The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION
100 Kingsley Lane, Suite 300
Norfolk, VA 23505

NEW PATIENT MEDICAL HISTORY

Date: _____
Chart # _____
Primary Care Physician _____

Patient's Name _____Ref Physician_____
Date of Birth: __/____/____ Age_____Weight _____Height_____Date of last tetanus_____
Problems with anesthesia □ YES □ NO If yes, explain _____
Current Conditions _____

Do you have an allergy to chicken and/or eggs or ever been told you should not receive the flu vaccination? □ YES □ NO

Allergies/Difficulty with Medications	Reaction	□ None	Current Medication	Dosage	□ None
1. _____			1. _____	_____	
2. _____			2. _____	_____	
3. _____			3. _____	_____	
4. _____			4. _____	_____	
5. _____			5. _____	_____	

Please Check All That Apply To You

PERSONAL MEDICAL HISTORY

__ No Illnesses	__ Pneumonia	__ Bladder/Kidney Infection	__Scarlet Fever
__ Diabetes	__ Tuberculosis	__ Arthritis	__ Bleeding Disorders
__ High Blood Pressure	__ Heart Attack or Heart Disease	__ Cancer	__ Intestinal Problems
__ Stroke	__ Ulcers	__ Mental or Nervous Disorder	__ Angina
__ Emphysema	__ Hepatitis	__ Seizures	__ Heart Murmurs/Valve Problems
__ Bronchitis	__ Gallbladder Disease	__ Venereal Disease	__ Other
__ Asthma	__ Pancreatitis	__ AIDS/HIV	__ Specify _____

SOCIAL HISTORY

Do you smoke cigarettes? □ YES □ NO
Do you drink alcohol? □ YES □ NO
Do you take drugs? □ YES □ NO
Marital Status □ Married □ Single □ Divorced □ Separated □ Number of Children _____
Are you □ Right Handed □ Left Handed
How many hours a day do you stand and/or walk while at work? □ 0-1 □ 1-3 □ 3-5 □ 5-8 While at home? □ 1-3 □ 3-5 □ 5-8
Employment: (Type) _____

FAMILY HISTORY (Siblings, parents and children)

			REVIEW DATE	
			Date	Initial
__ No Disease	__ Kidney Disease	__ Other (Specify)_____		
__ Diabetes	__ Arthritis	_____	_____	_____
__ High Blood Pressure	__ Asthma	_____	_____	_____
__ Heart Disease	__ Seizures	_____	_____	_____
__ Cancer	__ Excessive Bleeding	_____	_____	_____
__ Tuberculosis	__Problems with Anesthesia	_____		

Physician's Signature _____
R. Michael Graham, MD, FAAOS

Previous Surgery □ NONE Dates

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

RECENT DIAGNOSTIC TESTS (Please check all that apply within the last 3-6 months): □ NONE

____ Chest X-ray ____ Stress Test ___ Blood Work ___ EKG

REVIEW OF SYMPTOMS (Please check all that apply within the last 3-6 months)

GENERAL □ None
__ Fever
__ Chills
__ Night Sweats

ABDOMEN □ None
__ Nausea
__ Vomiting
__ Pain and/or Difficulty Swallowing
__ Gas
__ Indigestion
__ Abdominal Pain
__ Bloating
__ Constipation
__ Diarrhea
__ Hemorrhoids
__ Blood Stools

MUSCULOSKELETAL: □ None
__ Fracture
__ Sprain
__ Strains
__ Dislocations

HEAD □ None
__ Headaches
__ Blackouts
__ Seizures
__ Dizziness
__ Double and/or Blurred Vision
__ Ringing Ears
__ Sinusitis
__ Post Nasal Drip
__ Sore Throat
__ Hoarseness
__ Cold

URINARY □ None
__ Blood in Urine
__ Burning with Urination
__Bladder or Kidney Infection
__ Frequency and/or Difficulty with
__ Starting Urination
__ Difficulty with Leaking Urine
__ Getting Up at Night to Urinate

SKIN □ None
__ Rash
__ Itching
___ Psoriasis
__ Change in or Bleeding of Mole

CHEST □ None
__ Cough
__ Cold
__ Sputum
__ Coughing up Blood
__ Wheezing
__ Shortness of Breath
__ Chest Pain
__ Palpitations
__ Heart Murmur
__ Swelling of Feet
__ Rheumatic Fever

