New Patient Information

You have been scheduled for an appointment with Bruce J. Rudin, M.D. This appointment will take place at **First State Orthopaedics / Spine Care of Delaware**, located in the Harmony Plaza Shopping Center, 4102 Ogletown-Stanton Road, Newark, DE 19713.

Please download and fill out the Patient Forms and bring them with you to the appointment. Complete the cervical intake form for a neck problem or the lumbar intake sheet if you have a low back problem. Please do not mail them back to our office prior to the appointment taking place. Also, bring a copy of your current medications and dosages and your preferred pharmacy name and address. If your insurance requires a referral, please call your family doctor prior to your appointment with Dr.Rudin. If you are involved in a workman's compensation or auto accident case, you must have your complete insurance information, including claim number, filled out on the paperwork.

Your co-pay is due at the time of your visit.

You must have had an MRI of the applicable area of the spine within one year of your appointment with Dr. Rudin. Please bring your MRI film/disc with you to the first appointment. You will not be seen if you do not have the MRI film or disc with you. Due to the nature of the practice, please allow at least two hours for the appointment.

The office requires 48 hours for prescription renewals. This does not include weekends. Please plan any medication requests accordingly.

If you have any questions regarding this information, please feel free to contact Peggy Ann at (302) 731-2888 ext. 1138.

Thank you for your attention in this matter.

Date _____ Next Gen # _____

FIRST STATE ORTHOPAEDICS

☐ Dr. Axe ☐ Dr. Brady ☐ Dr. Hershey ☐ Dr. Johnson ☐ Dr. Katz ☐ Dr. Moran ☐ Dr. Pushkarewicz ☐ Dr. Rudin ☐ Dr. Steele
☐ Dr. Bodenstab ☐ Dr. Crain ☐ Dr. Hogan ☐ Dr. Kahlon ☐ Dr. Kim ☐ Dr. Newcomb ☐ Dr. Raisis ☐ Dr. Sowa

PATIENT INFORMATION

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____ Cell ( ) _____
Family Doctor _____ Phone ( ) _____
Referring Dr. _____ Phone ( ) _____
How did you hear about us? _____
Referring Attorney Name _____

Date of birth _____ Age ____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Relationship to responsible person _____
Social Security No. _____
Occupation _____
Employed by _____
Business phone ( ) _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____

Social Security No. _____
Relationship to Patient _____
Occupation _____
Employed by _____
Business phone ( ) _____

INSURANCE INFORMATION

PRIMARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to patient _____
Date of birth _____
Social Security No. _____

SECONDARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to patient _____
Date of birth _____
Social Security No. _____

(✓ Box) ☐ AUTO ACCIDENT ☐ WORK RELATED INJURY ☐ PERSONAL INJURY

Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____
Insurance Co. phone ( ) _____
Name of Adjuster _____
Name of Attorney _____ Phone ( ) _____

Date of Injury _____
State in which injury occurred _____
Claim No. _____
(Complete the following if accidental injury)
Where Accident Occurred _____
How Accident Occurred _____

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone #

FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE

The First State Surgery Center and Spine Care Delaware are Ambulatory Surgery Centers owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility .

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A., employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT/ INSURANCE ASSIGNMENT

I accept responsibility to insure that payment is made for all services rendered on my behalf. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to First State Orthopaedics, P.A., for all fee balances determined to be patient responsibility. I acknowledge that it is also my responsibility to obtain a referral from my PCP if required or I will be responsible for payment of FSO fees.

I hereby authorize and direct payment to First State Orthopaedics, P.A., for surgical and/ or medical benefits, if any otherwise payable to me under the terms of any applicable insurance. I authorize the release of any medical information necessary to process claims. I hereby authorize photocopies of this form to be as valid as the original.

First State Orthopaedics, P.A., is hereby authorized to take any legal action which may be necessary either in law or in equity in my name against any insurance company for any and all fee balances, and I covenant and agree to cooperate fully with First State Orthopaedics, P.A., in the presentation of such claims and to furnish all papers and documents necessary in such proceedings and to attend court and testify if First State Orthopaedics, P.A., deems such to be necessary.

In the event of default on any payment due First State Orthopaedics, P.A., which are my responsibility, I agree to pay a cost of collection including attorney fees. Balances not paid within 90 days are subject to collection procedures and a collection fee.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

Signature of patient, parent or legal guardian _____ Date _____

MEDICARE SIGNATURE ON FILE

"I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician(s). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits or the benefits payable for related services."

