BEACON
Orthopaedics & Sports Medicine

Patient History Form for Dr. Robert Burger

Patient Name (print): _____ **Date of Birth:** _____
Gender: □ Male □ Female **Marital Status:** □Single □ Married □ Divorced □ Widowed
Ethnicity: _____ **Race**:_____**Preferred Language**:_____
Referred to Dr. Burger by: □ Self □ Family □ Physician □ Attorney □ Other: _____

Reason for visit (Body part): _____ □ Right □ Left □ Both

How did your symptoms start? _____
When did your symptoms start? _____

Is this a new (acute) injury? □ Yes □No
Is this a sports related injury? □ Yes □ No
Is this a work related injury? □ Yes □ No
Is this an old (chronic) condition? □Yes □ No
If yes, list School & Sport(s) _____
Is this a result of a motor vehicle accident? □ Yes □ No

On a scale from 0-10 how would you rate your pain level? (Circle answer):
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Most Severe)

Please Circle the following which best describes the nature of your pain (circle all that apply)
Sharp Dull Stabbing Throbbing Aching Burning Other:_____
Please circle the timing of your symptoms (circle all that apply):
Constant Intermittent (Comes and Goes) Pain only with activities Pain wakes you from sleep
Please circle any associated symptoms you have experienced (circle all that apply):
Swelling Stiffness Instability Giving Way Numbness Tingling Popping Clicking Catching

Has this condition been evaluated by a Doctor? □ Yes □ No **If yes, who and when:** _____
What has been done for this condition?(circle all that apply):
Medications Rest Ice Heat X-rays MRI CT Physical Therapy Injection(s)

PLEASE CHECK IF YOU HAVE EVER HAD ANY OF THE SYMPTOMS LISTED BELOW:

Constitutional:
□ Fever
□ Weight loss
□ Fatigue
□ Weakness
□ Dizziness

Gastro-Intestinal:
□ Ulcer
□ Frequent heartburn
□ Reflux
□ GI Bleeding

Urinary:
□ Prostate problems
□ Kidney Stones
□ Chronic infections
□ frequent urination

Cardiovascular:
□ Chest Pain or angina
□ Shortness of breath
□ Heart murmur
□ Heart attack
□ Irregular heartbeat
□ Fainting or syncope
□ Ankle swelling
□ Rheumatic fever

Surgical:
□ Anesthesia problems
□ Wound healing problems

Psychological:
□ Depression
□ Anxiety disorder
□ Memory problems

Respiratory:
□ Asthma
□ COPD
□ Lung disease
□ Pneumonia
□ Tuberculosis

Hematologic:
□ Anemia
□ Poor Circulation
□ Phlebitis
□ Blood clots
□ Excessive bleeding
□ Blood transfusion

Allergy/Immune:
□ Seasonal Allergies
□ Skin conditions

Musculoskeletal:
□ Joint pain
□ Joint swelling
□ Muscle weakness
□ Muscle tenderness
□ Muscle spasms
□ Morning stiffness
□ Rheumatoid arthritis
□ Osteoporosis
□ Gout

Neurological and ENT;
□ Seizures or epilepsy
□ Stroke or TIA
□ Headaches
□ Trembling or Tremor
□ Balance problems
□ Hearing or vision loss

CONTINUE ON 2ND PAGE

BEACON
Orthopaedics & Sports Medicine

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE OR HAVE BEEN TREATED FOR:

AIDS/HIV	COPD	Depression	Hepatitis
Alcoholism	Cancer, Breast	Diabetes	Kidney Disease
Alzheimer's	Cancer,Lung	Drug Abuse	Seizures
Anemia	Cancer, Prostate	Gout	Thyroid
Asthma	Cancer (type) _____	Heart Disease	Ulcers
Blood Clots	Cholesterol	Hypertension	Osteopenia or Osteoporosis

Please list any other medical conditions we should be aware of: _____
_____
_____

Who is your Medical Doctor? _____
Do you see a Pain Management Doctor? □ **Yes** □ **No** **If yes, who do you see?**_____

What is your current height?_____ **What is your current weight?**_____
Do you have any allergies to medication? □ Yes □ No **If yes, list medication(s) and reaction:** _____
Are you allergic to nickel or any metals? □ Yes □ No **Do you have any metal in your body?** □ Yes □ No
Are you allergic to latex? □ Yes □ No

List any previous surgeries or overnight hospital stays (Please include year):_____
_____
_____

PLEASE CIRCLE THE FOLLOWING CONDITIONS YOUR IMMEDIATE FAMILY (MOTHER, FATHER OR SIBLINGS) HAVE BEEN TREATED FOR:

AIDS/HIV	COPD	Depression	Hepatitis
Alcoholism	Breast Cancer	Diabetes	Kidney Disease
Alzheimer's	Lung Cancer	Drug Abuse	Seizures
Anemia	Prostate Cancer	Gout	Thyroid
Asthma	Cancer (type) _____	Heart Disease	Ulcers
Blood Clots	Cholesterol	Hypertension	Osteopenia or Osteoporosis

List any other conditions:_____

Which hand do you write with? □ Right □ Left **Are you retired?** □Yes □ No
What is your occupation or job title? _____
Are you currently employed? □ Yes □ No **Who is your employer?** _____

Do you use tobacco? □ Yes □ No □ Former **If yes, which type?** Chewing Cigar Cigarettes Pipe
Please list amount and duration: (example 1 pack a day for 20 years)_____
Do you consume alcohol? □ Yes □ No □ Former:
Do you consume caffeine ? □ Yes □ No

Patient signature:_____ **Date:**_____

BEACON
Orthopaedics & Sports Medicine

Patient Name: _____ DOB: _____

Medications List

Allergies

_____ _____

_____ _____

Please list any medications you are currently taking

Drug Name	Dosage	Directions	Reason Taking

Preferred Pharmacy:_____ Date:_____

Location/Number:_____

BEACON
Orthopaedics & Sports Medicine

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.*

BEACON
Orthopaedics & Sports Medicine

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.

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

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