NEUROMUSCULAR □ None
__Joint Stiffness
__ Joint Pain
__ Swelling
__ Back Pain
__ Varicose Veins
__ Night Cramps
__ Bursitis
__ Tendonitis
__ Raynaud's

FEMALE PATIENTS

Do you take Birth Control Pills? □ YES □ NO
If YES, type _____
Do you take PREMARIN or ESTROGEN or other hormone replacements? □ YES □ NO
If YES, type _____
Is there any chance you are pregnant? □ YES □ NO

The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION
100 Kingsley Lane, Suite 300
Norfolk, VA 23505
Phone: 757.889.6580 ● Fax: 757.889.6583

OFFICE USE ONLY

ACCOUNT # _____ DR. _____ ☐

PLEASE PRINT

PATIENT INFORMATION

PATIENT NAME LAST	FIRST	MIDDLE INT.	SEX	BIRTHDATE	AGE	SOCIAL SECURITY #

HOME ADDRESS STREET	APT. NO	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	MARITAL STATUS
( )	( )	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED

EMPLOYED NAME AND ADDRESS	WERE YOU REFERRED BY A PHYISIAN
	☐ YES ☐ NO IF SO, WHO: _____

CURRENT PROBLEM	HOW DID YOU HEAR ABOUT OUR PRACTICE	PRIMARY CARE PHYSICIAN AND/OR REF. DR.

REASON FOR VISIT

DATE OF INJURY/SYMPTOMS FOR THIS PROBLEM.	WORK RELATED	AUTO ACCIDENT
	☐ YES ☐ NO	☐ YES ☐ NO

WERE YOU TREATED FOR THIS PROBLEM AT HOSPITAL ☐ YES ☐ NO	NAME OF HOSPITAL	WERE X-RAYS TAKEN FOR THIS PROBLEM ☐ YES ☐ NO WHERE _____

DATE PHYSICIAN FIRST CONSULTED FOR THIS PROBLEM _____	NAME OF YOUR ATTORNEY – IF APPLICABLE

IN CASE OF EMERGENCY CONTACT:	PHONE NUMBER(S)

SPOUSE/GUARANTOR INFORMATION

SPOUSE/GUARANTOR (IF PATIENT IS A MINOR)	HOME PHONE	WORK PHONE
	( )	( )

HOME ADDRESS STREET	APT. NO	CITY	STATE	ZIP CODE

PATIENT'S RELATIONSHIP TO GUARANTOR: ☐ SELF ☐SPOUSE ☐DEPENDENT CHILD ☐OTHER_____	SOCIAL SECURITY #	BIRTHDATE

EMPLOYED NAME AND ADDRESS	

INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH

SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO GUARANTOR: ☐ SELF ☐SPOUSE ☐DEPENDENT CHILD ☐OTHER_____

INSURANCE ID NO (Member/Certificate)	GROUP NO.	PLAN NO.	EFFECTIVE DATE
			From _____ TO _____

SECONDARY MEDICAL INSURANCE COMPANY

INSURANCE COMPANY NAME	SUBSCRIBER NAME (The primary name in which the insurance policy is held)	SEX	SUBSCRIBER DATE OF BIRTH

SOCIAL SECURITY #	PATIENT'S RELATIONSHIP TO GUARANTOR: ☐ SELF ☐SPOUSE ☐DEPENDENT CHILD ☐OTHER_____

INSURANCE ID NO (Member/Certificate)	GROUP NO	PLAN NO	EFFECTIVE DATE
			From _____ TO _____

_____ _____ _____

PATIENT/GUARANTOR SIGNATURE WITNESS DATE

The Orthopaedic Center for
FOOT AND ANKLE RECONSTRUCTION
100 Kingsley Lane, Suite 300, Norfolk, Virginia 23505 Phone: 757-889-6580 Fax: 757-889-6583

I HEREBY CONSENT TO TREATMENT by the Physicians of The Orthopaedic Center for Foot and Ankle Reconstruction (OCFAR), their associates and/or assistants and accept responsibility for fees for such medical services. I understand that treatment may include x-rays, injections, medical appliances, and/or such other procedures as deemed necessary by the physicians at OCFAR.

