SANO ORTHOPEDICS

NEW PATIENT INFORMATION

First Name: _____Last Name: _____M.I._____

DOB: _____SSN: _____ Sex: □ Male □ Female □ Other: _____

Address: _____City, State, Zip: _____

Home Phone: _____ Cell Phone: _____Email: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Legally Separated

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White or Caucasian □ Other

Language: □ English □ Spanish □ Other: _____

Are you currently in a Nursing/Rehab facility? □ Yes □ No □ If yes, facility name: _____

How/Where did your injury occur? □ Work □ Home □ Motor Vehicle Accident □ Sports Related □ Other

If work-related: Claim Number: _____Adjuster/Case Manager: _____

Employer Name: _____Employer Phone: _____

Employer Address: _____City, State, Zip: _____

Job Title: _____Type of work performed: _____

Employment Status: □ Employed and currently working □ Unemployed □ Student
□ Employed but not working □ Retired □ Disabled

If disabled or unemployed, is this due to your orthopedic condition? □ Yes □ No

Which description best characterizes your occupation?

- □ Sedentary: requires the ability to sit up to 6 hours in an 8-hour workday, occasionally lift light objects weighing up to 10 lbs.
- □ Light: requires the ability to stand up to 6 hours in an 8-hour workday, lift up to 10 lbs. frequently and up to 20 lbs. occasionally
- □ Medium: requires the ability to stand up to 6 hours in an 8-hour workday, lift up to 25 lbs. frequently and up to 50 lbs. occasionally
- □ Heavy: requires the ability to stand up to 6 hours in an 8-hour workday, lift up to 50 lbs. frequently and more than 50 lbs. occasionally

SOCIAL HISTORY

Tobacco Use: □ Never Smoked □ Former Smoker □ Occasional Smoker □ Exposed to Passive Smoke
□ Current Everyday Smoker: _____ packs per day □ Other Form of Tobacco

Alcohol Use: □ Does Not Drink Alcohol □ Occasional Drinker □ Occasional Heavy Use
□ 1-2 Drink Daily □ 3-5 Drinks Daily □ Daily Heavy Use

Drug Use: Are you taking any unprescribed drugs, including recreational drugs? □ Yes □ No

Exercise: □ Exercises Regularly □ Exercises Occasionally □ Does Not Exercise

SANO ORTHOPEDICS

Patient Name: _____ DOB: _____

HISTORY OF PRESENT ILLNESS / REASON FOR VISIT

Which is your dominant hand: □ Right □ Left □ Ambidextrous

Reason for today's visit: _____ Approximate date of onset/injury: _____

Any previous problems to this area: □ Yes □ No If yes, describe: _____

Have you been seen elsewhere for this problem? (ex: Emergency room, family physician, etc.) _____

Have you had any testing within the last year that pertains to your visit today? □ Yes □ No

Which Tests? □ MRI □ EMG □ CT □ X-ray □ Bone Density (DEXA)
□ None □ Other: _____

If tests were performed, where and when were they completed? _____

Please rate your pain on the scale below (0 = no pain, 10 = highest level of pain):

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

PERSONAL MEDICAL HISTORY

Please select all that apply:					
Alzheimer's	□	Gout	□	MRSA Infection	□
Anxiety	□	Heart attack	□	Osteoarthritis	□
Asthma	□	Heart disease	□	Osteoporosis	□
Autoimmune Condition	□	Hepatitis A	□	Peripheral neuropathy	□
Blood clot (DVT)	□	Hepatitis B	□	Pulmonary embolism	□
Cancer	□	Hepatitis C	□	Rheumatoid arthritis	□
Chronic pain	□	High blood pressure	□	Seizures	□
Clotting disorder	□	High cholesterol	□	Sleep apnea	□
COPD	□	HIV	□	Stomach ulcers	□
Depression	□	History of fractures	□	Stroke/TIA	□
Diabetes type 1	□	Kidney disease	□	Thyroid disease	□
Diabetes type 2	□	Liver disease	□	Vertigo	□
Esophageal reflux (GERD)	□	Migraines/Headaches	□	Other: _____	