Signed: Medicare Beneficiary _____ Date _____

THE PATIENT/ GUARANTOR IS RESPONSIBLE FOR ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID

First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

CERVICAL SPINE INTAKE FORM

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

REASON FOR VISIT - Ort Home

(Please check all that apply)

Body Part(s): _____ ☐ **Right** ☐ **Left** ☐ **Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: _____

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work:** _____

Doctors who have treated you for this problem: _____ **Did that doctor refer you here?:** ☐ Yes ☐ No

Diagnostic tests and treatment performed *(please list when/where/what)* **:** ☐ X-Ray _____ ☐ MRI _____

☐ Injection _____ ☐ Surgery: _____ ☐ NSAIDS (anti-inflammatories) _____ ☐ EMG _____

☐ CT/Scan _____ ☐ Bone Scan _____ ☐ Lab Work _____ ☐ Other: _____ ☐ PT _____

Have you ever had similar problems? If yes, please give details: _____

HISTORY OF PRESENT INJURY - Ortho OV>Specialty HPI>Cervical Spine

(Describe your pain, please check all that apply)

Onset of Pain: _____ ☐ Wk(s) ☐ Mo(s) ☐ Yr(s)

Severity : ☐ 1 (little pain) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (excrutiating pain)

Date of Injury: _____ ☐ **Auto Accident** ☐ **Workers' Comp**

Status of Pain: ☐ Improved ☐ No change ☐ Worse ☐ Resolved

Work Status: ☐ Currently working _____ hrs/wk ☐ Not working

Frequency of Pain: ☐ Daily ☐ Constant ☐ Intermittent ☐ Occasional

Location of Pain: ☐ Pain Resolved

	R	L	BL
Neck	☐	☐	☐
Arm	☐	☐	☐
Shoulder	☐	☐	☐
Intrascap	☐	☐	☐
Other: _____			

Radiation of Pain: ☐ None

	R	L	BL
Neck	☐	☐	☐
Trap	☐	☐	☐
Shoulder	☐	☐	☐
Elbow	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Other: _____			

Weakness: ☐ None

	R	L	BL
Wrist	☐	☐	☐
Arm	☐	☐	☐
Shoulder	☐	☐	☐
Hand	☐	☐	☐
Finger	☐	☐	☐
Elbow	☐	☐	☐
Other: _____			

Numbness/Tingling: ☐ None

	R	L	BL
Neck	☐	☐	☐
Trap	☐	☐	☐
Shoulder	☐	☐	☐
Elbow	☐	☐	☐
Arm	☐	☐	☐
Hand	☐	☐	☐
Other: _____			

Quality of Pain:
- ☐ Severe
- ☐ Aching
- ☐ Shooting
- ☐ Dull
- ☐ Resolved
- ☐ Other _____

Context

Symptoms Improved With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Symptoms Failed to Improve With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Aggravated By:
- ☐ Lifting
- ☐ Sitting
- ☐ Driving
- ☐ Office Work
- ☐ Sleeping
- ☐ End of Day
- ☐ Mornings
- ☐ Other: _____

Relieved By:
- ☐ Changing Positions
- ☐ Sitting
- ☐ Heat
- ☐ Exercise
- ☐ Medication: _____
- ☐ Rest
- ☐ Stretching
- ☐ Other: _____

Associated Symptoms/ Pertinent Negatives:
- ☐ Balance Disturbances
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Spasms
- ☐ Gait Disturbances
- ☐ Change in Handwriting
- ☐ Difficulty w/ Fine Motor Control
- ☐ Other: _____

Please check the box below that best describes your pain:
☐ Neck Pain = Arm Pain ☐ Neck Pain > Arm Pain ☐ Neck Pain < Arm Pain

REVIEW OF SYSTEMS - Ortho OV>Add Additional ROS>ROS Defaults>Globally Normal Ortho

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ **None**

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in **Weight:** _____lbs. **My Weight in the last 6 months has**: □ Not Changed □ Increased _____lbs. □ Decreased _____lbs.

