



Northwest Ohio Orthopedics & Sports Medicine, Inc.

Patient Information (Please print with pen)

Legal Last Name:	Legal First Name:	Middle Name:	SSN:
Mailing Address:	City:	State:	Zip:
Home Telephone:	Cell Phone:	Other Phone:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Date of Birth (mm-dd-yyyy):	Date of Injury/Onset:	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
If Medicare, are you currently residing in a Skilled Nursing Facility: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Facility _____			
If you are Medicare, have you received Physical, Occupational, or Speech Therapy services since the beginning of the year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If so, do you know if you have exceeded the Medicare cap? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Medicare, are you currently receiving Home Health Services: <input type="checkbox"/> Yes <input type="checkbox"/> No Type of service: _____			
If yes, Name of Agency: _____ Date of Last Service: _____			

Physician Information

Primary Care Physician (PCP):	City/State of PCP:	Physician who referred you here:
May we send medical information to your PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		City/State of Referring Physician:

Employer Information

Employer:	Employer Phone:	Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> None
Address:	City:	State: Zip:

Responsible Party (For Minors and/or Dependents for Insurance Purposes)

If Minor, Does child live with: <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____		
Mother's Full Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:
Father's Full Legal Name:	Home Phone:	Address (if different):
Date of Birth:	SSN:	Employer:

Emergency Contact

Contact Name:	Phone:	Relationship:
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Health Care Primary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		

Secondary Insurance

Name of Insurance:	Policy or Claim #:	Group #:	Co-pay:
Policy Holder:	Date of Birth (mm-dd-yyyy):	SSN:	
Employers Name:	Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____		

Authorization: I, with my signature, authorize Northwest Ohio Orthopedics and Sports Medicine, Inc. (NWO) to provide medical care for me, or to this patient for which I am the legal guardian.

I also authorize NWO, to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payment for these services to NWO, realizing I am personally responsible for the charges incurred, including items determined to be non-covered.

I also acknowledge that I have been given or have been offered a copy of the "Practice's" privacy policy as required by law. I request the following restrictions be placed on the "Practice's" use and/or disclosure of my health information (leave blank if NO).

Patient/Guardian: _____ Date: _____



Northwest Ohio Orthopedics & Sports Medicine, Inc.

Chiropractic Medical Questionnaire

Patient Name (Print) _____ Date _____

Age: _____ Gender: F M Dominant Hand: R L Height/Weight _____/_____

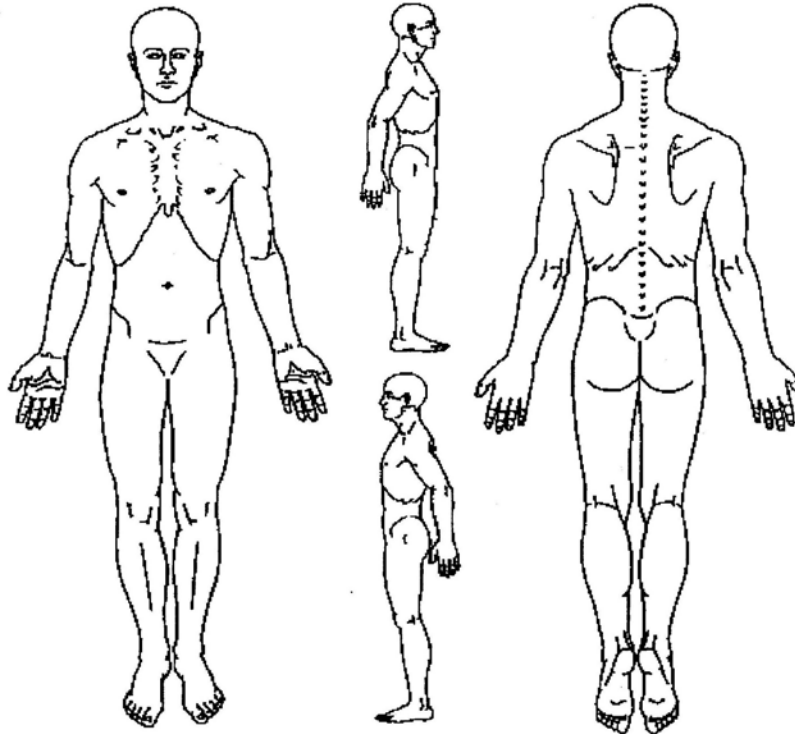
Family Doctor: _____ Who referred you to this office? _____

