOYER: _____

ADDRESS: _____

_____

PHONE: _____

SUPERVISOR: _____

BUREAU OF WORKERS COMPENSATION CLAIM? ☐ YES ☐ NO

CLAIM #: _____

DATE OF INJURY: _____

PAYMENT AUTHORIZATION/please initial each box

☐ I authorize DOSSMC (Dayton Orthopaedic Surgery & Sports Medicine Center) to release to my insurance company any information necessary to process insurance claims on my behalf.

☐ I request that all payments or benefits for services rendered by DOSSMC be payable to & sent to DOSSMC.

☐ I realize that I am ultimately responsible for payment of these charges & the balance not covered by my insurance/BWC claim.

Patient's Full Name: _____

SIGNATURE: _____

DATE: _____

DAYTON
ORTHOPAEDIC
SURGERY AND SPORTS MEDICINE CENTER

FINANCIAL POLICY

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. If your treatment is not being covered by insurance (BWC, private insurance, personal injury) please read and complete this form.

DOSSMC (Dayton Orthopaedic Surgery & Sports Medicine Center) is aware of the economic challenges that face our community. We are committed to providing quality healthcare. As part of providing quality services, making financial arrangements is also necessary.

PAYMENT/COPAY IS EXPECTED AT THE TIME OF TREATMENT.

However, if you are unable to pay your balance in full, we have set up guidelines to help you clear your balance.

- $50 balance or less: entire balance due 30 days
- $51-$500 balance: $50 minimum monthly payment
- $501-$1000 balance: $100 minimum monthly payment
- $1001-$2500 balance: $200 minimum monthly payment
- $2500+ balance: 10% of balance due each month

Returned checks: There is $25.00 fee for any checks returned by the bank.

Acknowledgement

I understand that payment is due by my next scheduled appointment or the 1st of each month, unless other arrangements have been made in advance. I also understand that failure to follow the agreed upon payment arrangement will result in the physician refusing to continue treatment and further action for the full amount of the charge.

Patient's Full Name:_____

Signature:_____

Date:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

DAYTON
ORTHOPAEDIC
SURGERY AND SPORTS MEDICINE CENTER

Dear Patient:

Due to Federal and State regulations it has become necessary, as well as ethical, to scrutinize the use of narcotic and narcotic type medications. It has and always will be the policy of this office to administer narcotic and narcotic type medications on an as needed basis only. The use of narcotic medications, while useful in the treatment of many disorders has been shown that if used improperly can cause serious and harmful effects including drug dependency and possibly even death. This office, its staff and associated physicians take very seriously and all complaints regarding the inappropriate use of medications known to cause dependency and impairment of function.

It is a well known fact that narcotic and narcotic type medications impair the body's own ability to fight pain. These types of medications have been shown to be of use in the treatment of chronic pain related conditions. These kinds of conditions that can be chronic in nature will be discussed with you by your physician/physician assistant. It will be left to their discretion whether or not you are a candidate for the use of periodic narcotic and narcotic type medications.

If you are currently taking or receiving these types of medication on a routine basis from another physician then it is absolutely imperative that we be informed. As always, such disclosure of this information is confidential.

Before becoming a patient of our practice it is necessary that sign this form, which makes it clear that **1) you have not been diagnosed with a dependency problem and; 2) are not receiving narcotic medications on a long term basis from any other physician.**

Additionally, it is the policy of this office that the narcotic or narcotic type prescription cannot and will not be refilled unless you have an appointment to do so. After hours and weekend call-ins for narcotic and narcotic type medications, unfortunately cannot be accepted. These measures are for your protection against an ever increasing dependency type problem found within the community at large. It is necessary that we are practicing physicians ethically treat each patient according to the standard of care within this community.

