NEBRASKA ORTHOPAEDIC CENTER

Date of Visit: _____

Patient #: _____

☐ New Patient ☐ Update

## Patient Information

Name: Mr./Mrs./Ms. _____
Last First Middle

Address: _____

Age: _____ Birthdate: _____ Sex: M F Marital Status: Single / Married / Divorced / Widowed

Social Security No: _____ Primary Phone: _____ Secondary Phone: _____

Email Address: _____

Race:
☐ Asian ☐ Black/African American
☐ Caucasian/White ☐ Hispanic
☐ Multi-Racial ☐ Other _____
☐ Decline to Answer

Ethnicity:
☐ Hispanic Origin
☐ non-Hispanic
☐ Decline to Answer

Language:
☐ English
☐ Spanish
☐ Other _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____

Spouse's Employer Address: _____

Name of Emergency Contact not living with you: _____

Relationship: _____ Primary Phone: _____ Secondary Phone: _____

Who Referred You? _____ Family Doctor: _____

## Medical Insurance Information

1) Primary Insurance: _____ Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____ City _____ State Zip _____

Relationship to Insured: _____ Policy ID #: _____ Group #: _____

Policy Holder's Social Security # ---------- _____ Policy Holder's Employer _____

2) Secondary Insurance: _____ Policy Holder Name: _____ DOB: _____

Policy Holder Address: _____ City _____ State Zip _____

Relationship to Insured: _____ Policy ID #: _____ Group #: _____

Policy Holder's Social Security # ---------- _____ Policy Holder's Employer _____

## Responsible Party (if patient is a minor)

Name: Mr./Mrs./Ms. _____
Last First Middle

Address: _____

Primary Phone: _____ Secondary Phone: _____

Employer: _____ Relationship to Patient: _____

## Patient Information

**Vitals**

Height: _____ ft _____ in  Weight _____lbs

**Race**

☐ African American ☐ Asian ☐ Caucasian ☐ Pacific Islander ☐ Other _____

**Ethnicity**

☐ Hispanic ☐ Non-Hispanic ☐ Other _____

**Preferred Language**

☐ English ☐ Spanish ☐ Chinese ☐ Other _____

**Preferred Pharmacy (address)**

_____

## How were you referred to our office?

☐ Physician ☐ Self-Referral ☐ Urgent Care/ ER ☐ Friend

If referred by a physician or Urgent Care/ER, please provide their name: _____

## Location of the problem

*Indicate the location of your primary complaint:*

Side of Body ☐ Left ☐ Right ☐Bilateral (both) Body Part: _____

**Location of the symptoms**

☐ Front ☐ Back ☐ Inside ☐ Outside ☐ Top ☐ Bottom

**Dominant Hand:**

☐ Right Hand ☐ Left Hand ☐Ambidextrous

## Injury History

*Please describe the onset of the symptoms?*

☐ **No injury** (gradual onset). If no injury, how long ago did the symptoms begin? _____

☐ **Injury**. Date of Injury (mm/dd/yyyy) _____ Please describe the injury _____

_____

☐ **Work Related Injury**. Date of Injury (mm/dd/yyyy) _____

Has a workers' comp claim been filed? ☐ Yes ☐No

Please describe the injury: _____

☐ **Auto Accident**. Date of Injury (mm/dd/yyyy) _____ Please describe the injury _____

_____

☐ **Sport Injury**. What sport were you playing? ☐ Football ☐ Basketball ☐Baseball ☐ Softball

