



David Argo, M.D.

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Female Male

Dominant Hand  R  L Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Occupation: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Who requested that you visit this office?  Doctor Name: \_\_\_\_\_  Self Referral  Attorney

Would you like to receive information by email?  N  Y Email Address \_\_\_\_\_

Are you :  Single  Married  Divorced  Widowed

1. \*(Chief Complaint) Main reason for visit?  Pain  Numbness  Weakness  Other

(If other please explain)

2. \*(Location) What body part is involved? (Check Below)

<input type="checkbox"/> Neck & radiates to	<input type="checkbox"/> R Arm <input type="checkbox"/> L Arm	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
<input type="checkbox"/> Back & radiates to	<input type="checkbox"/> R Leg <input type="checkbox"/> L Leg	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist <input type="checkbox"/> R <input type="checkbox"/> L	Finger <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe <input type="checkbox"/> R <input type="checkbox"/> L

3. \*(Duration) How long has this problem been present? \_\_\_\_\_  Days  Weeks  Months  Years

4. \*Check the ONE box below that best describes how your problem started? Use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

NO INJURY Onset was:  Gradual  Sudden COMMENTS:

Why do you think it started? \_\_\_\_\_

INJURY (From accident or sport NOT work or auto related)

Date: \_\_\_\_\_

Where & how did it happen? \_\_\_\_\_

What sport? \_\_\_\_\_

School: \_\_\_\_\_

INJURY AT WORK From a:  Lift  Twist  Bend  Pull  Reach

Date: \_\_\_\_\_

Date: \_\_\_\_\_ How did your job cause this injury? \_\_\_\_\_

B BBB B

AUTO ACCIDENT

Date: \_\_\_\_\_

How was the car hit? \_\_\_\_\_

Please checkout the box in each category that best describes your problem:

5. \*On a scale of 1-10 please rate your pain (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

6. \*Quality of pain?  Sharp  Dull  Stabbing  Throbbing  Aching  Burning

7. \*Timing of pain?  Constant  Comes & Goes (intermittent) Does the pain wake you from sleep?  Y  N

8. \*Do you have?  Swelling  Bruising  Numbness  Tingling  Weakness  Loss of bowel/bladder

9. \*Since my problem started, it is:  Getting Better  Getting Worse  Unchanged

10. \*What makes the symptoms worse?  Standing  Walking  Lifting  Exercise  Twisting

Lying in bed  Bending  Squatting  Kneeling  Stairs  Sitting  Coughing  Sneezing

11. \*What makes it better?  Rest  Heat  Ice  Elevation  Other \_\_\_\_\_

12. \*What medications have you taken for this problem? \_\_\_\_\_

13. \*Which treatments have you tried? \_\_\_\_\_

14. \*Were you seen in the Emergency Room for this problem?  N  Y Which ER and Date? \_\_\_\_\_

15. \*What tests have you had?  X-Rays  MRI  CAT Scan  Bone Scan  Nerve Test (EMG/NCV)

16. \*Have you already had surgery for this problem?  N  Y Surgeons Name \_\_\_\_\_ Date: \_\_\_\_\_

17. \*Did you have any adverse reactions to the anesthesia?  N  Y

18. \*Do you have any MEDICAL PROBLEMS?  N  Y (Please list or check below)

- |                                     |  |  |                                       |   |
|-------------------------------------|--|--|---------------------------------------|---|
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Blood Clots  | <input type="checkbox"/> Asthma               |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Ulcers     | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatoid Arthritis |

Cancer: \_\_\_\_\_ Other: \_\_\_\_\_

19.\* Do you have any ALLERGIES?  N  Y Please List \_\_\_\_\_

20.\* Did you bring any X-Rays or Discs with you today?  N  Y

21.\* Did a physician place you off work?  N  Y

22.\* Are you pregnant?  N  Y

23.\* Who is your medical Doctor? \_\_\_\_\_

24.\* Please list any previous surgeries including year \_\_\_\_\_

25.\* Do you use tobacco?  N  Y  Former How Frequently? \_\_\_\_\_ per day \_\_\_\_\_ per week

26.\* Do you consume alcohol?  N  Y How Frequently? \_\_\_\_\_ per day

27.\* Do you consume caffeine?  N  Y How Frequently? \_\_\_\_\_ per day \_\_\_\_\_ per week

28.\* Do you have a history of recreational drug use?  N  Y

29.\* Describe your activity level  Above average  Average  Sedentary

30.\* How frequently do you exercise?  2-3 times/week  3-4 times/week  5 times/week  Daily  Never

31.\* What is your occupation? \_\_\_\_\_

32.\* Do you have any hobbies? \_\_\_\_\_

**REVIEW OF SYMPTOMS**

Have you ever had a prior problem with the same Orthopaedic condition you are here for today?

Do you have OTHER JOINTS with  Morning Stiffness,  Swelling, or  Pain?

