Orthopaedic & Spine Surgery Institute
19450 Deerfield Avenue, Suite 300
Lansdowne, VA 20176
O: 703-723-6774 (OSSI)
F: 703-723-1494
www.OSSI-Virginia.com

Patient Information

Date: ____/____/____

Last Name: _____ First Name: _____ Middle Initial: ___

Date of Birth: ____/____/____ Age: _____ SSN: _____-_____-_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred Contact Phone Number:_____

Home Address: _____City:_____Zip Code_____

Are you currently residing in a Nursing/Rehab Facility? _____ Name of Facility:_____

Race ☐ Decline ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian ☐ other ☐ white

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline ☐ other

E-Mail Address: _____

Employer: _____ Address: _____ Zip code: _____

Occupation: _____

Referring Physician: _____

Referring Physician's Contact Information: _____

Primary Care Physician: _____Preferred Pharmacy: name/location_____

Primary Physician's Contact Information: _____

Emergency Contact: _____Phone_____Relationship_____

Insurance Information

Primary Insurance: _____

Carrier Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Name: _____ DOB: _____ Relationship: _____

Policy/Member #: _____ Group #: _____

Insurance Phone #: _____

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Secondary Insurance: _____

Carrier Address: _____

City: _____ State: _____ Zip Code: _____

Subscriber's Name: _____DOB_____ Relationship: _____

SSN: _____

Policy/Member #: _____ Group #: _____

Insurance Phone #: _____

Workman's Compensation

Workers Compensation Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer's Name: _____ Phone #: _____

W/C Contact Person: _____ Phone #: _____

W/C Case Manager: _____ Phone #: _____

W/C Claim Number: _____ Date of Accident: _____/_____/_____

What State did your injury occur in? _____

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General Medical History

Last Name: _____ **First Name:** _____

Age: _____ **Date of Birth:** ____/____/____ **Height:** _____ **Weight:** _____ **Date:** ____/____/____

Sex: ☐ **Male** ☐ **Female** **RR:** _____**(staff use)**

History of Present Illness

What is your present problem? _____

_____

_____

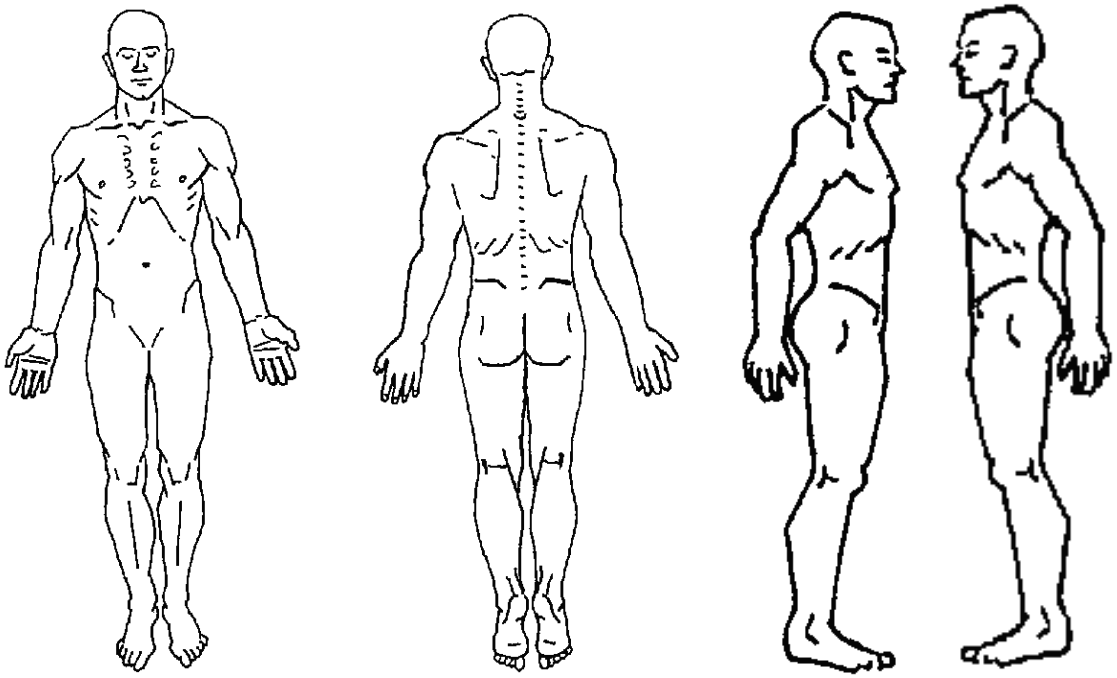
Date of Injury/Onset: _____/_____/_____ Secondary to: ☐ Illness ☐ Accident ☐ Work ☐ Chronic ☐ Other