Please list details of any special diet program: _____

Have you ever taken any anti-inflammatories/arthritis medications?: □Yes □No (ex: Naprosyn/Ibuprofen) If yes, please list: _____

ALLERGIES - Assistant Doc>Add Allergy

(Please check all that apply)

	Reaction:		**Reaction:**		**Allergy & Reaction:**
□ Aspirin	_____	□ NSAIDs (anti-inflammatories - ibuprofen, naprosyn)	_____	□ Other:	_____
□ Codeine	_____	□ Narcotics (Percocet, Vicodin)	_____	□ Other:	_____
□ IV Dye	_____	□ Penicillin	_____	□ Other:	_____
□ Latex	_____	□ Sulfa	_____	□ **No Known Drug Allergies**	

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ AIDS/HIV	□ COPD (Emphysema)	□ High Blood Pressure	□ Parkinson Disease	□ **None**
□ Alcoholism	□ Coronary Artery Disease	□ Hyperthyroidism	□ Peptic Ulcer Disease	
□ Alzheimers	□ Crohn's Disease	□ Hypothyroidism	□ Psoriasis	□ Other:
□ Anemia	□ Degenerative Joint Disease	□ Inflammatory Bowel Disease	□ PVD	
□ Angina	□ Depression	□ Juvenile Rheumatoid Arthritis	□ Renal Disease	_____
□ Arthritis	□ Diabetes	□ Kidney Disease	□ Rheumatoid Arthritis	
□ Asthma	□ Drug Abuse	□ Liver Disease	□ Scoliosis	_____
□ Atrial Fibrillation	□ DVT (Blood Clot)	□ Lyme Disease	□ Seizure Disorder	
□ Benigin Prostatic Hyertrophy	□ Fibromyalgia	□ Migraine Headaches	□ Sleep Apnea	_____
□ Cancer	□ Gallbladder Disease	□ Multiple Sclerosis	□ SLE (Lupus)	
□ Cerebrovascular Accident (Stroke)	□ GERD	□ Myocardial Infarction	□ Spinal Stenosis	_____
	□ Gout	□ Obesity	□ Thyroid Disease	
□ Congestive Heart Failure (CHF)	□ Hepatitis	□ Osteoarthritis	□ Valvular Disease (Heart valve problems)	_____
	□ High Cholesterol	□ Osteoporosis		

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ ACL Surgery	□ CABG	□ Hip Replacement	□ Pacemaker	□ Other:
□ Angioplasty	□ Cardiac (Heart) Valve Replacement	□ Knee Replacement	□ Small Bowel Resection	_____
□ Angio w/stent		□ Laminectomy	□ Thyroidectomy	
□ Appendectomy	□ Carpal Tunnel Release	□ LASIK	□ Tonsillectomy	_____
□ Athroscopy (Scope) Details:	□ Cataract Extraction	□ Meniscus Surgery	**Gender Specific**	
	□ Cholecystectomy (gallbladder removal)	□ Muscle Biopsy	**Female**	_____
_____		□ Neck Surgery - Details:	□ Cesarean Section	
□ Back Surgery - Details:	□ Colectomy		□ Hysterectomy	_____
	□ Colostomy	_____	□ Mastectomy	
_____	□ Discectomy		**Male**	_____
	□ Gastric Bypass	_____	□ Prostatectomy	
_____	□ Hernia Repair	□ ORIF	□ TURP	□ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? □ Yes □ No If no, age deceased _____ cause of death _____

Is your Mother Living? □ Yes □ No If no, age deceased _____ cause of death _____

Are any of your brothers/sisters deceased? □ Yes □ No If yes, age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol**: □ Yes □ No □ Former/Year Quit _____

Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____

First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

LUMBAR SPINE INTAKE FORM

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

REASON FOR VISIT - Ort Home

(Please check all that apply)

Body Part(s): _____ ☐ **Right** ☐ **Left** ☐ **Bilateral**

Complaint: ☐ Pain ☐ Injury ☐ Fracture ☐ Numbness ☐ Swelling ☐ Other: _____

Have you been off work for this problem?: ☐ Yes ☐ No **Dates off work:** _____

Doctors who have treated you for this problem: _____ **Did that doctor refer you here?:** ☐ Yes ☐ No

Diagnostic tests and treatment performed *(please list when/where/what)* **:** ☐ X-Ray _____ ☐ MRI _____

☐ Injection _____ ☐ Surgery: _____ ☐ NSAIDS (anti-inflammatories) _____ ☐ EMG _____

☐ CT/Scan _____ ☐ Bone Scan _____ ☐ Lab Work _____ ☐ Other: _____ ☐ PT _____

Have you ever had similar problems? If yes, please give details: _____

HISTORY OF PRESENT INJURY - Ortho OV>Specialty HPI>Lumbar Spine

(Describe your pain, please check all that apply)

Onset of Pain: _____ ☐ Wk(s) ☐ Mo(s) ☐ Yr(s)

Severity : ☐ 1 (little pain) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (excrutiating pain)

