First Settlement Orthopaedics
Patient Information Sheet

First Name: ____________________ **Middle:**________________ **Last Name:**____________________

Email Address____

Sex: Male / Female **Marital Status:** ___________

Date of Birth: _________ **Social Security #** _______________ **Student:** ___Yes ___No

Race: (circle one below)

American Indian/Alaska Native
Asian
Black/African American
Declined
Native Hawaiian/Pacific Islander
Other Race
White/Caucasian

Ethnicity: (circle one below)

Declined
Hispanic or Latino
Not Hispanic or Latino

Address:_______________________________ **City:**________________ **State:**_____ **Zip Code:**______

Home Phone: _________________ **Cell Phone:**___________________ **Work #:**___________________

Emergency Contact Name _________________________________**Phone #**_________________

Preferred Pharmacy: ______________________________ **City:** _________________ **State:** ________

Workers Comp: _____ **Yes** ______**No** **Date of injury:** ____________________

Employer Information:

Name: ________________________ **City:** _____________________ **State:** _____ **Zip Code:** _______

Position: ______________________ **Status:** Full-Time Part-Time **Employer Phone:** _______________

Insurance Information:

Primary Insurance Plan:________________________ **Policy #:** _______________________________

Group # (if applicable): _________________________ **Policy Holder:** ___________________________

Policy Holder Name: ________________ **DOB:** ________________ **SSN:** _____________________

Person Responsible for Payment: __________________________

Secondary Insurance Plan:_______________________ **Policy #:** _______________________________

Group # (if applicable): _________________________ **Policy Holder:** ___________________________

Policy Holder Name: ________________ **DOB:** ________________ **SSN:** _____________________

Revised 10/20/2014

FIRST SETTLEMENT ORTHOPAEDICS
FINANCIAL AUTHORIZATION

Claims Authorization for All Patients

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical facility to furnish any and all records pertaining to medical history, services rendered, or treatment given to me or my dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s).

I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer or an insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

Additional Authorization for Medicare Policyholders

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Assignment of Benefits

I authorize payments of medical and surgical benefits to be made on my behalf to my physician(s) in this office. I also understand I am fully responsible for this bill if the insurance co. either denies or neglects the amount due.

DATE: ______________

PATIENT / RELATIVE/ GUARDIAN

SIGNATURE: ______________________________________

PRINT NAME: ______________________________________

RELATIONSHIP TO PATIENT: ______________________________

First Settlement Orthopaedics, Inc.

Orthopaedic Surgery & Sports Medicine

Orthopaedic Surgery
& Sports Medicine

G.B. Krivchenia, M.D.
1929 - 2011
Gary W. Miller, M.D.
G.B. Krivchenia II, M.D.
Jesse R. Ada, M.D.
Naresh K. Nayak, M.D.
John S. Henry, M.D.
George Tokodi, D.O.
Jason L. Gessel, D.O.
Jacob B. Smith, D.O.
Angie Miller, O.N.P.C., F.N.P.C.

611 Second Street
Marietta, OH 45750
740-373-8756
740-373-0091 fax

809 Farson Street
Suite 106
Belpre, OH 45714
740-373-8756
740-373-0091 fax

MOV Medical Complex
800 Grand Central Mall
Suite 6
Vienna, WV 26105
740-373-8756
740-373-0091 fax

3 Benjamin Dr.
New Martinsville, WV
740-373-8756
740-373-0091 fax

Serving Ohio and West Virginia in these locations:

Belpre, OH
Marietta, OH
Athens, OH
Vienna, WV
New Martinsville, WV
Ripley, WV
Spencer, WV

Patient Name (printed) ____________________ Date of Birth ___/___/____

Commitment to Appointment

We reserve time for each patient in our practice. An appointment written in our schedule with your name in it is a bond of trust that we will be here to serve you and you will be present for treatment. Therefore, our office policy in this regard is extremely firm and inflexible. If you do not show for your appointment, there will be a $20.00 charge added to your account. Following three (3) missed appointments, you will be sent a letter of discharge from our practice.

Your signature below indicates that you understand this policy and will call and cancel if you are unable to keep your scheduled appointment.

