Name: Test, SRS
Chart: 86509466
Date: 3/19/2018

Welcome to Our Practice

Your Appointment is: _____

Provider: _____

In order to efficiently and effectively provide you with quality care, please complete the enclosed forms and be sure to bring this information to your appointment.

Additionally, we ask that you:

- Arrive 20 minutes before your appointment time.
- Bring any x-rays, MRIs, CT scans, EMGS or other related tests, along with the written reports. If your studies were done at Meadville Medical Center, you do not need to bring them.
- Bring your insurance card(s) and photo ID, such as a driver's license.
- Bring the co-pay amount required by your insurance plan; this will be due at the time of service.
- Self pay patients must pay for their services at the time of the office visit.
  We accept cash, personal checks, debit cards, Visa, and MasterCard.
- Contact your PCP to obtain a referral if you have Gateway, AmeriHealth Caritas, Coventry Cares or UPMC for You.
- Please check with your health insurance plan to be sure that Whole Health Joint Replacement Institute is in network. Or call our office with any questions.

If you cannot keep your appointment for any reason, please call our office at (814) 333-7109 to cancel. There is a $25 No-Show Fee for failure to cancel your appointment at least one business day in advance.

Minors must be accompanied by a parent, legal guardian or custodian.

Thank you for choosing Whole Health Joint Replacement Institute.

Name: Test, SRS
Chart: 86509466
Date: 3/19/2018

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Whole Health Joint Replacement Institute
11277 Vernon Place, Suite 202
Meadville, PA. 16335
Phone: 814-333-7109 • Fax: 814-333-7108
www.wholehealthjri.com

PATIENT PORTAL/EMAIL CONSENT FORM

The patient portal is a secure web portal that allows you as a patient to access medical records including medications, lab results, and medical history via the internet. It also allows you to communicate with our office via secure messaging. You may request refills and request appointments/appointment changes online.

Please read the following policy carefully:

- We will make every attempt to return portal messages within one business day. **You must call our office at 814-333-7109 if you have an urgent matter to discuss. Please do not use the portal for emergencies.**
- We do not accept requests for controlled substances over the portal.
- When communicating via Email, please put the purpose of your message in the subject line. Also, be sure to include your name, date of birth and return phone number in the body of your message.
- If you are not receiving emails from us, please check your JUNK email folder before contacting us.
- You understand that Whole Health Joint Replacement Institute is not responsible for information loss or delay, or for breaches of confidentiality, due to technical factors beyond Whole Health Joint Replacement Institute's control.
- You may discontinue your Patient Portal account at any time by contacting

- Whole Health Joint Replacement Institute has my permission to use my email address to send me instructions for the SRS Communicator patient portal.

I understand and agree to the above Email policy_____

Print Name: _____

Patient/POA/Guardian Signature: _____

Email address: _____

I decline participation in the above Email program_____

Print Name: _____

Patient/POA/Guardian Signature: _____

Name: Test, SRS
Chart: 86509466
Date: 3/19/2018

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PLEASE COMPLETE ALL SECTIONS

Patient Information

NAME: LAST: Test | FIRST: SRS | MIDDLE: | SOCIAL SECURITY #:

BIRTHDATE: 1/1/2011 | AGE: 7 years | SEX: U | LANGUAGE: ☐ English ☐ Spanish / ____

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

STREET ADDRESS: 123 Main St | RACE: ☐ White ☐ Asian ☐ Black ☐ American Indian ☐ Native American ☐ Unknown

CITY: Fort Wayne | STATE: IN | ZIP CODE: 46815

HOME PHONE#: (260) 466-3430 | CELL PHONE# | WORK/DAYTIME PHONE#

EMPLOYER | EMPLOYER ADDRESS

*If you have been a patient in the past under a different name, please enter that name:

Emergency Contact

NAME | RELATIONSHIP

ADDRESS

HOME PHONE# | CELL PHONE# | WORK/DAYTIME PHONE#

Financially Responsible Party if other than Patient

NAME | RELATIONSHIP

ADDRESS

HOME PHONE# | CELL PHONE# | WORK/DAYTIME PHONE#

Primary Care Physician

NAME | PHONE#

ADDRESS

Insurance

Primary Insurance Information
NAME OF INSURANCE | ID#

Secondary Insurance Information
NAME OF INSURANCE | ID#

Workers Compensation ☐ YES ☐ NO -OR- Auto Accident ☐ YES ☐ NO
NAME OF INSURANCE

CLAIM # | DATE OF INJURY / ACCIDENT

MEDICARE I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration of it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits assigned to Whole Health Joint Replacement Institute.