Date of Injury: _____ ☐ **Auto Accident** ☐ **Workers' Comp**

Status of Pain: ☐ Improved ☐ No change ☐ Worse ☐ Resolved

Work Status: ☐ Currently working _____ hrs/wk ☐ Not working

Frequency of Pain: ☐ Daily ☐ Constant ☐ Intermittent ☐ Occasional

Location of Pain: ☐ Pain Resolved

	R	L	BL
Lower Back	☐	☐	☐
Leg	☐	☐	☐
Buttock	☐	☐	☐
Groin	☐	☐	☐
Other: _____			

Radiation of Pain: ☐ None

	R	L	BL
Buttock	☐	☐	☐
Thigh	☐	☐	☐
Ankle	☐	☐	☐
Foot	☐	☐	☐
Great Toe	☐	☐	☐
Other: _____			

Weakness: ☐ None

	R	L	BL
Hip	☐	☐	☐
Leg	☐	☐	☐
Knee	☐	☐	☐
Foot	☐	☐	☐
Ankle	☐	☐	☐
Other: _____			

Numbness/Tingling: ☐ None

	R	L	BL
Buttock	☐	☐	☐
Thigh	☐	☐	☐
Ankle	☐	☐	☐
Foot	☐	☐	☐
Great Toe	☐	☐	☐
Other: _____			

Quality of Pain:
- ☐ Severe
- ☐ Aching
- ☐ Shooting
- ☐ Dull
- ☐ Resolved
- ☐ Other _____

Aggravated By:
- ☐ Bending
- ☐ Changing Positions
- ☐ Lifting
- ☐ Sitting
- ☐ Driving
- ☐ Walking
- ☐ Standing
- ☐ Pushing
- ☐ End of Day
- ☐ Mornings
- ☐ Other: _____

Relieved By:
- ☐ Changing Positions
- ☐ Sitting
- ☐ Laying Down
- ☐ Standing
- ☐ Heat
- ☐ Exercise
- ☐ Medication: _____
- ☐ Rest
- ☐ Stretching
- ☐ Other: _____

Associated Symptoms/ Pertinent Negatives:
- ☐ Balance Disturbances
- ☐ Bladder Incontinence
- ☐ Bowel Incontinence
- ☐ Spasms
- ☐ Gait Disturbances
- ☐ Weakness
- ☐ Change in Handwriting
- ☐ Other: _____

Context

Symptoms Improved With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Symptoms Failed to Improve With:
☐ PT ☐ Injections ☐ Time ☐ Meds

Please check the box below that best describes your pain:
☐ Back Pain = Leg Pain ☐ Back Pain > Leg Pain ☐ Back Pain < Leg Pain

REVIEW OF SYSTEMS - Ortho OV>Add Additional ROS>ROS Defaults>Globally Normal Ortho

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ Other: _____

☐ Other: _____

☐ Other: _____

☐ **None**

OVER

PATIENT'S MEDICAL CONDITION - Assistant Doc>Vital Signs

Height: ___ft ___in **Weight:** _____lbs. **My Weight in the last 6 months has**: □ Not Changed □ Increased _____lbs. □ Decreased _____lbs.

Please list details of any special diet program: _____

Have you ever taken any anti-inflammatories/arthritis medications?: □Yes □No (ex: Naprosyn/Ibuprofen) If yes, please list: _____

ALLERGIES - Assistant Doc>Add Allergy

(Please check all that apply)

Reaction:	**Reaction:**	**Allergy & Reaction:**
□ Aspirin _____	□ NSAIDs _____ (anti-inflammatories - ibuprofen, naprosyn)	□ Other: _____
□ Codeine _____	□ Narcotics _____ (Percocet, Vicodin)	□ Other: _____
□ IV Dye _____	□ Penicillin _____	□ Other: _____
□ Latex _____	□ Sulfa _____	□ **No Known Drug Allergies**

