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: _____ Sex: ___ Male ___ Female

Preferred Name: _____ Date of Birth: ____/____/____ Age: _____ SSN: _____/_____/_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Preferred Phone Number: _____**

Home Address: _____ City:_____ State: _____ Zip Code: _____

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

Email Address: _____

Preferred Pharmacy (Name/Location):_____

Race: ☐ African American ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Hawaiian ☐ Other ☐ Decline

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

Employer Name: _____ Occupation: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Insurance Information

Primary Insurance Company: _____ **Phone #**: _____

Claims Address: _____ City:_____ State: _____ Zip Code: _____

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

Policy/Member #: _____ Group#: _____

Secondary Insurance Company: _____ **Phone #**: _____

Claims Address: _____ City:_____ State: _____ Zip Code: _____

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

Policy/Member #: _____ Group#: _____

Workman's Compensation

Date of Injury: _____/_____/_____ What State did your injury occur in? _____

Claim #: _____ Workers Compensation Insurance Company: _____

Address: _____ City:_____ State: _____ Zip Code: _____

W/C Contact Person: _____ Phone#: _____

W/C Case Manager: _____ Phone#: _____

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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

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General Medical History

Last Name: _____ First Name: _____

Date: ____/____/_____ Age: _____ Date of Birth: ____/____/_____ Sex: ☐ Male ☐ Female

Height: _____ Weight: _____ Temp: _____ (staff only)

History of Present Illness

What is your present problem? _____

_____

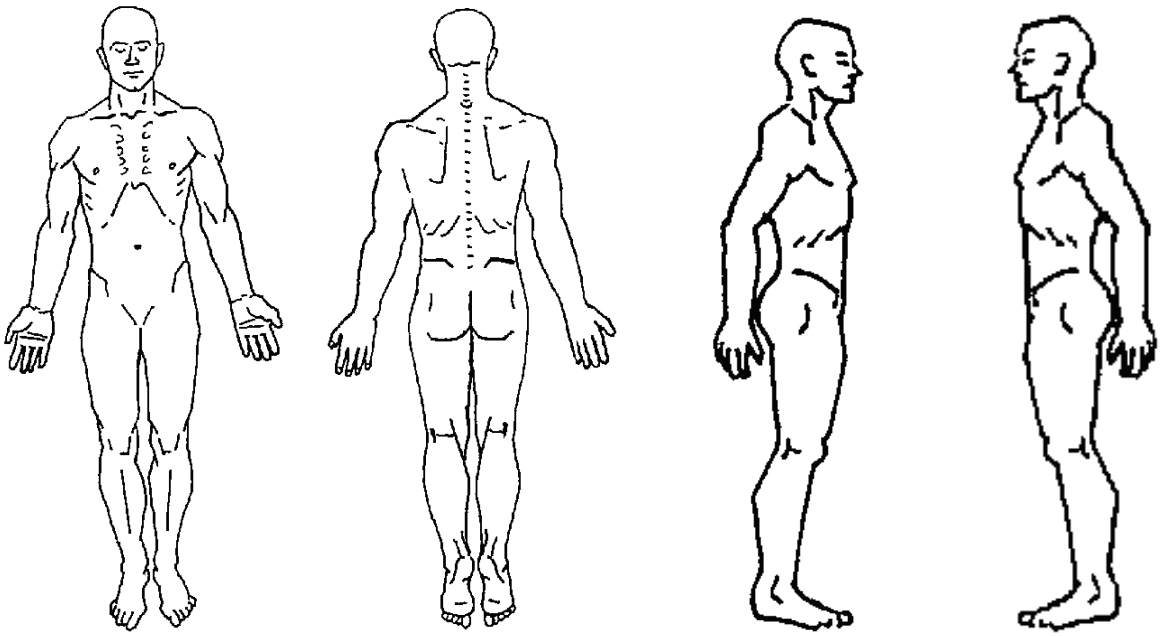
Date of Injury/Onset: ____/____/____ Secondary to : ☐ Illness ☐ Accident ☐ Work ☐ Chronic ☐ Other

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 your are having to the body diagram below.



Where is the worst pain out of 100%?