Describe how the injury happened: *(Be specific)*

_____

_____

Location of Pain/Injury: *(Please write and mark figures below)*
Using the following legend, add the letter that corresponds to the type of pain you are having to the body diagram below. Be sure to mark all areas where the pain is located.



Type of Pain	Symbol
Aching	AAA
Numbness	NNN
Pins & Needles	PPP
Burning	BBB
Stabbing	SSS

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Where is the worst pain out of 100%?
Neck pain ____% VS. Arm pain ____%
Back pain ____% VS. Leg pain ____%

How often do you have this pain? *(Check one only)* ☐ Constantly ☐ Intermittently

What is the quality of the pain? ☐ Aching ☐ Throbbing ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing

On a scale of 0 to 10 (0 = no pain; 10 = most unbearable pain), what is your pain score?

☐ Without activity ☐ With activity

What makes your pain better? *(e.g., Heat, cold, sitting, lying down, standing, stretching, PT, medications)*

_____

_____

What makes your pain worse? *(e.g. Bending, lifting, specific activities, sitting, standing) (Be specific)*

_____

_____

What conservative treatments have you had for this problem? *(e.g. Physical therapy, chiropractic care, acupuncture)*

Location:
_____

Dates:
_____

What injection or other procedure have you had for this problem? *(e.g. Joint injections, epidural and/or facet injections, nerve root injections, spinal stimulators, nerve ablations)*

_____

_____

_____

Please list any health care professionals that have treated you for this specific problem in the past, and the specific treatment rendered.

_____

_____

_____

_____

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Past Medical History: *(Check all that apply)*

- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Crohn's Disease
- ☐ CHF
- ☐ Blood Clots (DVT)
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Emphysema (COPD)
- ☐ Fibromyalgia
- ☐ HIV
- ☐ Heart Attack
- ☐ Heart Murmurs
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Failure
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Reflux (GERD)
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sinusitis
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tumors/Cancers
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Vascular Disease

Others (Explain): _____

_____

Past Surgical History: *(Please list all surgeries of all body parts ever performed)*

_____

_____

_____

Prior Hospitalizations (past 2 years): *(Please list all, regardless of cause)*

_____

_____

_____

Medication Allergies: _____

_____

Other Allergies: _____

_____

Medications: *(Please list dose and frequency; please also list over the counter medications and supplements)*

_____

_____

_____

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Family History: *(Check all that apply)*

☐ Arthritis	☐ Diabetes	☐ Kidney Failure	☐ Sinusitis
☐ Asthma	☐ Diverticulosis	☐ Kidney Stones	☐ Stomach Ulcers
☐ Back Pain	☐ Emphysema (COPD)	☐ Liver Disease	☐ Stroke
☐ Bleeding Disorders	☐ Fibromyalgia	☐ Neck Pain	☐ Thyroid Disease
☐ Bronchitis	☐ HIV	☐ Osteoporosis	☐ Tumors/Cancers
☐ Crohn's Disease	☐ Heart Attack	☐ Pancreatitis	☐ Tuberculosis
☐ CHF	☐ Heart Murmurs	☐ Reflux (GERD)	☐ Ulcerative Colitis
☐ Blood Clots (DVT)	☐ Hepatitis	☐ Rheumatoid Arthritis	☐ Vascular Disease
☐ Depression	☐ Hypertension	☐ Seizures	

Others (Explain): _____

Social History:

Occupation: _____ Years at present occupation: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of Children: ____

Smoking:(Circle one) never smoked- former smoker- Current Smoker (how much) _____

Occasional Smoker (how often) _____ Smokeless Tobacco

Do you drink: ☐ Yes ☐ No; How much every day: _____; Number of Years: ____ Have you ever abused alcohol? __ Y ☐ N ☐