OTHER I authorize Whole Health Joint Replacement Institute to furnish information to any insurance carrier concerning my illness and treatment and I hereby assign in Whole Health Joint Replacement Institute all payments for medical services rendered to myself or my dependents.

I also understand that I am responsible for any amount not covered by my insurance. Initials: _____

Signature _____

Name: Test, SRS
Chart: 86509466
Date: 3/19/2018

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Patient Name Test, SRS

Date of Birth 1/1/2011

NOTICE ACKNOWLEDGMENT

I understand that, under HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

NOTICE OF PRIVACY PRACTICES brochures are available at the registration department. I understand that Whole Health Joint Replacement Institute has the right to change it's privacy practices from time to time and I may contact Whole Health Joint Replacement Institute to obtain a current copy of the brochure.

I understand that I may request in writing that you restrict how my private information is used. I also understand that by law you may not be able to agree to the requested restrictions.

Name: Test, SRS **Signature:** _____ Date: 3/19/2018

MEDICAL RELEASE (including minors)

I hereby authorize Whole Health Joint Replacement Institute to furnish information and/or discuss information contained in my medical record, including appointment information, treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnosis with the following person or persons: (including nurse case managers, if applicable). Any request to restrict this information must be submitted in writing. I also understand that by law Whole Health Joint Replacement Institute. may not be able to agree to the requested restrictions.

YOU MUST LIST THE NAMES OF ALL FAMILY MEMBERS AND/OR OTHER PERSONS WE CAN RELEASE INFORMATION TO, EITHER WRITTEN OR VERBALLY, REGARDING YOUR CARE!

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Further, I hereby authorize and give my consent to Whole Health Joint Replacement Institute to leave messages on my answering machine/voicemail system for the following:

_____ Appointment reminders (including return telephone calls)
_____ Prescription Refills
_____ Test Results
_____ **Do not leave message**

_____ Permission to fax work status reports to employer
_____ Permission to fax gym/school excuses to school

Signature _____ Date 3/19/2018

Student Resident Consent

The physicians at Whole Health Joint Replacement Institute are proud to play an integral role in the teaching of residents and the training of student interns.

As part of their education, residents, students, and interns may be present for or participate in your care. Our physicians are responsible to oversee, direct and monitor each student. While a resident, intern or student may perform care without the attending physician present, rest assured that our physicians make all final decisions regarding your care and treatment.

AT ANY TIME, YOU HAVE THE RIGHT TO REQUEST THAT A RESIDENT, INTERN, OR STUDENT IS NOT PRESENT FOR YOUR CARE AND DOES NOT PERFORM YOUR CARE.

Your signature acknowledges you have received and read this information regarding your rights.

Signature _____ Date 3/19/2018

Name: Test, SRS
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Whole Health Joint Replacement Institute

11277 Vernon Place, Suite 202, Meadville, PA. 16335 • 814-333-7109
Fax: 814-333-7108

GUIDELINES FOR PRESCRIPTION REFILLS

1. Our office requires a **7 day notice for prescription refills.**
2. Medications will be refilled between **9 AM and 4 PM Monday - Friday. No refills on the weekends or holidays. The "on-call" physicians will not refill medications.**
3. Safety of your prescriptions is YOUR responsibility. **LOST PRESCRIPTIONS WILL NOT BE REFILLED.** Lock up your prescription medicines and keep them away from children.
4. Our physicians may not refill prescriptions for pain medicine if you are receiving similar medicines from another physician.
5. Be aware of the effect of other medications you may be taking. Ask your doctor or your pharmacist whether you can take them along with pain medication.
6. Do not drink alcoholic beverages while taking pain medication. Obey warnings regarding sedation of certain medicines.
7. Follow the prescribed dose of medication. Do not give your medications to other people and do not take medication from others.
8. Preferred Pharmacy & Location: _____
   (This pharmacy will be used for your refills unless otherwise specified.)
9. Whole Health Joint Replacement Institute may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I agree and will comply with the above guidelines.