Neck pain _____% VS. Arm pain _____%

Back pain _____% VS. Leg pain _____%

TYPE OF PAIN	SYMBOL
Aching	**AAA**
Numbness	**NNN**
Pins/Needles	**PPP**
Burning	**BBB**
Stabbing	**SSS**

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

How often do you have this pain? ☐ Constant ☐ Intermittently ☐ Episodic

How long have you experienced your pain or complaint? _____ Years _____ Months _____Weeks _____Days

Please describe your pain: ☐ Dull ☐ Ache ☐ Sharp ☐ Shooting ☐ Burning ☐ Stabbing

When do you experience your pain or complaint? ☐ Morning ☐ Evening ☐ Walking ☐ Standing ☐ Sitting ☐ Exercise

On a scale of 0 to 10 (0 = no pain; 10 = most unbearable pain), what is your pain score? ____ without activity ____ with activity

Indicate how your symptoms respond to following?

Standing	☐ Relieves	☐ Worsens	☐ No Difference
Sitting	☐ Relieves	☐ Worsens	☐ No Difference
Lying Down	☐ Relieves	☐ Worsens	☐ No Difference
Stretching/Exercise	☐ Relieves	☐ Worsens	☐ No Difference

Other (please specify): _____

What treatments have you tried thus far and how much relief have you received from them?

Medications	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Heat/Ice	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Physical Therapy	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Injections	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried
Chiropractor	☐ Excellent relief	☐ Moderate relief	☐ No relief	☐ Have not tried

If you have had injections or other procedures, please list them below: *(e.g. Joint injections, epidural and or/facet injections, nerve root inje 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. *(e.g. Primary care provider, physical therapy, pain management, chiropractic care, other orthopaedic physicians)*

_____

_____

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

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

☐Arthritis	☐Diabetes	☐Kidney Failure	☐Sinusitis
☐Asthma	☐Diverticulitis	☐Kidney Stone	☐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	

Other: _____

Past Surgical History: _____

_____

Past Hospitalizations (past 2 years): _____

_____

Medications: (*Please attach list if necessary; please include over the counter medications, vitamins, supplements, and topical)*

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____ ☐ No Known Drug Allergies

Family History: *(Check all that apply)*

☐Arthritis	☐Diabetes	☐Kidney Failure	☐Sinusitis
☐Asthma	☐Diverticulitis	☐Kidney Stone	☐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	

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

Social History

Occupation: _____ **Years present at Job**: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker ☐ Smokeless Tobacco

Alcohol Use: ☐ Yes ☐ No **How much alcohol per day?** _____

Have you ever abused alcohol? ☐ Yes ☐ No

Drug Use: ☐ 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/complaint? ☐ Yes ☐ No

Review of Symptoms:

(Please check all the following symptoms if they apply to you recently)

General:	☐ Change in weight, ☐ Appetite, ☐ Sleep, ☐ Taste/Smell ☐ Fatigue ☐ Fever
Skin:	☐ Rash ☐ Itching
Head & Neck:	☐ Dizziness ☐ Balance Problems ☐ Vision/Eye Problems ☐ Hoarseness ☐ Trouble Swallowing
Pulmonary:	☐ Chronic cough ☐ Emphysema ☐ Tuberculosis ☐ Bronchitis
Cardiovascular:	☐ High Blood Pressure ☐ Chest pain ☐ Heart Attack ☐ Shortness of Breath ☐ Blood Clots (DVT)
Gastrointestinal:	☐ Stomach ulcers ☐ Stomach bleed ☐ Heartburn ☐ Diarrhea ☐ Constipation
Urinary:	☐ Kidney Stone ☐ Kidney Infections ☐ Painful Urination ☐ Incontinence ☐ Bleeding
Reproductive:	☐ Sexually transmitted diseases ☐ Bleeding ☐ Impotence
Hematologic/Lymphatic:	☐ HIV or AIDS ☐ Lymphoma ☐ Bleeding problems ☐ Sickle cell disease
Musculoskeletal:	☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle disorder
Neurological:	☐ Fainting ☐ Headache ☐ Seizure ☐ Memory loss ☐ Dizziness ☐ Numbness

Patient Signature: _____ Date: ____/____/_____

CC: _____ (staff use only)