PATIENT'S MEDICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ AIDS/HIV	□ COPD (Emphysema)	□ High Blood Pressure	□ Parkinson Disease	□ **None**
□ Alcoholism	□ Coronary Artery Disease	□ Hyperthyroidism	□ Peptic Ulcer Disease	
□ Alzheimers	□ Crohn's Disease	□ Hypothyroidism	□ Psoriasis	□ Other:
□ Anemia	□ Degenerative Joint Disease	□ Inflammatory Bowel Disease	□ PVD	
□ Angina	□ Depression	□ Juvenile Rheumatoid Arthritis	□ Renal Disease	_____
□ Arthritis	□ Diabetes	□ Kidney Disease	□ Rheumatoid Arthritis	
□ Asthma	□ Drug Abuse	□ Liver Disease	□ Scoliosis	_____
□ Atrial Fibrillation	□ DVT (Blood Clot)	□ Lyme Disease	□ Seizure Disorder	
□ Benign Prostatic Hyertrophy	□ Fibromyalgia	□ Migraine Headaches	□ Sleep Apnea	_____
□ Cancer	□ Gallbladder Disease	□ Multiple Sclerosis	□ SLE (Lupus)	
□ Cerebrovascular Accident (Stroke)	□ GERD	□ Myocardial Infarction	□ Spinal Stenosis	_____
	□ Gout	□ Obesity	□ Thyroid Disease	
□ Congestive Heart Failure (CHF)	□ Hepatitis	□ Osteoarthritis	□ Valvular Disease (Heart valve problems)	_____
	□ High Cholesterol	□ Osteoporosis		

PATIENT'S SURGICAL HISTORY - Histories>Additional History

(Please check all that apply)

□ ACL Surgery	□ CABG	□ Hip Replacement	□ Pacemaker	□ Other:
□ Angioplasty	□ Cardiac (Heart) Valve Replacement	□ Knee Replacement	□ Small Bowel Resection	_____
□ Angio w/stent		□ Laminectomy	□ Thyroidectomy	
□ Appendectomy	□ Carpal Tunnel Release	□ LASIK	□ Tonsillectomy	_____
□ Athroscopy (Scope) Details:	□ Cataract Extraction	□ Meniscus Surgery	**Gender Specific**	
	□ Cholecystectomy (gallbladder removal)	□ Muscle Biopsy	**Female**	_____
_____		□ Neck Surgery - Details:	□ Cesarean Section	
□ Back Surgery - Details:	□ Colectomy		□ Hysterectomy	_____
	□ Colostomy	_____	□ Mastectomy	
_____	□ Discectomy		**Male**	_____
	□ Gastric Bypass	_____	□ Prostatectomy	
_____	□ Hernia Repair	□ ORIF	□ TURP	□ **None**

PATIENT'S FAMILY HISTORY - Histories> Additional Family History

Is your Father Living? □ Yes □ No If no, age deceased _____ cause of death _____

Is your Mother Living? □ Yes □ No If no, age deceased _____ cause of death _____

Are any of your brothers/sisters deceased? □ Yes □ No If yes, age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY - Histories>Social History

Tobacco Use: □ Yes □ No □ Former/Year Quit _____ **Consume Alcohol**: □ Yes □ No □ Former/Year Quit _____

Activity Level: □ Sedentary □ Moderate □ Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____

FIRST STATE ORTHOPAEDICS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of First State Orthopaedics Notice of Privacy Practices.

Print Name

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of First State Orthopaedics Notice of Privacy Practices but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

This Notice describes the practices at all our offices and First State Surgery Center, as well as the practices of the medical staff who provide services at First State Surgery Center. If you have any questions about this notice, please contact the First State Orthopaedics Privacy Officer.

FIRST STATE ORTHOPAEDICS LEGAL RESPONSIBILITIES

We are required by applicable federal and state law to maintain the privacy of your health information, including demographic information that may identify you that relates to your past, present or future physical health and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. This notice takes effect April 14, 2003, and will remain in effect until any changes are made. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. The new notice will be effective for all protected health information we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy. This can be obtained through our website, www.fsortho.com, verbal request or at the time of your appointment.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

For Treatment: We may use your health information about you to provide medical treatment or services. We may use or disclose your health information to a physician or other healthcare providers providing you treatment. We may disclose your medical information to doctors, hospitals, nursing homes, visiting nurse associations, physical therapy, rehabilitation facilities and diagnostic testing and laboratory facilities.

For Payment: Your protected health information will be used, as needed, to obtain payment for treatment and services you receive at First State Orthopaedics. First State Orthopaedics may bill and receive payment from you, an insurance company or a third party. For example, we may need to give your health plan information regarding your treatment in order for your plan to reimburse you or us for services rendered, to obtain prior approval for services or determination of covered benefits. In order to manage your care and treatment, we will also disclose your protected health information to worker's compensation and auto carriers, adjusters, nurse case managers, employers, disability carriers, attorneys and your various insurance companies.

For Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, employee review activities, training of medical students, conducting training programs, accreditation, certification and licensing or credentialing activities. For example, we may disclose your protected health information to medical school students at our office. In addition, we may have you sign in at the registration desk indicating your physician. We may also call you by name from the waiting room when the physician is available. We may use or disclose your protected health information necessary to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that provide activities, such as billing and transcription services for the practice. Whenever an arrangement between the office and a business associate involves the use of disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected information.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder of an appointment for treatment or medical care. Unless you object, we may leave a message on an answering machine in order to contact you or provide you with appointment reminders. No details regarding your diagnosis or treatment will be left on an answering machine.

YOUR AUTHORIZATION: Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke this, in writing, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care.

LAW ENFORCEMENT, LAWSUITS & DISPUTES: We may release medical information if asked to do so by law enforcement officials in response to a valid court order, subpoena, discovery request, warrant, summons or similar process. We will disclose medical information about you when required to do so by federal, state or local law. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a valid court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

MILITARY, VETERANS & NATIONAL SECURITY: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities.

PUBLIC HEALTH RISKS: We may disclose medical information about you for public health activities. These activities generally include the prevention of controlled diseases, injury or disability; to report a death; to report reactions to medications or problems with products; or to notify people of recalls of products they may be using. We may also notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence or the possible victim of other crimes. We will only make this disclosure if you agree or when required or authorized by law. We may disclose your health information to the extent necessary to avert a serious threat to your health or the health or safety of others.

CORONERS, MEDICAL EXAMINERS & FUNERAL DIRECTORS: We may release medical information to a coroner, medical examiner or funeral director. This may be necessary to identify a deceased person or determine cause of death.

RESEARCH PURPOSES: We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols address the privacy of your protected health information.

PRISONERS: If you are a prisoner of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or to obtain payment for services provided to you.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system and government programs.

PATIENT RIGHTS - You have the following rights regarding medical information we maintain about you.

Right to Inspect and Copy: You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing or complete one of our release forms. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, chart retrieval or other supplies we use to fulfill your request.

We ordinarily will respond to your request within 30 working days if the information is located in our facility. If your information is in our off site storage facility, we may require an extension with respect to the time limits for providing access. If we need additional time to respond, we will notify you in writing within the time frame above to explain the reason for the delay. The right to inspect your medical information will be carried out in a private room with a privacy officer or an appointed First State Orthopaedics representative.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we deny part or all of your request, we will provide a written denial that explains our reasons for doing so, and a description of your rights to have that decision reviewed and how you can exercise those rights.

If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. Your request to amend must be made in writing and you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask to amend information that was not created by us, if it is not part of the medical information kept by First State Orthopaedics, if it is not part of the information which you would be permitted to inspect for copy or is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. The list does not include uses and disclosures that have been made for treatment, payment, or health care operations, or disclosures that were made to you or with your authorization or consent. You must submit your request in writing. Your request must state a time period no longer than six years and may not include dates before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the First State Orthopaedics Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Confidential Communications: You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. You must make your request in writing. You are not required to provide us with an explanation, however, your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. To obtain another copy of this Notice, request a copy from the First State Orthopaedic Privacy Officer in writing.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our waiting rooms. This notice will contain on the first page, in the top right-hand corner, the effective date.

OTHER USES OF MEDICAL INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint with First State Orthopaedics or with the Secretary of the Department of Health and Human Services. Complaints to First State Orthopaedics must be submitted in writing.

We support your right to the privacy of your health information. We will not penalize you in any way if you choose to file a complaint with us or the Secretary of the Department of Health and Human Services.

Privacy Officer: Telephone number: 302-731-2888 Fax: 302-731-7049

FIRST STATE ORTHOPAEDICS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of First State Orthopaedics Notice of Privacy Practices.

Print Name

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of First State Orthopaedics Notice of Privacy Practices but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

Physician: _____

Patient Medication List

Date: 04/14/11

Patient Name: _____ Date of Birth: _____ Nextgen Acct # _____

Please list all prescription, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies.

** Pharmacy and Pharmacy Number is required for First State Orthopaedics to prescribe medications**

PHARMACY: _____ PHARMACY NUMBER: _____

PHARMACY: _____ PHARMACY NUMBER: _____

MEDICATION NAME	DOSE (mg, units, drops)	WHEN TAKEN (daily, at bedtime, etc)	REASON (blood pressure, diabetes, etc.)

LATEX ALLERGY (required) Please circle one: YES or NO

ALLERGIES to Medications:_____ REACTION:_____

_____ _____

_____ _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____

Processed by:_____ Date: _____ Processed by: _____ Date: _____