☐ Soccer ☐ Hockey ☐ Gymnastics ☐ Tennis ☐ Golf ☐ Lacrosse

☐ Track/Field ☐ Other: _____

Date of Injury (mm/dd/yyyy) _____ Please describe the injury _____

_____

## Pain History

**Rate the pain at its worst (10 being the most pain).**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

**Rate the pain at its best (10 being the most pain).**

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

**Does the pain Radiate?** ☐ Yes ☐ No

If yes, Pain Radiates from/to: (ex. From low back to right leg): _____

**How would you describe the symptoms?**

☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Stabbing ☐ Throbbing

**How often are the symptoms present?**

☐ Off and on ☐ Most of the time ☐ All the time

**Is the problem getting better or worse?**

☐ Getting better ☐ Getting worse ☐ Unchanged

**Do you have any other additional complaints?**

☐ Catching ☐ Clicking ☐ Decreased ROM ☐ Instability ☐ Grinding ☐ Nighttime Discomfort
☐ Popping ☐ Swelling ☐ Weakness ☐ Limping ☐ Locking ☐ Stiffness ☐ Snapping

**Do you experience any numbness or tingling?** ☐ Yes ☐ No

*If yes, where is the numbness or tingling located?*

☐ Neck ☐ Upper Arm ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Fingers
☐ Low Back ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot ☐Toes

**What makes the symptoms better?**

☐ Nothing ☐ Bending Over ☐ Changing Positions ☐ Elevation ☐ Lying Down
☐ Sitting ☐ Standing ☐ Walking ☐ Stretching

## Treatment / Testing

**Please indicate any prior tests for this problem**

☐ None
☐ MRI Date (mm/dd/yyyy): _____ Location (ex. AMI): _____
☐ X-Ray Date (mm/dd/yyyy): _____ Location (ex. Bryan ER): _____
☐ CT Scan Date (mm/dd/yyyy) :_____ Location (ex. STE): _____
☐ Dexa
☐ Bone Scan
☐ Ultrasound
☐ Nerve Test (EMG)

**Have you been seen by another physician for this problem?** ☐ Yes ☐ No

*If yes, physician name*: _____

**Have you received any treatment for this problem (i.e. *medication, therapy, injections, etc.*)?** ☐ Yes ☐ No

**Please indicate if you have had any of the following treatment (on your own or directed by a Physician) and if it helped or not:**

| | *Helped* | *No Help* | *Temporary Relief* | *Not Tried* |
|---|---|---|---|---|
| **Ice** | ☐ | ☐ | ☐ | ☐ |
| **Heat** | ☐ | ☐ | ☐ | ☐ |
| **Rest/Activity Modification** | ☐ | ☐ | ☐ | ☐ |
| **Anti-Inflammatory Medication(s)** | ☐ | ☐ | ☐ | ☐ |
| **Pain Medication(s)** | ☐ | ☐ | ☐ | ☐ |
| **Chiropractor Care** | ☐ | ☐ | ☐ | ☐ |
| **Therapy** | ☐ | ☐ | ☐ | ☐ |
| **Home Exercise Program** | ☐ | ☐ | ☐ | ☐ |
| **Injections** | ☐ | ☐ | ☐ | ☐ |
| **Bracing** | ☐ | ☐ | ☐ | ☐ |
| **Changing Positions** | ☐ | ☐ | ☐ | ☐ |
| **Massage** | ☐ | ☐ | ☐ | ☐ |
| **Over the Counter Topical Creams** | ☐ | ☐ | ☐ | ☐ |
| **Tylenol** | ☐ | ☐ | ☐ | ☐ |

Other/Comments: _____

**Have you ever had surgery on this body part?** ☐ Yes ☐ No
*If yes, please list the type of surgery, date, and name of surgeon*: _____
_____

## Medical Questions

**Mark all that currently apply:**

☐ None ☐ Home Oxygen ☐ Sleep Apnea ☐ Taking Blood Thinners ☐ Dialysis
☐Pacemaker

**Is the patient diabetic?** ☐ Yes ☐ No If yes, Patient's last HgB A1c was: _____
*If yes, previous complications?*
☐ None ☐ Neuropathy ☐ Wound Problems ☐ Decreased blood flow ☐ Eye Complications
☐ Kidney Complications ☐ Skin Issues

**Has the patient experienced malignant hyperthermia in reaction to anesthesia?** ☐ Yes ☐ No
**Has the patient's immediate family members experienced malignant hyperthermia in reaction to anesthesia?** ☐ Yes ☐ No