Sincerely,
Jonathan J. Paley, M.D.
Dayton Orthopaedic Surgery & Sports Medicine Center

SIGNATURE DATE

No Show Policy Statement

Patient Name:_____

In order to be respectful to the medical needs of our patients, please be courteous and call our medical office promptly if you are unable to attend an appointment. This appointment time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel or reschedule your appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another patient the possibility to have timely access to medical care.

Cancellations that are less than 24 hours in advance will be considered as a "NO SHOW" and there will be a $25.00 charge.

Please anticipate possible dismissal from Dayton Orthopaedic Surgery if there are two(2) no-show/late canceled appointments.

Patient/Guardian:_____ **Date:**_____

PATIENT HISTORY Date _____

Name _____ Age _____ Sex (M or F) Hand Dominance R / L

Occupation _____ Referring M.D. or Hospital _____

HISTORY OF PRESENT ILLNESS OR INJURY

1. Chief complaint and location of pain? _____
2. When did this occur? _____ Work Related Yes – No
3. How did it occur? _____ Injury Yes – No
4. When is it painful? _____
5. What makes it worse? _____
6. What makes it better? _____
7. Have you seen another physician for this condition, if so what was the treatment?

   _____
8. Have you had any tests (x-rays, nerve studies, MRI, other) for this problem? If yes, list date and place

   _____
9. Have you missed work? Yes or No If yes, last date worked _____

Medical Problems (your health issues)

- ☐ None
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid disease
- ☐ Other _____
- ☐ Acid reflux
- ☐ Cancer
- ☐ Stroke
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Peptic ulcer disease

Allergies to medications

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Other _____

Surgical History

_____ date _____
_____ date _____
_____ date _____
_____ date _____
_____ date _____
_____ date _____

Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you on blood thinners? ☐ Yes ☐ No

Family History

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Stroke
- ☐ Other _____

Social History

Smoking: ☐ No ☐ Yes _____packs/day

Alcohol:

☐ none ☐ occasional ☐ frequent

Height: _____ Weight: _____

To the best of my knowledge, the information provided is accurate.

Patient/Responsible Party signature: _____ Date: _____

Provider Signature _____

New Patient Questionnaire

Patient Name: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Check all Positive symptoms

☐ Negative Response to All Symptoms

General-
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ General Weakness
☐ Trouble sleeping

Skin-
☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes

Head-
☐ Headache
☐ Head injury

Eyes-
☐ Vision Loss
☐ Blurry or double vision
☐ Flashing lights

Ears-
☐ Decreased hearing
☐ Ringing in ears
☐ Earache
☐ Drainage

Nose-
☐ Stuffiness
☐ Itching
☐ Hay fever
☐ Nosebleeds
☐ Sinus pain

Throat-
☐ Dry mouth
☐ Sore throat
☐ Hoarseness
☐ Thrush
☐ Non-healing sores

Musculoskeletal-
☐ Muscle pain
☐ Joint pain
☐ Stiffness
☐ Back pain
☐ Redness of joints
☐ Swelling of joints

Neck-
☐ Pain
☐ Stiffness
☐ Lumps
☐ Swollen glands

Respiratory-
☐ Cough
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular-
☐ Chest pain or discomfort
☐ Chest Tightness
☐ Palpations
☐ Shortness of breath with activity
☐ Difficulty breathing lying down
☐ Leg Swelling
☐ Sudden awaking from sleep with shortness of breath

Gastrointestinal-
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

Neurologic-
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Weakness
☐ Numbness or tingling hands or arms
☐ Numbness or tingling feet or legs
☐ Tremor

Vascular-
☐ Calf pain with walking
☐ Leg cramping

Hematologic-
☐ Ease of bruising
☐ Ease of bleeding

Endocrine-
☐ Heat or cold intolerance
☐ Sweating
☐ Frequent urination
☐ Thirst
☐ Change in appetite

Urinary-
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence

Psychiatric-
☐ Nervousness
☐ Stress
☐ Depression
☐ Memory loss
☐ Panic Attacks
☐ Insomnia
☐ Bipolar

Date: _____ Physician Signature: _____