SIGNATURE ORTHOPEDICS

Date: ___________ □ New Patient □ Update

Referred to this Office by: □ Patient □ Physician □ ER (Hospital) Name of Person/Hospital:______________

Patient's name (Last, First MI)__________________________________DOB_____________ Age___ Sex ____

Patient Email_______________________ SSN_____________ Marital Status __ Spouse's Name_____________

Patient Address _______________________________ City______________________ State ___ Zip__________

Home Phone____________________ Cell Phone______________________ Work Phone___________________

Patient's Employer:____________________ Employer's Address: ______________________________________

PARTY RESPONSIBLE FOR BILL (AND SPOUSE) IF OTHER THAN PATIENT

Both Parents, if patient is a minor (under 21)

Name (Last, First MI)__________________________Relationship________SSN_______________ DOB______

Address______________________ City_____________ State __ Zip_____ Phone #__________ Work #______

Employer's name_____________________ Employers Address____

Name (Last, First MI)__________________________Relationship________SSN_______________ DOB______

Address______________________ City_____________ State __ Zip_____ Phone #__________ Work #______

Employer's name_____________________ Employers Address____

INSURANCE INFORMATION: PLEASE HAVE INSURANCE CARD(S) AVAILABLE TO COPY

Primary Insurance____ Effective Date______________________

ID#__________________________________ Group #____

Subscriber Full Name__________________________________ Subscriber SSN________________DOB_____

Secondary Insurance____ Effective Date____________________

ID#__________________________________ Group #____

Subscriber Full Name__________________________________ Subscriber SSN________________DOB_____

Other Insurance____ Effective Date______________________

ID#__________________________________ Group #____

Subscriber Full Name__________________________________ Subscriber SSN________________DOB_____

INJURY REPORT/NATURE OF INJURY

□ Worker's Comp □ Recreational □ Auto □ Home □ Other □ Date of Injury________

SIGNATURE ORTHOPEDICS - SIGNATURE MEDICAL GROUP

PATIENT REGISTRATION CONSENT & ACKNOWLEDGMENTS

CONSENT TO TREAT

I consent to Signature Medical Group (SMG) physicians, practitioners, and other providers ("provider"), their assistants and staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for the patient below. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the attending Provider of any decision to terminate treatment. I agree to provide at least 24 hours notice prior to canceling an appointment and understand that failure to provide notice may result in a cancellation fee. In the event of an emergency while receiving care at SMG, I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical condition.

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG, I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's Payment Policies provided with this form. I acknowledge that I will be responsible for payment of legal and collection fees in addition to the outstanding balance should SMG refer my account to an outside agency for collection.

RELEASE OF INFORMATION/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to SMG's release of the patient's protected health information (PHI) for treatment, payment and operations purposes in accordance with HIPAA. I acknowledge that SMG may release medical records and PHI to the third-party health plan or payer, including Medicare, Medicaid, health insurer, HMO, or other company or program that arranges or pays for the cost of some or all of the patient's health care. SMG may also release PHI to other health care providers involved in treating the patient including physicians, hospitals, laboratories, pharmacies and others. I have been provided with SMG's Notice of Privacy Practices that further describes the uses and disclosures of certain PHI by SMG. To facilitate treatment or payment, including communication of appointment reminders, prescriptions/refills, laboratory results and other information, I consent to SMG sharing PHI with the following individuals:

Full Name___________________________________Relationship____________________Phone #__________________
Full Name___________________________________Relationship____________________Phone #__________________
Full Name___________________________________Relationship____________________Phone #__________________

Initial all applicable information:

___Medical/Treatment/PHI including retrieval of medical records and prescription refills
___Lab/Ancillary Testing/Radiology/MRI/Imaging Results
___Billing/Insurance Information
___Authorized to leave message on voicemail or by other designated communication systems
___Other, Describe____

ADVANCE DIRECTIVES FOR HEALTH CARE (*Living Will/Healthcare Directive, Durable Power of Attorney for Healthcare*)

(If applicable to the practice setting, patient to initial appropriate statement):

____The patient does NOT have an Advance Directive
____The patient has the following Advance Directive(s): ____
____
and will provide a copy to the attending SMG physician practice

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Print Patient's Full Name _______________________________________Patient DOB_______________________

Print Name of Legal Guardian ___________________________________Relationship to Patient____________________