May we contact your Family Doctor? Y N

What is the main reason for this visit? _____

On the diagram below, please indicate where you are experiencing pain right now and use the appropriate symbol as indicated

A = Ache B = Burning N = Numbness P = Pain PN = Pins & Needles
S = Stabbing SF = Stiffness W = Weakness O = Other



Please make a slash through this line as to the level of your current pain

No Pain At All ←-----→ Worst Pain Possible

Rate the **severity** of your pain from 1 (least pain) to 10 (most pain) (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the **type** of your pain? Sharp Dull Stabbing Throbbing Aching Burning

Is your pain: Constant Intermittent (comes and goes) Shooting Cramping Tingling

Does your pain awake you from sleep? Y N Does your pain interfere with your daily routine/recreation? Y N

Estimate the average hours of sleep each night: _____ Estimate how many times you are awakened each night _____

Do you have: Numbness Weakness Swelling Weight Changes Changes in bowel/bladder frequency or urgency Night Sweats
Dizziness Lightheadedness Stiffness Bruising Loss of control of bowel or bladder functioning

Since your problem started is it: Getting Better Getting Worse Unchanged

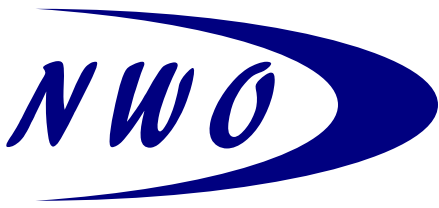
What makes your symptoms **worse**? Standing Walking Lifting Exercise Twisting Bending Squatting
Kneeling Sitting Coughing Sneezing

Lying Down: On side On back On stomach Using Stairs: Up Down Both

What makes your symptoms **better**? Rest Elevation Ice Heat Position _____ Other _____

Have you taken any medications/OTC medications today? Y N Last time taken? _____

What vitamins/supplements are you currently taking? Please list with dosage: _____



CHIROPRACTIC HEALTH AND FAMILY HISTORY FORM

HEALTH HISTORY

Have you had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors, Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Typhoid Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Depression/Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No				
		Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No				

EXERCISE

WORK ACTIVITY

HABITS

<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Smoking	Packs/Day _____
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Alcohol	Drinks/Week _____
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> Coffee/Caffeine Drinks	Cups/Day _____
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor	<input type="checkbox"/> High Stress Level	Reason _____

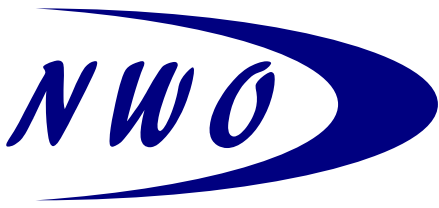
Are you pregnancy? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

FAMILY HISTORY

Have your immediate family members had any of the following:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Back Problems	<input type="checkbox"/> Headaches
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcer or Stomach Problems	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Circulation Problems
<input type="checkbox"/> Seizures-Convulsions	<input type="checkbox"/> Kidney Diseased	<input type="checkbox"/> Arthritis-Rheumatism	<input type="checkbox"/> Cancer
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Osteoporosis		



EXPLANATION OF CONDITION

Patient Legal Name: _____
First MI Last

CONDITION/ACCIDENT/INJURY DETAILS

Symptoms first begin on: ____/____/____ or have been experiencing for ____ days ____ weeks ____ months ____ years.

What symptoms are you experiencing? _____

What body parts are affected? _____

Have any of these body parts been injured before? YES NO If yes, please describe: _____

What medications are you currently taking? _____

Give a brief description of the accident. Please include location of the accident (home, work, school, auto, etc.) and a brief description (fall, bump against, collision, cut, struck by, etc.). _____

Will you seek payment from another party? YES NO If yes, who? BWC MVA Other

If an attorney is involved, please provide name, address, and phone number: _____

Was this injury sustained in an automobile accident? YES NO If yes, please complete the following:

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: ____/____/____ State Accident Occurred: _____ Time: _____

Auto Insurance Name: _____ Adjuster's Name: _____

Adjuster's Phone Number: _____ Name of Insured: _____

Claim Number: _____ Policy Number: _____ MVA Work Related? Y N

We will bill your motor vehicle insurance; however, you are ultimately responsible for your account balance. We do require your health insurance information since most auto coverage is limited. We will bill your health insurance for any remaining balance after your Auto Insurance has paid. **Please note that should your motor vehicle accident require litigation proceedings, you will be required to speak with our financial counselor to arrange monthly payments in order to keep your account current during your hearings.** Once your claim has been settled, any overpayments you have made on the account will be refunded to you at that time.