I understand that the payment of copays at the time of service sis required by my insurance company and expected by OCFAR and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not covered by my insurance. I further understand that if a balance exists on my account at the time of any litigation settlement relating to injuries for which I am being seen, my account with this practice will be the first bill paid and paid in full at the time of the settlement. **Should collection actions become necessary, I understand that I will be liable for any and all costs, including a fifty percent fee for placement with collections, interest at the rate of eighteen percent per annum from the date of treatment, and any attorney fees associated with collecting the unpaid balance owed on my account.**

I hereby authorize the release of any information necessary for filing of any insurance and authorize the assignment of all payments for medical services, for myself or my dependent, to the physicians of OCFAR. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A copy of this authorization shall be considered as effective and valid as the original. I will advise OCFAR of any changes in insurance coverage. Failure to provide proper notice of insurance that result in denial for timely filing will result in my being responsible for the entire balance.

I also authorize OCFAR to speak with and exchange information with other medical professionals regarding my medical condition and treatment. These medical professionals may include, but are not limited to: physical therapists, occupational therapists, athletic trainers, nurses, physician's assistants, rehabilitation specialists, case workers, primary care physicians, referring physicians, and nurse practioners.

I understand that as a condition of my treatment at OCFAR, in the event litigation is required in this case, neither the physician nor the office staff will be available to appear in court. Conferences and/or depositions are scheduled.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

I agree to pay a fee of $25.00 for any check that is returned to the practice for insufficient funds.

I agree that I may be charged and I will pay a $50 fee for any appointment I do not keep without at least 24 hours notice of cancellation.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness

THE ORTHOPAEDIC CENTER FOOT AND ANKLE RECONSTRUCTION

AUTHORIZATION TO **OBTAIN** PROTECTED HEALTH INFORMATION

**** Please Note:** all of the following information must be completed in order to process this request.

_____ _____

Print Patient's Full Name Birth Date (Mo/Day/Yr)

_____ _____

Street Address Social Security Number

_____ _____

City, State, Zip Code Phone Include Area Code

I, _____, authorize the facility named below,

_____

_____

to release my medical records as marked below, dates of ALL, to:

The Orthopaedic Center for Foot and Ankle Reconstruction
100 Kingsley Lane, Suite 300
Norfolk, VA 23505
Phone: (757) 889-6580 / Fax: (757) 889-6583

____ All clinical notes, except _____ ____ All medical reports, except_____

_____ _____

____ All clinical notes, except _____ ____ All medical reports, except_____

_____

Purpose of Disclosure: _____ medical treatment / continuing care

_____ other (please list) _____

_____

I, _____, authorize disclosure of protected health information on the above named patient. This authorization is valid for 6 months from the date signed. I understand I can revoke this authorization with written notification, but that it will not affect any information previously released prior to the notice of cancellation. I understand the information disclosed may be subject to re-disclosure by the person, persons or facility receiving and would no longer be protected by federal regulations. I understand the medical provider to whom this authorization is furnished may not condition its treatment on me on whether or not I sign the authorization.

Signed:_____ _____ _____

Patient or Responsible Party Date Witness

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(757)889-6580 Fax (757) 889-6583

HIPAA NOTICE OF PRIVACY PRACTICES

THIS INFORMATION 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 of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TP) for purposes permitted that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your PHI may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI as necessary, to a home health agency that provides care to you. For another example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

HEALTH CARE OPERATIONS

We may disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

PLEASE TURN PAGE OVER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of the HIPAA notice of privacy practices and understand that protected health information may be released to other healthcare providers, hospitals, insurance companies, etc. as outlined in the privacy policy.

In general, the HIPAA's privacy rule gives individuals the right to request a restriction on uses and discloses on their protected health information. The individual is also provided the right to request confidential communications.

I wish to be contacted in the following manner:

Home/Cell Phone _____
Authorized to leave a message **Y / N**

Work Phone _____
Authorized to leave a message **Y / N**

May we release information to your family? **Y / N**

Please list any family members that we may release information to:

_____

_____

_____

Please list any family members that we **SHOULD NOT** release information to:

_____

_____

_____ _____
Signature Date