

Dear Patient,

Welcome to Beacon Orthopaedics and Sports Medicine! Your appointment is confirmed for \_\_\_\_\_ at \_\_\_\_\_ am/pm with Dr. \_\_\_\_\_.

Please complete the enclosed registration and history forms. Please bring the completed forms with you to your appointment. If you have had any x-rays taken or other testing done prior to your visit, please bring those as well.

We also require a picture ID and insurance cards at the time of your appointment. If your insurance carrier requires a referral, please contact your primary care physician immediately. We need to receive the referral authorization prior to your visit.

If this is a work related injury, we will require the following information:

- Employer's name, phone number, and contact person
- First Report of Injury
- Name and address of MCO
- Claim Number
- Date of Injury

Please refer to the highlighted address on the left side of this letter for the location of your office visit.

We look forward to serving you.

# PATIENT HISTORY

## BEACON ORTHOPAEDICS & SPORTS MEDICINE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Was this due to an injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of Injury \_\_\_\_\_ Did this occur at work? Yes \_\_\_\_\_ No \_\_\_\_\_

Has the injury been treated? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how has this been treated and by whom? \_\_\_\_\_

Have you had a previous similar injury? Yes \_\_\_\_\_ No \_\_\_\_\_ Please explain: \_\_\_\_\_

Current Weight: \_\_\_\_\_ 1 year ago \_\_\_\_\_ Height \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Occupation: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ D \_\_\_\_\_ Do you live alone? Yes \_\_\_\_\_ No \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_

Do you Smoke? Quit \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ If yes how many per day? \_\_\_\_\_ Total years you have smoked? \_\_\_\_\_ Have you ever tried to quit? Y \_\_\_\_\_ N \_\_\_\_\_

Do you consume alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes how much per week? \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Latex Allergy? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

Current Medications: \_\_\_\_\_

Hospitalizations or Previous Surgeries: \_\_\_\_\_

Past Medical Problems: \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ yes \_\_\_\_\_ no If yes give date: \_\_\_\_\_

### PLEASE USE BACK OF FORM TO ADD ANY OTHER PERTINENT INFORMATION

Have you or your family members had any of the following conditions? (Please check all that apply):

	Self Yes no	Mother Yes no	Father Yes no	Children/Other Relatives Yes no	
Heart Disease	____	____	____	____	<b>For Women Only:</b> <b>Pregnant: Yes _____ No _____</b>  <b>Last Menstrual Period: _____</b>
High Blood Pressure	____	____	____	____	
Stroke	____	____	____	____	
Cancer	____	____	____	____	
Glaucoma	____	____	____	____	
Diabetes	____	____	____	____	<b>Are there any other serious illnesses /health conditions affecting you or your family of which we should be aware?</b> <b>Yes _____ No _____</b> _____ _____
Epilepsy/Convulsions	____	____	____	____	
Bleeding Disorder	____	____	____	____	
Thyroid Disease	____	____	____	____	
Mental Illness	____	____	____	____	
Osteoporosis	____	____	____	____	
Tuberculosis	____	____	____	____	
Kidney Disease	____	____	____	____	

**Please check if you have ever had the symptom listed – Check all that apply**

<u>Constitutional</u>	<u>Eyes</u>	<u>ENT/Mouth</u>	<u>Cardiovascular</u>	<u>Respiratory</u>
____ Fever	____ Double Vision	____ Deafness	____ Chest Pain	____ Shortness of Breath
____ Weight Loss	____ Blurring	____ Sinusitis	____ Heart Murmur	____ Asthma
____ Fatigue	____ Trauma	____ Ringing in Ears	____ High Blood Pressure	____ Lung Disease
		____ Dizziness	____ Heart Attack	____ Bronchitis
		____ Balance Problems	____ Irregular Rhythm	____ Pneumonia
<u>GI</u>	<u>GU</u>	<u>Musculoskeletal</u>	<u>Neurological</u>	<u>Psych</u>
____ Weight Change	____ Leaking Urine	____ Fracture	____ Seizures/Epilepsy	____ Depression
____ Diarrhea	____ Prostate Disease	____ Pain	____ Weakness	____ Sleep Disorder
____ Constipation	____ Pain with Urination	____ Swelling	____ Stroke	____ Memory Problems
____ Ulcer	____ Frequent Urination	____ Arthritis	____ Headaches	
____ Gallbladder Disease	____ Kidney Stones	____ Spasm/Muscle	____ Blackouts/Fainting	
____ Change in Bowel Habits		____ Gout	____ Tremble	
		____ Rheumatoid Arthritis	____ Head Injuries	
<u>Vascular</u>	<u>Hematologic</u>	<u>Allergy/Immunology</u>	<u>Skin/Breast</u>	
____ Blood Clots	____ Hepatitis	____ Hay Fever	____ Breast Abnormality	
____ Poor Circulation	____ Anemia	____ Dermatitis	____ Change in Skin/Hair	
	____ Lymph Node			
	____ AIDS			

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By \_\_\_\_\_ MD Date \_\_\_\_\_

Note: This is a confidential Record of your medical history and will be maintained in this office. The information contained here will not be released to any person except who you have authorized to do so.