Please check any that apply to YOU or mark NONE

Heart Burn  Nausea  Vomiting  Loss of Appetite  Stomach pain with anti-inflammatory pills

Excessive Thirst  Heat/Cold intolerance  Trouble Swallowing  Fever  Weight Loss  Hoarseness

Blood in Stool  Easy Bleeding  Easy Bruising  Anemia  Painful Urination  Blood in Urine

Blurred Vision  Double Vision  Vision Loss  Headaches  Dizziness  Hearing Loss

Chronic Cough  Shortness of Breath  Rash  Skin Ulcers  Lumps  Psoriasis

Chest Pain  Palpitations  Drug/Alcohol Addiction  Depression  Sleep Disorder

Please list any other medical conditions we should be aware of? \_\_\_\_\_

Please check any that apply to YOU OR your IMMEDIATE family (Mother, Father or Siblings) & please specify as to which member of your family is afflicted

AIDS/ HIV \_\_\_\_\_  COPD \_\_\_\_\_  Depression \_\_\_\_\_  Hepatitis \_\_\_\_\_

Alcoholism \_\_\_\_\_  Colon Cancer \_\_\_\_\_  Diabetes \_\_\_\_\_  Kidney Disease \_\_\_\_\_

Alzheimers \_\_\_\_\_  Lung Cancer \_\_\_\_\_  Drug Abuse \_\_\_\_\_  Osteoarthritis \_\_\_\_\_

Anemia \_\_\_\_\_  Breast Cancer \_\_\_\_\_  Gout \_\_\_\_\_  Seizures \_\_\_\_\_

Asthma \_\_\_\_\_  Prostate Cancer \_\_\_\_\_  Heart Disease \_\_\_\_\_  Ulcers \_\_\_\_\_

Blood Clots \_\_\_\_\_  Cancer (type) \_\_\_\_\_  Hypertension \_\_\_\_\_  Osteopenia or Osteoporosis \_\_\_\_\_

List any others \_\_\_\_\_

**For Office Use Only**

Reviewed by Dr. David Argo \_\_\_\_\_ Date: \_\_\_\_\_





## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with and understand this facility's Notice of Privacy Practices (HIPAA information). This notice provides a complete description of the uses and disclosures of my health information.

Patient Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

\_\_\_\_\_  
\*Patient or Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient  
(ex: parent, power of attorney)

*\*If the patient is a minor child or otherwise unable to sign this authorization, then obtain the signature of the authorized individual.*



## Designation of a Personal Representative

A patient **may** designate a personal representative in writing. This person may be a spouse, adult child, members of the patient's family, or close friend. They may also be any individual with power of attorney or other legally recognized authority to make medical decisions on behalf of the patient if he or she is incapacitated or otherwise unable to make decisions. As a general rule, a parent or legal guardian of a minor child will be recognized as their personal representative.

A personal representative may act on behalf of the patient for the purpose of receiving information that otherwise would be given to the patient. Such information could include: appointment changes, messages regarding surgery and/or testing, physician's responses to phone messages and medication requests.

**PLEASE NOTE: an answering machine cannot be used as an acceptable way of leaving information.**

A staff member may refuse to disclose information to a person identified as a patient's personal representative if he/she believes such information should be given directly to the patient.

*Please note:* This form does not grant permission to release medical records to these designated representatives. Requests for medical records must be made separately through the Medical Records department. Please allow approximately five business days to process a request for medical records.

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Person(s) to whom my information may be disclosed:

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

_____	_____	_____
Name	Relationship	Phone Number

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Patient/Authority Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*You may revoke or terminate this authorization at any time by submitting a written revocation to Beacon Orthopaedics & Sports Medicine, Ltd./Beacon Orthopaedics Surgery Center, LLC.*

*Revised March 2012 - 45 CFR 164.502(g)*

**Beacon Orthopaedics and Sports Medicine, LLC Financial/Credit Policy**  
Effective April 2009

Patient name: \_\_\_\_\_ Account #: \_\_\_\_\_  
Please print

Beacon Orthopaedics and Sports Medicine, LLC (BOSM), believes that in the interest of good health care practices, it is best to establish a patient financial/credit policy between our patients and ourselves in order to avoid any misunderstandings. Our Account Representatives will be glad to discuss your account with you at any time and set up payment plans. Our primary responsibility is to deliver quality health care services. We wish to spend our time and energy toward that responsibility. We expect you to show us the same consideration as you do your other creditors, and to be honest and forthright regarding your financial responsibility.

(PLEASE INITIAL THE FOLLOWING)

\_\_\_\_\_ 1.) We expect that all co-pays, co-insurance and deductible be paid in full at each visit and prior to surgery, diagnostic testing and physical therapy. We accept cash, check, Debit Card, MasterCard, VISA, American Express, and Care Credit.