Print Patient Name: Test, SRS DOB: 1/1/2011

Signature: _____ Date: 3/19/2018
(Patient, Parent or Guardian)

Name: Test, SRS
Chart: 86509466
Date: 3/19/2018

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INITIAL PAST MEDICAL HISTORY

Name Test, SRS Date 3/19/2018

Date of Birth 1/1/2011 Date of injury _____

1. Do you have or have you ever had any of the following? If so, please check.

HEART AND VASCULAR
__Heart attack
__Angina or chest pain
__High blood pressure
__Palpitation/heart skipping
__Heart murmur
__Stroke
__Edema - ankle swelling
__Varicose veins
__Phlebitis or blood clots
__Other heart-circulation problems
__Sleep apnea

LUNGS
__Bronchitis
__Emphysema
__Asthma
__Tuberculosis
__Sinusitis
__Hay-fever
__Respiratory infections
__Shortness of breath
__Black lung
__Other lung problems
_____

OTHER SYSTEMS
__Diabetes - Insulin/Non
__Thyroid problems
__Kidney/bladder problems
__Stomach or duodenal ulcer
__Heartburn or burping
__Convulsions - epilepsy
__Dizzy or fainting spells
__Hepatitis/jaundice/liver
__Pregnant Y / N
__HIV/AIDS
__Depression / Anxiety
__Arthritis/rheumatism
__Glaucoma
__Bleeding problems/anemia
__Psychiatric problems
__Back problems
__Alcoholism
__Drug Addiction
__Cancer - type _____
__Bone disorders
__Fibromyalgia
__Other _____

2. Please list prior surgeries and dates _____

3. Are you taking any medications on a daily basis? Please list below or attach a separate listing.
Drug Name Strength Dosage

4. Do you have any allergies to medications? If so, please list medication and reaction

5. List any unusual childhood illnesses (scarlet or rheumatic fever, etc.)

6. Do any medical problems run in your family? _____DVT/Blood Clots _____Other
_____Hypertension _____Diabetes _____Heart Disease _____Rheumatic arthritis. _____Cancer

7. Do you smoke cigarettes, cigars or a pipe?
If so, how many per day? _____, for how many years? _____

8. Do you drink alcohol? Yes No If yes, how much per week _____

9. Tattoo within the past 6 months? _____

10. Do you live in a _____one story home, _____two story home or other? _____

11. Who lives at home with you? _____

12. Do you typically use a walker/cane/wheelchair? _____

13. What is your occupation? _____

14. Are you able to operate a vehicle? _____

15. Who is your primary care physician? _____

(for office use) Height _____ Weight _____ B/P _____ Age 7 years BMI _____

The above information is true and complete to the best of my knowledge.

Patient Signature _____ Date 3/19/2018

Physician/PA Signature _____ Date 3/19/2018

Name: **Test, SRS**
Chart: **86509466**
Date: **3/19/2018**

* 8 6 5 0 9 4 6 6 - 5 2 *

KNEE HISTORY

Name **Test, SRS** Date of Birth **1/1/2011**

Is this examination for your _____ right knee, _____ left knee or _____ both knees?

Is this problem due to any of the following?

_____ Auto accident
_____ Falling
_____ Motorcycle accident
_____ Snowmobile accident/ATV accident
_____ Sports Injury
_____ Work related

_____ Other, please state _____

Where did injury occur? _____

BRIEF HISTORY OF ONSET AND DURATION OF KNEE PROBLEM: _____

If you are having pain, please check all that apply:

_____ Daily pain (limits normal daily activities)
_____ Night pain
_____ Pain limiting sleep
_____ Lower extremity numbness or tingling

PLEASE CIRCLE EACH ANSWER.

Do you have knee pain in the morning? YES NO
Do you have knee stiffness in the morning? YES NO
Do you have swelling in your knee? YES NO
Have you had any swelling in your knee in the past? YES NO
If yes, please state when this occurred _____
Have you had any swelling in other joints? YES NO
Do you have pain in your (please circle) hip, low back, groin region?
Do you have pain in your knee when _____ walking, _____ running, _____ sitting or _____ standing for prolonged periods of time?
Do you use _____ cane, _____ walker, _____ crutches? If yes, how often? _____
Do you use _____ furniture _____ shopping carts for support?
Do you have pain on climbing stairs? YES NO
Do you have a grinding sensation in your knee? YES NO
Do you have a clicking sensation in your knee? YES NO
Do you have a feeling of giving way in your knee? YES NO
Does rainy weather bother your knee? YES NO
Does activity make it (please circle) better or worse?
Do over the counter pain medications relieve the pain or ache in your knee? YES NO
If yes, which _____
Can you fully straighten your knee? YES NO
Have you had a previous injury or problem with your knee? YES NO
If yes, please state how this occurred, date and treatment _____

Are you on any medications at the present time for this problem? YES NO
If you, please state _____
Have you attempted any weight loss as treatment for this problem? YES NO
Have you tried a brace or other knee support? YES NO
Has physical therapy or therapeutic exercise been attempted? YES NO

If you have seen another physician for this problem, please name _____

If you have been off work because of this problem or injury, please give the date last worked _____

Other history or information, please use reverse side if more room or further communication is needed: _____