

PATIENT INTRODUCTION (PAGE 2)

Insurance coverage information (primary)

Subscribers Name _____ Date of birth _____

BWC Medical Mutual Anthem UHC Medicare Other _____

Certificate _____ Group no. _____

Industrial case: Date of injury _____ Self insured _____ Claim # _____

MCO: _____ Group no. _____

Insurance coverage information (secondary)

Subscribers Name _____ Date of birth _____

BWC Medical Mutual Anthem UHC Medicare Other _____

Certificate _____

PAYMENT AUTHORIZATION

I AUTHORIZE DAYTON ORTHOPAEDIC SURGERY 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 DAYTON ORTHOPAEDIC SURGERY BE PAYABLE TO, SENT TO DAYTON ORTHOPAEDIC SURGERY.

I REALIZE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THESE CHARGES AND THE BALANCE NOT COVERED BY MY INSURANCE WILL BE MY RESPOSIBILITY.

Acknowledgement

Patient's Full Name: _____

Email address: _____

Signature: _____ Date _____

Centerville Office (Main)
5491 Far Hills Ave.
Dayton, OH 45429
937-436-5763
937-436-7399 Fax

North Dayton Office
7271 N. Main St.
Dayton, OH 45415
937-436-5763
937-436-7399 Fax

Springfield Office
2330 E. High St.
Springfield, OH 45505
937-436-5763
937-436-7399 Fax

West Chester Office
4936 Wunnenberg Way
West Chester, OH 45069
937-436-5763
937-436-7399 Fax



PATIENT INTRODUCTION (PAGE 1)

Patient information

Name _____ Date _____
 Male Female Age _____
 Address _____ City _____ St _____ ZIP _____
 Ht _____ Wt _____ Birth date _____ SS# _____ Telephone _____
 (circle one) Married/ Single/ Widowed/ Divorced Have you been treated here before? No Yes
 Family physician _____ Referred by _____
 Address _____ Address _____

Employment information

Company _____ Telephone _____
 Address _____ City _____ St _____ ZIP _____
 Type of work _____ Contact person _____

Spouse information

Name _____ DOB _____ Age _____
 Address _____ City _____ St _____ ZIP _____
 SS# _____ Telephone _____ Employer _____

Responsible party information

Name _____ Age _____ *if same as patient check here*
 Address _____ City _____ St _____ ZIP _____
 SS# _____ Telephone _____ Birthdate _____
 Employer _____ The patient is my _____

Centerville Office (Main)
5491 Far Hills Ave.
Dayton, OH 45429
937-436-5763
937-436-7399 Fax

North Dayton Office
7271 N. Main St.
Dayton, OH 45415
937-436-5763
937-436-7399 Fax

Springfield Office
2330 E. High St.
Springfield, OH 45505
937-436-5763
937-436-7399 Fax

West Chester Office
4936 Wunnenberg Way
West Chester, OH 45069
937-436-5763
937-436-7399 Fax

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

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: _____

Are you on blood thinners? Yes No

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

Patient/Responsible Party signature: _____ **Date:** _____

Provider Signature _____