***Have you ever had a surgical procedure?*** ☐ Yes ☐ No

| | | Body Part | Year | Physician or Facility |
|---|---|---|---|---|
| Abdominal Surgery | ☐ | | | |
| Arthroscopy | ☐ | | | |
| Fracture | ☐ | | | |
| Heart Surgery | ☐ | | | |
| Joint Replacement | ☐ | | | |
| Spine Surgery | ☐ | | | |
| Vascular/Vein/Artery | ☐ | | | |

Please list all other surgical procedures, including approximate date of the procedure below:
_____
_____
_____

## Family History

Have any direct relatives had any of the following disorders?

| ☐None for All | **Father** | **Mother** | **Sibling(s)** |
|---|---|---|---|
| | ☐None | ☐None | ☐None |
| | ☐Diabetes | ☐Diabetes | ☐Diabetes |
| | ☐Heart Disease | ☐Heart Disease | ☐Heart Disease |
| | ☐Hypertension | ☐Hypertension | ☐Hypertension |
| | ☐Bleeding Problems | ☐Bleeding Problems | ☐Bleeding Problems |
| | ☐Epilepsy | ☐Epilepsy | ☐Epilepsy |
| | ☐Connective Tissue | ☐Connective Tissue | ☐Connective Tissue |
| | ☐Muscular Dystrophy | ☐Muscular Dystrophy | ☐Muscular Dystrophy |
| | ☐Stroke | ☐Stroke | ☐Stroke |
| | ☐Osteoporosis | ☐Osteoporosis | ☐Osteoporosis |
| | ☐Rheumatoid Arthritis | ☐Rheumatoid Arthritis | ☐Rheumatoid Arthritis |
| | ☐Cancer | ☐Cancer | ☐Cancer |
| | ☐Other: | ☐Other: | ☐Other: |

## Social History

**Do you smoke tobacco?**

☐ Ex-smoker ☐ Never ☐ Heavy tobacco smoker ☐ Light tobacco smoker ☐ Occasional smoker

***If a smoker***, what year did you start smoking? _____

How many packs do you smoke per day? ☐ 0-1 pack ☐ 1-2 packs ☐ 2 or more packs

***If a former smoker***, what year did you quit smoking? _____

**Do you drink alcohol?** ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

**Do you currently use recreational drugs?** ☐ Yes ☐ No

If yes, pleas list the recreational drugs used and how often you use them: _____

_____

**What is your marital status?** ☐ Married ☐Single ☐ Divorced ☐ Widowed ☐ Domestic partnership

**Are you currently working?**

☐ Yes Occupation: _____ Employer: _____

Please list work restrictions, if any (ex. Lifting, prolonged sitting, etc.): _____

_____

☐ No

☐ Retired What year did you retire? _____

☐ Disabled

☐ Student School Name: _____

**Do you participate in Sports?** If so, please list which ones: _____

## Medications

Please list all medications you take on a regular basis, including name, dose, frequency, and route:

| Name | Dosage (ex. 75mg) | Frequency (ex. 1/day) | Route (ex. By mouth) |
|---|---|---|---|
| | | | |
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## Allergies

Do you have a latex allergy? ☐ Yes ☐ No

Do you have any other allergies? ☐ Yes ☐ No

If yes, please list below:

| Allergy (medication, food, etc.) | Severity (ex. Low) | Reaction (ex. Hives, itching) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Current Medical Conditions