Please list any medications you are currently taking



## 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. If person is POA, we must have a copy of the Power of Attorney paperwork.*

### **Consent to Be Contacted**

Beacon Orthopaedics & Sports Medicine, or third parties on our behalf, may need to contact you regarding your healthcare or your account with us. Those communications may include appointment and exam confirmation and reminders, wellness checkups, pre-registration instructions, pre-operative instructions, post-discharge instructions, post-appointment follow-up, prescription notifications, and other messages relating to your care, scheduling, benefits, billing, payment, or other financial responsibilities. By providing your phone number, you agree to receive calls or text messages from Beacon Orthopaedics & Sports Medicine, or a third party on its behalf, at the number you have provided. Such calls may be placed using an automatic telephone dialing system.

Please provide your preferred contact information below.

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

Cell Phone Number: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

- ☐ I would like to receive emails from Beacon Orthopaedics & Sports Medicine regarding new services, educational content, events, and other content related to orthopaedic conditions/treatment options.

Email Address: \_\_\_\_\_

## Designation of a Personal Representative Form

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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. 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.***

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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/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***If patient is a minor***, please provide the following information:

Mother's Name: \_\_\_\_\_  
AND  
Father's Name: \_\_\_\_\_  
OR Legal Guardian(s): \_\_\_\_\_

*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 2019.*

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

**Patient Name:** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_  
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, Discover 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 change 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 the purpose 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 a 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.

Name - Person Completing Form (Print): \_\_\_\_\_ Birthdate of Person: \_\_\_\_\_

Signature - Person Completing Form: \_\_\_\_\_ Date: \_\_\_\_\_



**Driving Directions to Beacon Orthopaedics**

**Miamisburg Location  
2835 Miami Village Drive  
Miamisburg, Ohio 45342  
513-354-3700**

**From I-75 North**

Head north on I-75  
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township  
Use the right 2 lanes to turn right onto Austin Blvd  
Use the left 2 lanes to turn slightly left toward OH-741 N  
Use any lane to turn left at the 1st cross street onto OH-741 N  
Turn right onto Miami Village Drive  
The Beacon Location will be on your left

**From I-75 South**

Head south on I-75  
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township  
Use the left 2 lanes to turn left onto Austin Blvd  
Use the left 2 lanes to turn slightly left toward OH-741 N  
Use any lane to turn left at the 1st cross street onto OH-741 N  
Turn right onto Miami Village Drive  
The Beacon Location will be on your left

**From I-675 South**

Head west on I-675 S  
Use the left 2 lanes to merge onto I-75 S toward Cincinnati  
Take Exit 41 for Austin Blvd toward Miamisburg/Washington Township  
Use the left 2 lanes to turn left onto Austin Blvd  
Use the left 2 lanes to turn slightly left toward OH-741 N  
Use any lane to turn left at the 1st cross street onto OH-741 N  
Turn right onto Miami Village Drive  
The Beacon Location will be on your left



Orthopaedics & Sports Medicine

**Driving Directions to Beacon Orthopaedics  
Summit Woods Complex  
500 E-Business Way  
Sharonville, Ohio 45241  
513-354-3700**

**From I-75**

Take I-275 East to Reed Hartman (Exit #47)

*Stay in middle lane on exit ramp and follow signs to Kemper Road.*

Turn right on Reed Hartman and *immediately* get into the left lane for Kemper Road Connector.

Turn left at the first traffic signal. This will take you up a short hill to Kemper Road and by the Double Tree Inn.

Turn right (east) on Kemper to second traffic signal, which is E-Business Way.

Turn left to Beacon Orthopaedic Center at 500 E-Business Way.

**From I-71**

Take I-275 West to Reed Hartman (Exit #47).

Turn left and cross over the interstate.

Once over the interstate, Reed Hartman turns into two lanes. *Stay in the left lane.*

Turn left at first traffic signal. This will take you up a short hill to Kemper road and by the Double Tree Inn.

Turn right (east) on Kemper to second traffic signal, which is E-Business Way.

Turn left to Beacon Orthopaedic Center at 500 E-Business Way.