Signature & Date Signed _______________________________________Witness to Signature______________________

PAYMENT POLICIES
SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to automated payment card payments by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. **The patient/responsible party or guarantor signing below (“you”) must provide us with the patient’s current and correct medical coverage/insurance/health plan (“health plan”) or other responsible third-party payor.**
2. **You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).**
3. **You are responsible for paying any deductibles, co-payments, non-covered services or other costs not covered by the health plan.**
4. **Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of parental custody, divorce or separation terms.**
5. **WORK RELATED INJURIES:**
    a. **If the patient’s employer has approved treatment, you will not be charged or billed.**
    b. **If the patient’s employer does not approve treatment and <u>YOU SELECT US FOR YOUR TREATMENT</u>, you may be billed and you may be responsible for payment of services not approved by the employer.**
6. **If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.**
7. **We file group health plan claims and by law, must file Medicare claims.**
8. **If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your bill.**

We expect payment in full at time of service for all charges which are not covered by the patient’s health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: ___________________________________/Date of Birth: _________________

Print Guarantor Name & Relationship to Patient: ____

Signed: ____/Date: __________________
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): ____

SIGNATURE ORTHOPEDICS
INITIAL MEDICAL EVALUATION

Name:______________________________ Age:_______ Date:______________

Which is your dominant hand? ☐ Right ☐ Left Gender: ☐ Male ☐ Female Height______ Weight_______

Work status: (check one) ☐ Working ☐ Retired ☐ Student ☐ Disabled ☐ Other ____________________

Occupation______________________Employer______________________________

Who referred you to our clinic? ☐ Self ☐ Friend ☐ Physician Name: _________________________

Name of your Primary Care Physician: ____

Reason for Visit/Chief Complaint: Please describe injury/complaint and how long condition has been present:

____

____

Date of onset injury/symptom ______________ Is this work related? ☐ YES ☐ NO Has it been reported? ☐ YES ☐ NO

Have any x-rays or tests been performed ☐ YES ☐ NO Date____________ Facility Name ___________________

Name of tests: ____

Past Medical History (Please check all that apply) ☐ **NO PAST MEDICAL HISTORY**

- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  Specify type:______________
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Crohn's disease
- ☐ Coronary Artery disease
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Elevated Lipids (high cholesterol)
- ☐ Fibromyalgia
- ☐ Fracture
- ☐ Gout
- ☐ Headache/Migraine
- ☐ Hepatitis/liver disease
- ☐ HIV
- ☐ High Blood Pressure
- ☐ Inflammatory bowel disease
- ☐ Lyme disease
- ☐ Myocardial infarction (heart attack)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Peptic Ulcer disease
- ☐ Psoriasis
- ☐ Renal disease (kidney disease)
- ☐ Scoliosis
- ☐ Seizure disorder
- ☐ Sleep Apnea
- ☐ Spinal Stenosis
- ☐ Spondyloarthopathy (Spondyloarthritis)
- ☐ Stroke
- ☐ Systemic lupus erythematosus (Lupus)
- ☐ Thyroid disease
- ☐ Vascular disease
- ☐ Other Medical Problems:
  ____
  ____
  ____
  ____
  ____

Reviewed Initials & Date
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Please list the name of the physician who is treating you for any of the following conditions: Diabetes, peripheral neuropathy, atherosclerosis of the arteries in your extremities, Buerger's disease, cardiology or chronic thrombophlebitis.

Name__________________________ Location____________________ Date last seen______________

Past Surgical History (Please specify TYPE of surgery, DATE of surgery and left, right, etc.): ___________________

____

____

____

Current Medications & dosage (if known): ☐ **NO Medications** *If you brought a list, please ask us to make a copy.*

____

____

____

____

____

Allergies: (Please name substance and reaction) ☐ **NO Known Allergies**

Known DRUG allergies ____

Known FOOD allergies ____

Known METAL allergy: ☐ Yes ☐ No Known LATEX allergy: ☐ Yes ☐ No

Relevant Family History: ☐ **Adopted - no family history known**

Relative	Alive	Deceased	Heart Disease	Cancer *(Specify type)*	Diabetes	High Blood Pressure	Renal disease	Thyroid disease
Father								
Mother								
Brother(s)								
Sister(s)								
Maternal Grandfather								
Maternal Grandmother								
Paternal Grandfather								
Paternal Grandmother								

Social History:

General Education: ☐ High School (If local, list name) ______________________ ☐ College ______________________

☐ Post graduate or other ____

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

Tobacco use: ☐ Yes ☐ No _____ Packs per day for _____ years Quit: ☐ Yes ☐ No Age when quit: _________

Alcohol use: ☐ Yes ☐ No Frequency/Amount: ____

Other substance use: ____

Work demands: ☐ Sedentary ☐ Moderate activity ☐ Heavy Labor

Do you exercise regularly? ☐ Yes ☐ No Describe: ____

What sports or activities do you participate in? ____

PATIENTS 65 YEARS AND OLDER:

Have you had any falls in the last year? ☐ Yes ☐ No *IF YES*, Number of falls: ____________

Did the fall(s) result in injury? ☐ Yes ☐ No *IF YES*, Details: ____

Do you use an assistive device (walker, cane, wheelchair, etc.)? ______________________________________

Have you ever received a Pneumonia vaccine? ☐ Yes ☐ No *IF YES*, what month/year? ______________________

Current Medical Status/Review of Systems: Please circle any you have had recently

Fatigue	Chest Pain	Poor coordination
Fever	Leg swelling	Muscle weakness
Night sweats	Irregular heartbeat	Seizures
Weight gain	Constipation	Tremors
Weight loss	Diarrhea	Anxiety
Blurred vision	Loss of Appetite	Depression
Double vision	Nausea	Insomnia
Headache	Vomiting	Rash
Ringing in ears	Painful urination	Skin Infections
Vertigo	Blood in urine	Skin lesions
Vision loss	Cold intolerant	Bleeding
Asthma	Heat intolerant	Bruising
Cough	Difficulty walking	Environmental allergies
Labored breathing	Dizziness	Food allergies

Pharmacy Name: ____________________________________ **Pharmacy Ph#:** _____________________________

Pharmacy Address: ____________________________________

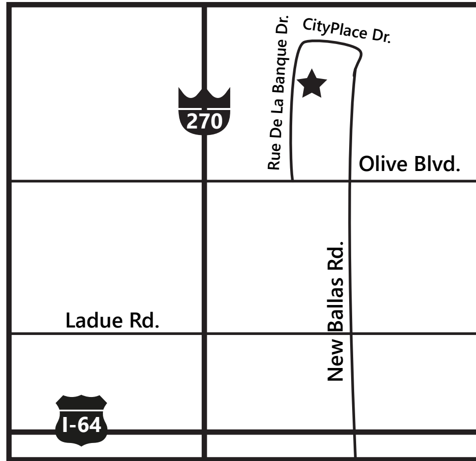
Name of person supplying information____Date:_____________

Signature: ____

Signature Orthopedics

Signature Orthopedics - West County

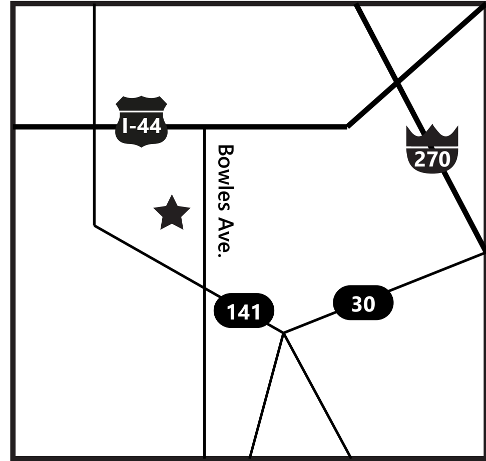
845 N. New Ballas Ct., Suite 200
St. Louis, MO 63141
314.983.4700



If you are traveling south on 1-270, exit Olive Boulevard, exit #14. Turn east, or left, onto Olive Boulevard to the second stop light and turn left onto Ballas Road. Go to the first stop light and turn left onto CityPlace Drive. Go to the first stop sign and turn left onto Rue De La Banque Drive to the parking garage entrance on your immediate left. Continue up the garage to Level 2 (green level) to park. The parking garage entrance on Level 2 will bring you to the second floor.

