

Patient Demographics

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date _____

Billing Address _____ Apt. # _____ City _____ State _____ Zip _____

Main Phone # type: Cell Home Work _____ Additional Phone # type: Cell Home Work _____ Sex: M / F
Gender (Circle One)

S / M / W / D / DP _____

Marital Status (Circle One) _____ Social Security # _____ Email address _____

Employer _____ Phone _____

Have you had *recent* X-rays or an MRI for this issue? Yes No If yes, where? _____

Do you have a primary care physician? Yes No If yes, who? _____

How did you hear about us? Friend Internet Other Referring Physician

Emergency Contact Information

Contact Name _____ Contact Phone # _____ Relationship to Patient _____

Contact Address _____ Apt. # _____ City _____ State _____ Zip _____

Responsible Party (if under 18 years of age)

Responsible Party's Legal Name _____ Birth Date _____ Relationship to Patient _____

Responsible Party's Address _____ City _____ State _____ Zip _____ Phone # _____

PIP Insurance Information

Insurance Company _____ Claim # _____ Adjuster Phone # _____

Adjuster's Name _____ Adjuster Fax # _____

Secondary Insurance Company _____ Policy # _____ Group# _____

Policy Holder's Name _____ Policy Holder's Birth Date _____ Relationship to Patient _____

Adjuster Name _____ Adjuster Phone # _____ Adjuster Fax _____

By signing below I agree to the following:

- Provide correct and or updated insurance information. OSIC will bill my insurance. My insurance company will directly pay OSIC.
- To pay the allowable balance of medical bills after my insurance company has paid.
- To pay interest on all past-due amounts (>60 days) (at the rate of 18% per annum or 1.5% per month until paid in full).
- To allow OSIC to refer my unpaid account balance to a collection agency.
- The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility.

Signature of Patient or Guardian _____ **Date** _____

Patient Health History/Subjective Information **DATE:** _____

Legal First Name _____ Legal Last Name _____ Middle Initial _____ Birth Date _____ / ____ / ____

Pharmacy Preference _____ Pharmacy Address _____ Fax Number _____

Reason for today's visit: _____

How long have you been experiencing these problems? _____ Current Weight _____ lbs. Current Height _____' ____"

Have you had any injuries/pain in these area(s) prior to your recent pain onset? Yes No Describe: _____

Please List Any Medications You Are Currently Taking, Including Over-The-Counter Medications, Vitamins, etc.

Name of Medication	Dosage	How Often Taken	Are You Allergic to Any Medications?	
			Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list them below.	
			Name of Medication	Type of Reaction

List All Hospitalizations/Surgeries	Date

Have you ever had any problems with Anesthesia?
Yes No If yes, please list problems below

If you need additional space for Medications or Hospitalizations/Surgeries, please use the back of this form.

Treatments Attempted	No Relief	Good Relief
Bed Rest		
Physical Therapy		
Chiropractic		
Home Exercise or Home Health Services		
Heat or Cold Therapy		
Wearing a Sling, Brace or Orthotics		
Spinal or Muscle Injections		
TENS Unit		

Personal Habits

Tobacco? Yes No
Packs per day _____
For how long _____
Quit date _____

Alcohol? Yes No
Drinks per day _____
Type (beer, Wine, Liquor, etc.) _____

Rate your pain by marking 0-10 on the scale below.
Zero (0) = No pain and Ten (10) = Extremely Intense Pain
0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

General Medical History					
Heart Disease	Cancer/Tumor	Asthma	Ulcers or GI Bleeding	Pregnant	
High Blood Pressure	Diabetes	HIV/AIDS	Liver or Kidney Disease	Pacemaker	
Heart Murmur	Arthritis	Hepatitis	Osteoporosis	Epilepsy	
Fibromyalgia	Scoliosis	Emphysema	Thyroid Disorder	Weight Loss/Gain	
Bleeding Disorder	Tuberculosis	Stroke	Depression	Circulation Problems	

Patient Name: _____ Patient Signature: _____ Date: _____

Late and No-Show Policy

OSIC patients are asked to show up at least 15 minutes prior to their scheduled appointment time. If an OSIC patient is unable to keep their scheduled appointment, they must notify our front desk manager by phone twenty-four hours in advance of their scheduled appointment to avoid no-show charge. If a patient arrives 15 minutes after their scheduled appointment time, they may be asked to reschedule. If a patient "no-shows", they will be charged a \$100 fee for the first "no-show", \$250 for the second "no-show", \$400 for the third "no-show", \$600 for the fourth "no-show", \$800 for the fifth "no-show" and \$1000 per additional "no-show" appointment after that within a twelve-month period. After a second no-show, a refundable deposit will be required for rescheduling or they may be dismissed as a patient of OSIC.

AI Tools in Practice

To enhance the efficiency of care and to fully utilize the time providers have during patient interactions, Orthopedic Spine & Injury Center may use secure, AI powered scribe technology during your visit. This tool helps document the interaction you and your provider have which will allow your provider to focus more fully on you while ensuring thorough and timely recordkeeping.

The AI scribe does not make medical decisions or diagnoses. It is only used to assist in note taking. All documentation is thoroughly reviewed by your provider for accuracy.

Privacy Practices

I understand that Orthopedic Spine & Injury Center will only use my personal health information in the following ways: Treatment, Payment & Health Care Operation. Orthopedic Spine & Injury Center will not release my medical information to individuals without a signed release form. If I have further questions, I may receive a copy of Orthopedic Spine & Injury Center's Notice of Privacy Practices.

Text Messaging

I agree to receive SMS messages from OSIC regarding updates to visits, billing notifications, prescription reminders, care management, and care management and service line informational messages. Standard message and data rates may apply. Message Frequency may vary. Reply STOP to opt out at any time. Reply HELP for help.

Consent

I voluntarily consent to receive medical care and treatment from Orthopedic Spine & Injury Center. This may include physical exams, diagnostic procedures, laboratory tests, imaging, administration of medications, and other treatments deemed necessary. I understand that treatment can only be provided while I am physically present in the provider's licensed state.

I have reviewed and consent to all information listed above.

Patient Name: _____ **Date:** _____

Signature of Patient _____