OBSTETRICAL HISTORY (FOR FEMALES ONLY)

Are you currently pregnant? □ Yes □ No Number of children: _____ Number of pregnancies: _____

SANO ORTHOPEDICS

Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY

	Father	Mother
Blood clots (DTV)	☐	☐
Cancer	☐	☐
Chronic pain	☐	☐
Clotting disorder	☐	☐
Heart attack	☐	☐
High blood pressure	☐	☐
Pulmonary embolism	☐	☐
Stroke/TIA	☐	☐

REVIEW OF SYSTEMS

Are you experiencing any of the following?	Yes	No
Recent weight change	☐	☐
Sensory changes (inability to touch or feel)	☐	☐
Trouble swallowing	☐	☐
Night sweats	☐	☐
Fevers	☐	☐
Joint pain	☐	☐
Joint swelling	☐	☐
Loss of joint motion	☐	☐
Locking/catching sensation	☐	☐
Recurrent falls	☐	☐
Poor balance	☐	☐
Paralysis or tremors	☐	☐
Extremity numbness/tingling (arms & legs)	☐	☐
Extremity weakness (arms & legs)	☐	☐
Groin numbness/tingling	☐	☐
Difficulty urinating	☐	☐
Abnormal bowels	☐	☐

SANO ORTHOPEDICS

Patient Name: _____ Today's Date: _____

DOB: _____ Height: _____ Weight: _____

MEDICATIONS

Are you taking any blood thinning medications?

- ☐ None
- ☐ Aspirin or aspirin-containing medication
- ☐ Anti-inflammatory medication (Ex: Advil, Motrin, Celebrex)
- ☐ Fish Oil
- ☐ Prescription Medications
- ☐ Other: _____

Are you taking any supplements or vitamins? ☐ No ☐ Yes: _____

Medication Name	Dose/Strength	Frequency	Reason Prescribed

***If you have additional medications, please provide a list at your appointment, or continue writing on the back of this page.**

ALLERGIES

Are you allergic to any of the following? ☐ Latex ☐ Metal ☐ Contrast dye ☐ Iodine

Medication allergies AND reaction: _____

Other allergies AND reaction: _____

SURGICAL HISTORY

Please select all that apply:			
Shoulder Replacement - Circle: Left or Right	☐	Fixation of Fracture	☐
Knee Replacement - Circle: Left or Right	☐	Gastric Bypass	☐
Hip Replacement - Circle: Left or Right	☐	Cancer Removal	☐
Knee Ligament or Meniscus - Circle: Left or Right	☐	Hernia Repair	☐
Shoulder Rotator Cuff or Labral - Circle: Left or Right	☐	C-Section	☐
Hip Surgery (non-replacement) - Circle: Left or Right	☐	Tonsillectomy	☐
Cardiac Stent	☐	Gall Bladder Removal	☐
Pacemaker	☐	Gastric Bypass	☐
Spine Surgery	☐	Other: _____	☐

***If you have had additional surgeries, please provide a list at your appointment, or continue writing on the back of this page.**

CONTROLLED SUBSTANCE POLICY

The staff of Advanced Orthopedics and Sports Medicine d/b/a Sano Orthopedics ("Sano") is dedicated to providing our patients with the most appropriate and complete treatment for the injuries they suffer from. If you do not agree with or do not think that you can comply with our Controlled Substance Agreement and Prescription Policy, please notify us. Sano will do our best to devise a plan for you, which may include referral to a pain management specialist or referral to another providing physician. By signing this agreement, you are agreeing to abide by the following agreement and policy.