\_\_\_\_\_ 2.) We file claims to your insurance company for your primary and secondary policies. You must bring your insurance card with you to every visit and make us aware of any changes in coverage. We also require a copy of your driver's license to confirm identity. Please remember insurance coverage is a contract between the patient and the insurance company. When BOSM files for benefit for services performed, benefits are assigned to BOSM. BOSM will look to the patient for payment in full if insurance does not cover the services provided. If we do not participate with your insurance, you will likely have a higher out-of-pocket expense, so please be prepared to pay this amount

\_\_\_\_\_ 3.) ***We do not file any insurance with your Automobile Insurance Company, or any other third party (business insurance company, employer, attorney, separated spouses, etc.) for purposes of obtaining payment.*** We will make every effort to provide you with proper documentation for you to receive reimbursement from those parties (i.e., claim form, statement or report). Please speak with our billing representative. We do not accept Letters of Guarantee or other promises to pay when cases settle. You will be extended credit only if arrangements are made in advance and only within our standard guidelines for credit.

\_\_\_\_\_ 4.) If the patient is under age 18, a parent or guardian must sign below. If the minor does not reside with both parents, and there is a dispute over which parent is responsible for any remaining balances, we will ultimately rely upon the parent/guardian who brought the child to the office for financial responsibility. All minors will not be seen unless accompanied by a guardian or a signed authorization from that guardian allowing our physicians to provide medical treatment.

\_\_\_\_\_ 5.) A service charge of \$20.00 will be applied to returned checks. You will be asked to bring cash, money order or cashiers check to our office to cover the amount of the check plus the service charge. If you present two (2) checks that are returned to us, we will require cash for future services.

\_\_\_\_\_ 6.) 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. All fees assessed by the agency or attorney will be charged to you and become part of your outstanding balance.

By signing this agreement, you are acknowledging that you understand our financial/credit policy and agree to pay for all services that are received.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# BEACON

Orthopaedics & Sports Medicine

**Driving Directions to Beacon West**  
**6480 Harrison Ave**  
**Cincinnati, Ohio 45247**  
**513-354-3700**

**From Northern Cincinnati**

Travel South I-75  
Take 275 West to I-74 East to the Rybolt Exit  
Turn left at the exit  
Turn right onto Harrison Ave  
Go up the hill and stay in the left lane  
You will pass Kohls and Meijers  
Turn left at 6480 Harrison Avenue  
Proceed ahead up the hill to Beacon Orthopaedics

**From West Harrison and Indiana**

Take I-74 east to Rybolt Exit  
Turn left at the exit  
Turn right onto Harrison Ave  
Go up the hill and stay in the left lane  
You will pass Kohls and Meijers  
Turn left at 6480 Harrison Ave  
Proceed ahead up the hill to Beacon Orthopaedics

**From Northern Kentucky**

Travel I-75 North to I-74 West  
Take Exit #11 Harrison/Rybolt Exit  
Turn left onto Harrison Ave  
You will pass Kohls and Meijers  
Turn left at 6480 Harrison Ave  
Proceed ahead up the hill to Beacon Orthopaedics

**From Harrison Avenue, South**

Take Harrison Ave North from Race Road for approximately 2+ miles  
Turn right at 6480 Harrison Ave  
Proceed ahead up the hill to Beacon Orthopaedics



Directions to

## Beacon Lawrenceburg

605 Wilson Creek Rd, Lawrenceburg, IN 47025

513-354-3700

### **COMING FROM THE WEST ON I-74**

Take the Lawrenceburg/St. Leon Exit (Exit #164)

Turn Right onto IN 1 S (13.4 miles)

Turn Right onto US 50 W (3 miles)

Turn Right onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

### **COMING FROM OHIO ON I-74**

Take I-275 South towards Kentucky

Take the Lawrenceburg exit (Exit #16)

Turn Left onto US 50 W (3 miles)

Turn Right onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

### **COMING FROM OHIO ON I-275**

Take the Lawrenceburg Exit (Exit #16)

Turn Left onto US 50 W (3 miles)

Turn Right onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

### **COMING FROM KENTUCKY ON I-275**

Take the Lawrenceburg exit (Exit #16)

Turn Left onto US 50 W (3 miles)

Turn Right onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

### **COMING FROM CLEVES / NORTH BEND / ADDYSTON / DELHI**

Take US 50 W (River Road)

Turn Right onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building

### **COMING FROM MILAN**

Take IN 350 East (13.1 miles)

Turn Left onto US 50 East (3.4 miles)

Turn Left onto IN 48 (2.3 miles)

Beacon Lawrenceburg is located on Wilson Creek Rd. in the Medical Office Building



## Directions to the Batesville Indiana Office 1360 E. State Road 46 Batesville, IN 47006

### From Cincinnati:

- Take I-74 West, into Indiana
- Take Exit 149, Batesville/Oldenburg
- Turn left on IN 229, .2 miles
- Turn left on IN 46, travel 1.5 miles, Junction 129
- Turn left at the light, office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

### From Lawrenceburg:

- Take US 48 west to IN 129 N to Batesville. At the junction with IN 46 go straight through the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

### From Greensburg/Indianapolis:

- Take I-74 E to exit 149, Batesville/Oldenburg
- Turn right on IN 229 For .2 miles
- Turn left on IN 46, Travel 1.5 miles to Junction with 129
- Turn left at the light
- The office is on the right, behind Friendship State Bank, the Hobo Hut and next to the bowling alley