Signature Orthopedics - Fenton

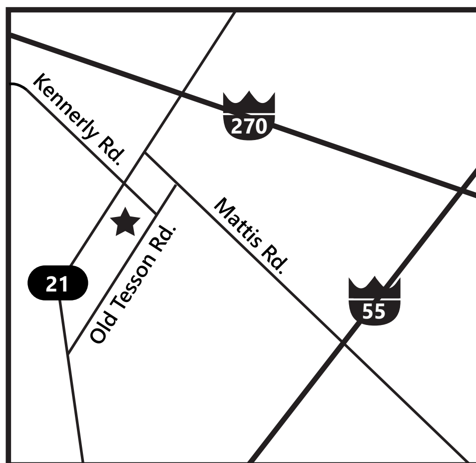
1011 Bowles Ave., Suite 100
Fenton, MO 63026
314.849.0311



If you are traveling east on I-270 S, exit I-44/US-50 W, exit #274A. Merge onto I-44/US-50 W, and take the Bowles Avenue exit on the right. Stay in the middle lane to turn left onto Bowles Avenue at the first stoplight. After turning left, stay on Bowles Avenue until you see SSM St. Clare hospital on the right. Turn right, pass the emergency room and continue on the road until you see the St. Francis building. There is a free parking lot in front of the St. Francis building. Once you walk into the St. Francis building, we are the first suite on the right (Suite 100).

Signature Orthopedics - South County

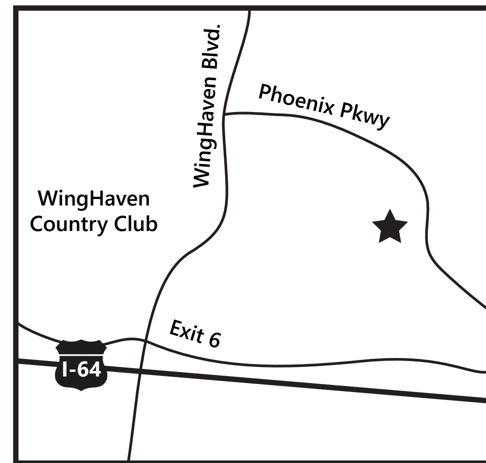
12639 Old Tesson Rd., Suite 100 & 115
St. Louis, MO 63128
314.849.0311



If you are travelling south on I-270, exit on Tesson Ferry Rd. and turn right. Drive 2 lights to Kennerly Road and turn left. Go one block to the stop sign and turn right onto Old Tesson Rd.

Signature Orthopedics - O'Fallon

9323 Phoenix Village Parkway
O'Fallon, MO 63368
314.983.4700



If you are traveling west on I-64/US-40, exit at Winghaven Boulevard, exit #6. Turn north, or right, onto Winghaven Boulevard and go to the third stoplight and turn right onto Phoenix Parkway, which is just past Hammock Court. Take the first right onto Phoenix Village Parkway and the office will be on your left.

SPINE PATIENT QUESTIONNAIRE

Date: ____________________

Patient Name: ______________________________________ Date of Birth: _________________________________

Height: _______ Weight: _______ Gender: ☐ Male ☐ Female Race and Ethnicity: _______________________

Phone: __________________________________ Email: ____

Pharmacy: ____________________________________ Pharmacy Phone: _________________________________

Preferred Language: ____

Primary Care Physician: ______________________________ Primary Care Physician Phone: __________________

Referring doctor's name and phone: ____

If you were not referred, how did you choose this clinic? ____

Please describe your main complaint (check all that apply):

☐ Neck pain ☐ Back pain ☐ Arm: ☐ pain ☐ numbness ☐ weakness ☐ Leg: ☐ pain ☐ weakness ☐ numbness ☐ Other: ____________________

How long has the pain/problem been present?____

Has your problem worsened recently? ☐ No ☐ Yes If yes, how recent?_____________________________________

What started the pain/problem? ____

What makes the pain/problem worse? ☐ Sitting ☐ Standing ☐ Other: _______________________________

What makes the pain/problem better? ☐ Sitting ☐ Standing ☐ Other: _______________________________

What distance can you walk before having symptoms or have to stop: _____ minutes, or _____ miles

Do you have to stop because of symptoms in your: ☐ legs ☐ back ☐ both ☐ neither

Is your pain/problem worse: ☐ when going uphill ☐ when going downhill

Is your pain/problem worse: ☐ when getting out of bed ☐ when trying to sleep

Coughing or sneezing increases the symptoms	☐ yes	☐ no
Straining with a bowel movement increases the symptoms	☐ yes	☐ no
I have suffered from a loss of bowel or bladder control	☐ yes	☐ no
I have missed work because of this problem	☐ yes	☐ no