Do you use any drugs? ☐ Yes ☐ No

Have you ever used drugs in the past? ☐ Yes ☐ No

Are you currently involved in any litigation or lawsuit relating to your injury? ☐ Yes ☐ No

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Review of Systems: (Please check as many as needed and provide explanation if needed)

General: ☐ Change in weight, ☐ Appetite, ☐ Sleep, ☐ Taste or Smell, ☐ Fatigue, ☐ Fever

Skin: ☐ Rash, ☐ Itching

Head & Neck: ☐ Hearing impairment, ☐ Dizziness, ☐ Balance problems, ☐ Vision & eye problems, ☐ Nose bleed, ☐ Hoarseness, ☐ Mouth sores, ☐ Difficulty swallowing

Breasts: ☐ Any abnormal enlargement or tenderness

Lungs: ☐ Chronic cough, ☐ Emphysema, ☐ Tuberculosis, ☐ Bronchitis

Cardiovascular: ☐ High blood pressure, ☐ Chest pain, ☐ Heart attack, ☐ Shortness of breath, ☐ Murmurs, ☐ Congestive heart failure, ☐ Deep vein thrombosis (DVT)

Gastrointestinal: ☐ Stomach ulcers, ☐ Stomach bleed, ☐ Heartburn, ☐ Rectal bleed, ☐ Hiatal hernia, ☐ Pancreatitis, ☐ Diarrhea, ☐ Constipation

Urinary Tract: ☐ Kidney stone, ☐ Kidney infections, ☐ Painful urination, ☐ Incontinence, ☐ Bleeding

Reproductive System: ☐ Sexually transmitted diseases, ☐ Bleeding, ☐ Impotence

Endocrine System: Thyroid disease, Diabetes, Pituitary or other gland or hormonal diseases

Blood & Lymphatics: ☐ HIV or AIDS, ☐ Lymphoma, ☐ Bleeding problems, ☐ Sickle cell disease

Musculoskeletal System: ☐ Osteoarthritis, ☐ Rheumatoid arthritis, ☐ Back pain, Joint pain, ☐ Muscle disorder

Nervous System: ☐ Fainting, ☐ Headache, ☐ Seizure, ☐ Memory loss, ☐ Dizziness, ☐ Numbness

Psychiatric History: ☐ Depression, ☐ Anxiety, ☐ Psychosis

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AUTHORIZATION FOR CLAIMS AND PAYMENTS

I hereby authorize the **Orthopaedic & Spine Surgery Institute (OSSI)** to apply for benefits on my behalf. I request that payment for covered services are made directly to **Orthopaedic & Spine Surgery Institute (OSSI)** unless it would indicate otherwise. I certify that the information I have reported about my insurance coverage is correct and further authorize the release of information, medical and other, as necessary I processing of claims. I acknowledge and understand that I am responsible for the payment of all services rendered to me or any member of my family.

Should any employee or other individual be exposed to my blood or bodily fluids, I hereby consent to testing my blood for Hepatitis virus and AIDS (HIV) virus as necessary.

I hereby certify that the information is true and correct to the best of my ability.

YOUR SIGNATURE below constitutes that you fully understand, acknowledge, and agree with the above policies of **Orthopaedic & Spine Surgery Institute (OSSI)**

Signature: _____ Date: _____/_____/_____

Printed Name: _____

CANCELLATION POLICY

Orthopaedic & Spine Surgery Institute (OSSI) requires 24 hours advanced notice for canceled appointments and/or procedures. Our receptionists are available from 8:30 am to 5 pm to accept your phone calls to cancel or reschedule appointments.

Any appointment or procedure that is not canceled with a 24 hours' notice will be subject to a cancellation fee as follows:

Office Visit: $35.00

The cancellation fee is the responsibility of the patient and will not be billed to your insurance company.

Your signature below constitutes that you fully understand, acknowledge, and agree with above policies of **Orthopaedic & Spine Surgery Institute (OSSI)**

Signature: _____ Date: _____/_____/_____

HIPAA POLICY

I have read and received the HIPAA (Health Insurance Portability and Accountability Act) Policy.

Signature: _____ Date: _____/_____/_____

The following person(s) may receive information about me and my healthcare:

_____name

_____name