Patient/Representative Signature: ______________________________

Date: ____________________

E-Prescribing PBM Consent Form

E-prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing this consent form you agree that First Settlement Orthopaedics can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient/Representative Signature: ______________________________

Relations if other than Patient: ______________________________

Date: ____________________

First Settlement Orthopaedics

Authorization for Use or Disclosure of Protected Health Information

I, ____, authorize First Settlement
(Patient Name)

Orthopaedics staff to discuss the following with ____
(Name)

____ (parent, spouse, child, other)
(Relationship)

Please check the following that apply:

_______ Appointment information (leave message on machine or with person answering)

_______ Prescriptions

_______ Discuss Diagnosis

_______ Laboratory and/or X-ray results

_______ Question regarding treatment

_______ Billing/Insurance questions

_______ Other

____ ____________________________
Signature Date

____ ____________________________
Witness Date

This Authorization expires one year from the date it was signed unless terminated before that time by the patient.

Bone Density Criteria

Degeneration of bones can make fractures occur easier and more often. Your insurance company may pay for a bone density scan to test your bone strength if you meet certain criteria. Medicare and most insurances will cover bone density scans every 2 years to assess risks, which could lead to premature fractures.

This screening is required by most insurances prior to a bone density being ordered.

If you answer yes to one or more of these questions you may want to ask your physician about ordering a Bone Density test.

Y **N** Are you a female age 65 and older?

Y **N** Are you a male age 65 and older?

Y **N** Did you go through menopause before age 45?

Y **N** Are you a female 50 years old with a mother, father, sister or grandmother with osteoporosis?

Y **N** Have you had a fall within the last 12 months?
How many?______________
What was the cause of the falls?____

Y **N** Did any of the falls result in an injury?
What was the injury?__________________________________

Y **N** Do you use thyroid medications, steroids, or progestin (such as Depo Provera) ?
How Long have you been taking these medications?__________________

Y **N** Are you a woman with the following risk factors; Caucasian, Asian, small body frame, smoker?

Y **N** Have you ever had a Bone Density test?
If yes, date of the test?____________

Y **N** Were you diagnosed the osteoporosis?

Y **N** Has anyone spoken to you regarding calcium,vitamin D intake, and exercise for treatment of osteoporosis?

Y **N** Are you taking a calcium or vitamin D supplement for osteoporosis?
What medication are you taking?_________________________________

Y **N** Do you routinely exercise?

_________I am aware that I meet some of the required criteria to qualify for a bone density screening, I am not interested in a screening at this time.

Patient Name____**Date**____________

PATIENT MEDICAL HISTORY
FIRST SETTLEMENT ORTHOPAEDICS, INC

Date of Birth: __________ **Sex:** ○ Male ○ Female **Age:** ________ **DATE:** ____________
Patient's Name: ____________________________ **Height:** ________ **Weight:** ________
Primary Care Doctor: ____
Did they refer you? ○ Yes ○ No-who referred you? ___________________________________
Body part to be examined: ○ Left ○ Right ○ Both ____________________________________
What is the problem? ____
Date of Injury/Onset: __________________ **Dominant Hand:** ○ Left ○ Right
How did this happen? ____
Where did this happen? ____
Describe the pain: ○ Sharp ○ Stabbing ○ Locking ○ Clicking ○ Other: __________________
When does it occur? ○ All the time ○ Daytime ○ Nighttime ○ Mornings ○ With activity
Rate the Severity: ○ Mild ○ Moderate ○ Severe
Have you had PT or a home exercise program for this problem: ○ Yes ○ No
How long and when? ____
Have you been seen anywhere else for this or a similar problem? ○ Yes ○ No
If yes, please state: When: ____________ **Where:** ______________ **By Whom:** _______________
Were x-ray/MRI films taken? ○ Yes ○ No If yes: **When:** ________ **Where:** __________________

IS THIS A WORK RELATED PROBLEM? ○ Yes ○ No If Yes: **Was injury reported to employer?** ○ Y ○ N
Employer Contact Person: __________________________ **Phone #:** ______________
Are you presently working? ○ Y ○ N- **How long have you been off work?** ________________

ORTHOPAEDIC REVIEW

Please mark any of the following conditions you have had or now have:

○ **None** ○ Gout ○ Neck Pain ○ Osteoporosis ○ Rheumatoid Arthritis ○ Knee Arthroscopy
○ Arthritis: Where _________________ ○ Total Joint Replacement: Where __________
○ Bone Infection: Where ______________ ○ Bursitis: Where __________________
○ Loss of joint motion: Where __________ ○ Rotator Cuff Repair: ○ Left ○ Right
○ Vertebral Fracture: Where ___________ ○ Back Surgery: Where______________
○ Dislocated Joint: Where ____________ ○ Fractured Bone: Where _______________
○ Tendonitis: Where ________________ ○ Torn cartilage/meniscus: Where __________
○ Torn Muscle: Where ______________
○ Metal implants/plates/clips/screws: Where ________________________________
○ Other: ____

PAST MEDICAL HISTORY
CHECK ALL THAT APPLY TO YOU

○ Anemia/low blood count ○ Gallbladder Problems ○ Jaundice ○ Prostate Disease
○ Anxiety/panic attacks ○ Heart Attack ○ Kidney Disease ○ Seizures/Epilepsy
○ Asthma ○ Hepatitis ○ Liver Disease ○ Stent Placement
○ Blood Clots (phlebitis) ○ Hiatal Hernia ○ Low Blood Pressure ○ Stomach Ulcers
○ Bronchitis ○ HIV/AIDS ○ Migraines ○ Stroke
○ Colitis ○ High Cholesterol ○ Mitral Valve Prolapse ○ Thyroid Problems
○ COPD ○ High Blood Pressure ○ Pancreatitis ○ Tuberculosis
○ Emphysema ○ Irregular Heartbeat ○ Pneumonia
○ Insulin-Dependent Diabetes ○ Non-Insulin Diabetes
○ Cancer Type: ___________________ ○ Other: ________________________

*********PLEASE TURN PAGE OVER*******

PAST SURGICAL HISTORY

○ None	DATE OF SURGERY		DATE OF SURGERY
○ Angioplasty	______	○ Hernia Repair	______
○ Appendectomy	______	○ Organ Transplant	______
○ Breast Surgery	______	○ Oral Surgery	______
○ Cardiac Surgery	______	○ Tonsil/adenoidectomy	______
○ Cesarean Section	______	○ Thyroid Surgery	______
○ Gallbladder Surgery	______	○ Other ______	

CURRENT MEDICATIONS

(NAME, STRENGTH, DOSAGE & INCLUDE HERBS/VITAMINS/MINERALS/ANTI-INFLAMMATORIES)

____

____

____

____

PAIN MEDICATIONS

Med/Strength/Dosage: ______ **Prescriber:** ______

Med/Strength/Dosage: ______ **Prescriber:** ______

Med/Strength/Dosage: ______ **Prescriber:** ______

ALLERGIES

List any medications, latex, metals, or foods you are allergic to and the reaction.

○ None ○ Latex Reaction: ______ ○Jewelry or Metal Sensitivity Reaction: ______

OTHERS NAME and Reactions: ______

PAST FAMILY HISTORY

Check all that apply to IMMEDIATE family members and list what family member:

Father/Mother/Paternal Grandparent/Maternal Grandparent/Brother/Sister/Son/Daughter/Aunt/Uncle

○ Bleeding Disorder Who? ______	○ High Cholesterol Who? ______
○ Blood Clots Who? ______	○ Low Blood Pressure Who? ______
○ Cancer Type: ______ Who? ______	○ Osteoporosis Who? ______
○ Diabetes Who? ______	○ Rheumatoid Arthritis Who? ______
○ Heart Disease Who? ______	○ Vascular Disease Who? ______
○ High Blood Pressure Who? ______	○ Other______ Who? ______

SOCIAL HISTORY:

Have you ever used tobacco products? ○Y ○N If yes, how much per day? ______

If yes, when did you start? ______ If you have stopped, when did you stop? ______

Do you drink alcohol? ○Y ○ N If yes, how many drinks per week? __ When did you start? ______

Drug Abuse? ○Y ○N If yes, please describe: ______

What kind of treatment did you receive? ______

Marital Status: ○ Married ○ Single ○ Widowed ○ Separated ○ Divorced

Are you currently employed? ○Y ○N Occupation: ______

I hereby certify by my signature that medical information given on this form is correct and complete to the best of my knowledge.

______________________ ______________

Patient's Signature Date