Treatments have included:

	Neck	**Back**	
Physical therapy: exercise	☐	☐	
Narcotic medication	☐	☐	
Anti-inflammatory medications	☐	☐	
Epidural injections	☐	☐	times: ___________
Massage and ultrasound	☐	☐	
Trigger point injections	☐	☐	
Tens Unit	☐	☐	
Manipulation	☐	☐	

Other treatments: ____

☐ No medicines, therapy, manipulations, injections or braces

Because of this spine problem, I have filed or plan to file: ☐ A lawsuit ☐ A workers' compensation claim

List pain medicines and dose taken for this problem:

____

Previous doctors seen about this problem: ☐ None

PHYSICIAN AND SPECIALTY	CITY (IF NOT ST. LOUIS)	TREATMENTS

Tests done to evaluate your problem: ☐ None

TESTS	DATES	LOCATION OF TEST PERFORMED
Plain X-rays ☐ Neck ☐ Back		
Myelogram ☐ Neck ☐ Back		
Cat Scan ☐ Neck ☐ Back		
MRI ☐ Neck ☐ Back		
EMGs ☐ Neck ☐ Back		
Bone Scan ☐ Neck ☐ Back		

REVIEW OF SYSTEMS: Check all that apply.

☐ Chills
☐ Fever
☐ Frequent headaches
☐ Loss of hearing
☐ Heart or chest pain
☐ Frequent cough
☐ Difficulty breathing
☐ Recent weight change
☐ Swollen ankles
☐ Abnormal heartbeat
☐ Loss of consciousness
☐ Frequent constipation
☐ Frequent Diarrhea
☐ Poor appetite
☐ Nausea
☐ Vomiting
☐ Hemorrhoids
☐ Difficulty swallowing
☐ Painful/difficult urination
☐ Frequent urination
☐ Urinary incontinence
☐ Seizure
☐ Anxiety
☐ Depression
☐ Insomnia
☐ Frequent rash
☐ Bruising
☐ Other: ______________________

Is your primary doctor aware of the above checked problems? ☐ Yes ☐ No

MEDICAL HISTORY: Check all that apply.

☐ Blood clots
☐ Diabetes
☐ Kidney problems
☐ High blood pressure
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Sleep apnea
☐ Stroke
☐ Stomach ulcers
☐ Heart disease
☐ Cancer (Type: __________________)
☐ Pulmonary disease
☐ Other: ___________________________

SURGICAL HISTORY: List previous surgeries/procedures, surgeon and dates.

SURGERY	SURGEON	DATE

FAMILY HISTORY: ☐ No Relevant Family History ☐ Adopted

RELATIVE	HEALTH PROBLEM	CAUSE OF DEATH IF APPLICABLE
Mother		
Father		
Sister		
Brother		

CURRENT MEDICATIONS: ☐ None

MEDICATION NAME	STRENGTH/DOSE	PILLS PER DOSE	TIMES PER DAY

ALLERGIES TO MEDICATIONS: ☐ No Known Medication Allergies

MEDICATION NAME	REACTION

SOCIAL HISTORY:

1. Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced
2. Number of living children: ____________ # of sons: ________ # of daughters: ________
3. I live: ☐ alone ☐ with family ☐ with significant other
4. Employer and occupation: ____
5. Tobacco Use: ☐ Never ☐ I smoke ________ packs per day of cigarettes for ________ years
   ☐ I quit on date: ________ after smoking ________ packs per day for ________ years.
   ☐ Chewing tobacco ☐ Cigars: ________ per day ☐ Pipe smoker
6. Alcohol Use: ☐ Never or Rare ☐ Social ☐ Frequently (more than twice a week)
   ☐ Alcoholic ☐ Recovering alcoholic
   What type of alcohol do you drink and how often?______________________________
7. Drug overuse: ☐ Never ☐ Currently ☐ In the past

For Patients 65 years and older:

Have you had any falls in the last year? ☐ Yes ☐ No If yes, number of falls: ________________