AUTHORIZATION

I, with my signature, authorize Northwest Ohio Orthopedics And Sports Medicine, Inc., and any employee working under the direction of the care provider, to provide medical care for me, or to this patient for which I am the legal guardian. I also authorize Northwest Ohio Orthopedics And Sports Medicine, Inc., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes, and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, deductible, and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Patient/Legal Representative: _____ Date: _____



FINANCIAL POLICY

Regarding Your Insurance:

Our office participates in a variety of insurance plans, and we will submit all claims to those carriers. We make every effort to get claims paid; however, please remember that your insurance policy is a contract between you, your employer, and your insurance company. Any balance remaining after the insurance has paid, is the **patient/guarantor's responsibility** (i.e. co-pay, co-insurance, non-covered benefits, exclusions, etc.). If NWO is not in your insurance plan, the patient/guarantor is responsible for all charges. If you do not have insurance, a payment plan must be arranged, prior to treatment, with our Financial Counselor. Partial payment for self-pay patients is required at the time of the initial visit.

In an effort to minimize insurance errors and maximize insurance payment, please bring your most recent insurance card(s) with you to every visit. **Co-payments are to be paid at the time of your visit.** In the event we receive payment from your insurance company for services you have paid for, a refund will be made to you in a timely manner.

Payment Information:

We accept cash, check, and credit/debit card payments. Credit cards and/or checks can be "kept on file" for your convenience. This information is securely stored by an authorized vendor. Notification will be given before a payment transaction is performed. If you are unable to pay your balance in full, a payment plan arrangement can be made or you can sign up for CareCredit with the option of no interest financing. Contact our Financial Counselor at 419-427-3116 for more information. These options will lessen the possibility of your account being sent to a collection agency because of non-payment. A fee of \$30.00 will be applied and collected from your account if payment is returned non-paid.

Past Due Accounts:

If your balance is not paid in a timely manner, we reserve the right to forward your account to an outside collection agency or attorney. A 10-day notice prior to sending your account to a collection agency will be mailed to you.

Orthopedic No-Show Fee:

Missed or non-cancelled appointments may result in a service fee.

Imaging No-Show Fee:

Cancellation within 24 hours prior to a scheduled MRI or a scheduled CT will be subject to a \$50 no-show fee.

Durable Medical Equipment:

If you need to return a product, and you are the original purchaser, you need to do so within 10 days of receiving. All products must be returned in its original packaging with all instructions and parts. The product must be in new condition. We reserve the right to refuse any product not in new condition for health safety reasons. There is a 30% restocking fee on all returns. Upon notification that the product has been returned in new condition, a credit will be issued to your account less the restocking fee. For product exchanges, upon receipt of the returned product we will credit your account minus the 30% restocking fee if a product needs to be exchanged. This charge will be waived if NWO made the mistake in providing you with the wrong product.

FMLA, Disability, and Drug Company Assistance Forms:

Any patient needing forms filled out by our office will incur a one time \$15.00 fee per form. Payment for this service is due at the time of drop-off or pick-up.

Medical Records Copying Fees:

Charges for copying medical records vary depending on whether the individual/organization requesting the information is the patient/personal representative or a non-personal representative. In compliance with the Ohio Revised Code Section 3701.742, if the person requesting records is the patient/personal representative, fees are: \$2.84/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Fees for a non-personal representative are: \$17.48 retrieval fee, \$1.15/page for pages 1-10, \$.59/page for pages 11-50, and \$.24/page for pages 51+. Film prices for patient/representative and non-representative are: \$1.94/sheet or \$1.00/disc. Postage paid to send records will also be paid by the requestor.

Patient/Guarantor Signature

Date