Controlled medications that are prescribed by Sano physician include but not limited the Schedule II narcotics Tramadol, Hydrocodone and Oxycodone. In order to help prevent dependency, abuse or overuse of such medications, Sano will follow the prescribing policy listed as follows:

- Tramadol and/or Hydrocodone and/or Oxycodone will initially be prescribed for severe, acute, traumatic injuries (broken bone, laceration, ligament / tendon rupture, etc.) or for post-operative pain control, if indicated clinically necessary. The choice of medication and the amount prescribed will be the physician's discretion. The prescribed duration, approval of refills and discontinued use of medication is also up to the Provider.
- Sano will not prescribe any Schedule II narcotic medications for chronic conditions.

ACKNOWLEDGEMENT

- I understand this agreement is essential to the trust and confidence necessary in a doctor / patient relationship and that my doctor undertakes to treat me based on this agreement.
- I understand that due to potential abuse or diversion of medications, strict accountability is necessary. I understand that if I break this agreement, my doctor will stop prescribing controlled substances, refer me to another physician and comply with legal reporting requirements of abuse.
- I will only take the prescribed medication as instructed. I will not share, sell or trade prescription medicine.
- I will safeguard all prescribed pain medications / controlled substances from loss or theft. I understand lost or stolen medications will not be replaced by a Sano physician or staff member.
- I understand that refills will be made only during office hours Monday-Thursday and may take 24 - 48 hours. Refills will not be available during the evenings, Fridays, weekends or on any federally recognized holidays that Sano's office is closed. A photo ID is required to pick up a prescription. If someone is delegated to pick the script up for you, they will need to sign and show a photo ID.
- Refills may not be refilled earlier than the Provider's prescribed renewal date.
- I will inform the doctor of all medications that I currently take as well as new prescribed medications.
- I agree to follow all guidelines that have been fully explained to me in this agreement. All questions and concerns have been adequately addressed.

The undersigned certifies that he/she has read and understands the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Patient / Guardian Signature: _____ Today's Date: _____

Printed Name: _____ Date of Birth: _____

PATIENT AUTHORIZATION

All the information provided is complete and accurate to the best of my knowledge. I authorize Advanced Orthopedics & Sports Medicine d/b/a Sano Orthopedics to release my personal, confidential health and billing information to my emergency contact, guarantor, referring provider, primary care physician, pharmacy, health insurance(s), workers' compensation carrier / agent and attorney. I understand that my photo identification, insurance card(s) and any applicable copayment or general deductible payment are required at the time of the visit.

Patient / Guardian Signature: _____ Today's Date: _____

Printed Name: _____ Relationship to Patient: _____

Authorization for Medical Treatment

I have been informed of the treatment procedures considered necessary and that the treatment / procedures will be directed by a physician and performed by employees of Sano Orthopedics. I understand that no guarantee for assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

INITIALS _____

Insurance Assignment and Financial Acknowledgement

I hereby authorize Sano Orthopedics to furnish information to insurance carriers concerning my care and treatment and assign to the provider all payments for medical services rendered. I understand I am financially responsible for all charges whether or not covered by my insurance. I understand I am also responsible for providing up-to-date and accurate insurance information. I certify I will pay to Sano any co-payments, co-insurance, deductibles or cost of non-covered products or services. I will promptly pay Sano any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by insurance if I fail to provide appropriate insurance information for billing.

If insured by Medicare, I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services (CMS) or its 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 either to myself for to party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible in part for my treatment.

INITIALS _____

Notice of Privacy & Release of Information

Sano Orthopedics will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed Privacy Policy to help you better understand our policies regarding your personal health information. The terms of the notice may change with time and we will always post the current notice on our website and have copies available for distribution. I have the legal right to review the Sano's Privacy Practices before I sign this consent, and Sano encourages reading it in full.

INITIALS _____

Controlled Substance Agreement and Prescription Policy Agreement:

Sano Orthopedics has made a copy of the Controlled Substance policy readily available to me. I acknowledge receipt of this information and agree to adherence to the policy set-forth by Sano Orthopedics.

INITIALS _____

I certify that I have read and understand the foregoing, is the patient or one authorized by the patient to execute the above and accepts the terms thereof.

Patient / Guardian Signature: _____ Today's Date: _____

Printed Name: _____ Relationship to Patient: _____