Did the fall result in injury? ☐ Yes ☐ No

If yes, please provide details: ____

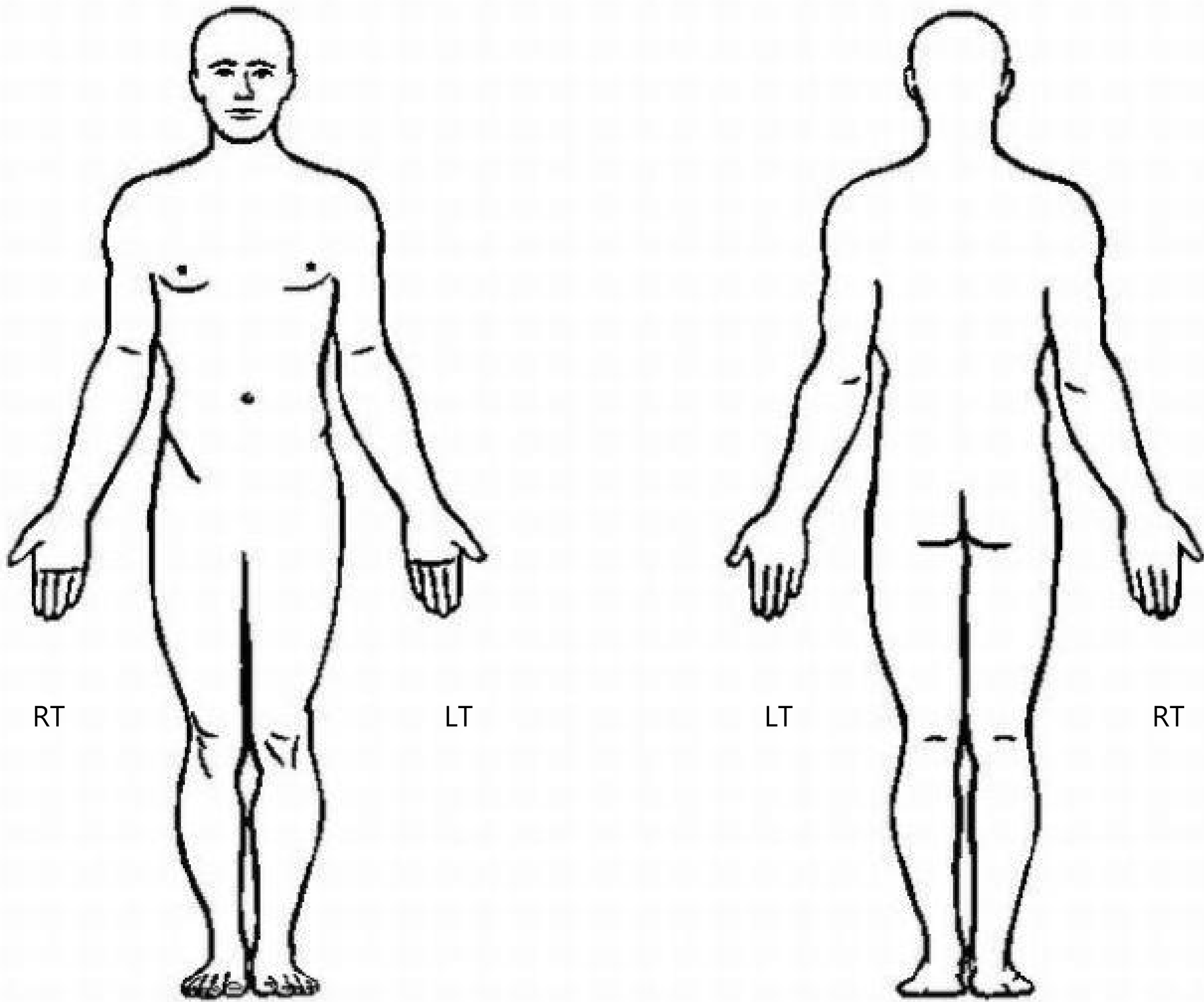
Have you ever had a pneumonia vaccination? ☐ Yes ☐ No If yes, approximate date: ________________________

Do you have an advance directive? ☐ Yes ☐ No

PAIN DIAGRAM:

On the diagram below, mark the areas on your body where you feel the described sensations. Mark the areas of radiation, include all affected areas. Use the appropriate symbols.

	= = = =		☐ ☐ ☐ ☐		/ / / /
NUMBNESS	= = = =	PINS & NEEDLES	☐ ☐ ☐ ☐	STABBING	/ / / /
	= = = =		☐ ☐ ☐ ☐		/ / / /



Mark your pain level:

No Pain					Moderate Pain					Worst Pain
0	1	2	3	4	5	6	7	8	9	10