**Please select if you have any of the following <u>current</u> medical conditions:**

☐ Aneurysm - Where: _____
☐ Angina (chest pain)
☐ Arthritis - Type: _____
☐ Asthma
☐ Bone or Joint Infections
☐ Bursitis
☐ Cancer – Type: _____
☐ Celiac Disease
☐ Chemotherapy/Radiation
☐ Congestive Heart Failure
☐ COPD
☐ Crohn's Disease
☐ Diabetes – Type: _____
☐ Diverticulitis
☐ Blood Clotting Disease
☐ Mental Illness
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Gout
☐ Heart Attack
☐ Hepatitis – Type: _____
☐ HIV/AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Kidney Disease
☐ Kidney Stones
☐ Liver Disease
☐ Lyme Disease
☐ Alcohol Addiction
☐ Migraines
☐ MRSA Infection
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Pulmonary Embolism (PE)
☐ Bleeding Disorder
☐ Reaction to Anesthesia
☐ Seizures
☐ Serious Illness
☐ Serious injuries
☐ Stomach Ulcers
☐ Stroke/TIA
☐ Tuberculosis
☐ Drug Addiction
☐ Other: _____

**Authorization to Release Information, Consent to Treatment and Assignment of Benefits**

Patient Name_____ Patient Account number_____

I certify that the information that I have reported with regards to my insurance coverage is correct.

I hereby authorize NEBRASKA ORTHOPAEDIC CENTER, P.C. to file claims and release any medical information necessary to process these claims. I also authorize payments to be made directly to NEBRASKA ORTHOPAEDIC CENTER, P.C. for the services provided to me (or the above-named patient), and authorize NEBRASKA ORTHOPAEDIC CENTER, P.C. to render appropriate treatment/procedures relating to the diagnosis.

I understand that I am financially responsible to NEBRASKA ORTHOPAEDIC CENTER, P.C. for the services provided to me or my dependent. I agree to pay the full amount of all charges incurred by the above-named patient that are not covered by my insurance carrier. I also agree to pay the cost of collection and/or court costs and reasonable fees should this be required.

I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our services providers, including but not limited to, third party debt collectors, now and in the future, may be used as a means to contact me for any reason, including but not limited to, billing and collecting payment, and that this office and our service providers may leave messages for me manually and by using automatic systems such as by artificial or prerecorded voice. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communications. In the future, should I acquire a new or different cellular, landline or email address, I agree that this consent would stay effective.

I agree that Nebraska Orthopaedic Center, P.C. may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)

I hereby authorize Nebraska Orthopaedic Center, PC to appeal all claims for charges I will incur as a patient of this practice.

_____ _____

Date Signature (must be signed by parent/legal guardian if patient is a minor)

**CONSENT TO RELEASE MEDICAL AND BILLING INFORMATION**
**TO INDIVIDUALS/FAMILY MEMBERS**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, allows your healthcare provider or staff of Nebraska Orthopaedic Center (Practice) to discuss your medical or billing information with members of your family or other individuals involved in your medical care upon your approval, or when given the opportunity, you do not object, or when your healthcare provider reasonably infers from the circumstances, based on his/her professional judgment, that you do not object to such disclosure. To assist our Practice in determining your desires with respect to such disclosures, we ask that you complete this form. You may revoke or modify this consent at any time by submitting a revised form.

I **AUTHORIZE** Practice to disclose, to the following individuals, medical care and billing information, whether in person, over the phone or in writing, directly relevant to such individual's involvement with my medical care or payment related to my medical care; provided, however, in the event I am incapacitated or there is an emergency situation, my healthcare provider may disclose my medical and billing information, whether in person, over the phone or in writing, that is directly relevant to those involved in my medical care, even though their name does not appear below, if the healthcare provider, based on his/her professional judgment, determines the disclosure is in my best interests.

| | |
|---|---|
| Name | Relationship to Patient |
| Name | Relationship to Patient |
| Name | Relationship to Patient |
| Name | Relationship to Patient |
| Print Patient Name | Date of Birth |
| Patient Signature | Date |
| Patient ID | |

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I was given the opportunity to receive a copy of Nebraska Orthopaedic Center P.C.'s Notice of Privacy Practices which are effective December 13, 2024.

I understand that the Notice describes the uses and disclosures of my protected health information and informs me of my rights with respect to my protected health information.

Date

Patient Printed Name

Patient Signature*

*Parent/Guardian Signature if patient is a minor

******FOR OFFICE USE ONLY******

Patient ID