BEACON
Orthopaedics & Sports Medicine

An OrthoAlliance Partner Practice

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.

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Patient Name: _____

DOB: _____

Date: _____

Could you please complete this Questionnaire?
It is designed to give us information about your health that will allow us to better understand and assist you.

CURRENT HISTORY

What is the main reason for your visit today? (Check all that apply)

☐ Back Pain ☐ Leg Pain ☐ Neck Pain ☐ Arm Pain

☐ Other: _____

How long has this been a problem?

☐ Less than 2 Months ☐ 2-6 months ☐ 6-12 months ☐ Greater than 1 year

☐ Further Comments: _____

_____

_____

Have you been treated by any other Care Giver for this condition? YES ☐ NO ☐

If yes, please list: _____

_____

What treatments have you had for this problem? (Check all that apply):

☐ Nothing ☐ Chiropractic Care ☐ Acupuncture ☐ Injections

☐ Physical Therapy (Please check all that apply)

☐ *Stretching* ☐ *Strengthening* ☐ *Traction* ☐ *Iontophoresis/Topical Steroid* ☐ *TENS*

☐ *Massage* ☐ *Ultrasound* ☐ *Heat/ice* ☐ *Therapeutic Ball*

☐ Medications

☐ *Muscle Relaxants* ☐ *Pain Medications* ☐ *Anti- Inflammatory (Prescription)*

☐ *Anti-Inflammatory Over the Counter (Aspirin, Tylenol, Advil, Aleve, etc)*

☐ Other: _____

Have you had any tests for this problem? YES ☐ NO ☐

☐ X-Ray ☐ MRI ☐ Discography ☐ CT ☐ EMG

☐ CT/Myelogram ☐ Bone Scan ☐ Other (Please Specify): _____

_____

Current problem is the result of a(n) (Check all that apply):

☐ Injured at work ☐ Auto Accident ☐ Sports ☐ No apparent cause

☐ Other _____

Is there any litigation pending? ☐ Lawsuit ☐ Workers Comp ☐ Disability Claim ☐ Social Security Claim

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Patient Name: _____

Date: _____

Current problem began: (Check all that apply)

☐ Suddenly ☐ Gradually ☐ Lifting ☐ Twisting ☐ Fall

☐ Bending ☐ Pulling ☐ Other_____

What makes the pain worse?

☐ During Exercise ☐ After Exercise ☐ Prolonged Sitting ☐ Prolonged Standing ☐ Walking

☐ Bending Forward ☐ Bending Backward ☐ Pushing ☐ Pulling ☐ Squatting

☐ Night Pain ☐ Other:_____

What reduces your pain?

☐ Nothing ☐ Lying down ☐ Sitting ☐ Standing ☐ Walking

☐ Medication ☐ Shifting/Changing positions

☐ Other_____

PAST MEDICAL HISTORY

SPINE Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Surgical History:

Date	Surgery	Complication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or Past Illnesses:

Date:	Illness or Hospitalization:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Patient Name: _____

Date: _____

Medication Allergies **Are you Allergic to Latex:** YES ☐ NO ☐

_____

_____

_____

Medication and Dosage:

	Medication	Strength	# of pills per day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SOCIAL HISTORY

Age: _____

Occupation: _____

Are you? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you working? ☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Not working

Do you exercise? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Type of exercise/activity? _____

Do you have children? Yes ☐ No ☐ How many?_____

Do you live alone? Yes ☐ No ☐

Do you have lots of stairs? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ Packs per day_____for_____years.

Use other nicotine products? Yes ☐ No ☐

Which product do you use? ☐ Chew ☐ Gum ☐ Patch ☐ Cigars ☐ Other _____

Have you Quit smoking? Yes ☐ No ☐ How long ago?_____

Drink alcohol? ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month ☐ 1-2 x/year ☐ Never

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Patient Name: _____

Date: _____

FAMILY HISTORY

Do you have a family history of:

Arthritis	YES ☐	NO ☐	Blood clots/excessive-bleeding	YES ☐	NO ☐
Hypertension	YES ☐	NO ☐	Diabetes	YES ☐	NO ☐
Cancer	YES ☐	NO ☐	Adverse Reaction to Anesthesia	YES ☐	NO ☐
Mental Health Disorders	YES ☐	NO ☐	Cardiac Disorders	YES ☐	NO ☐

Other_____

REVIEW OF SYSTEMS

Are you currently or have you had problems with:

			Please describe all yes answers
Skin	Yes ☐	No ☐	_____
Ears, Nose, Throat	Yes ☐	No ☐	_____
Cardiac/High blood pressure	Yes ☐	No ☐	_____
Lungs, (Asthma, Infection)	Yes ☐	No ☐	_____
Stomach/Digestion	Yes ☐	No ☐	_____
Bladder/Bowel problems	Yes ☐	No ☐	_____
Hematologic/Bleeding problems	Yes ☐	No ☐	_____
Diabetes	Yes ☐	No ☐	_____
Cancer	Yes ☐	No ☐	_____
Musculoskeletal	Yes ☐	No ☐	_____
Neurological	Yes ☐	No ☐	_____
Psychiatric problems	Yes ☐	No ☐	_____
Reproductive/Sexual Problems	Yes ☐	No ☐	_____
Fever/Chills	Yes ☐	No ☐	_____
Night Sweat	Yes ☐	No ☐	_____
Night Pain	Yes ☐	No ☐	_____
Unexpected Weight loss	Yes ☐	No ☐	_____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Physician Signature _____

BEACON Orthopaedics & Sports Medicine

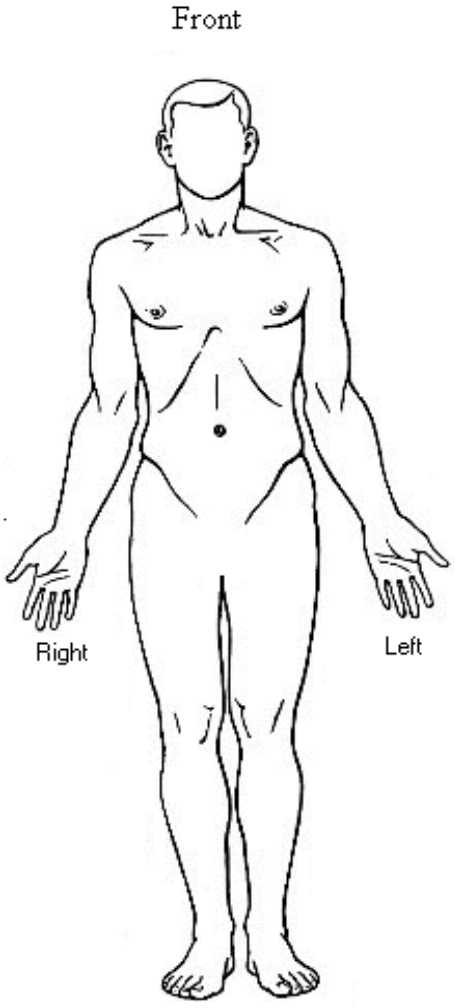
Michael T. Rohmiller, M.D.

Patient Name: _____

Date: _____

Spine Surgery New Patient Questionnaire

WHERE IS YOUR PAIN NOW?



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total	100	%

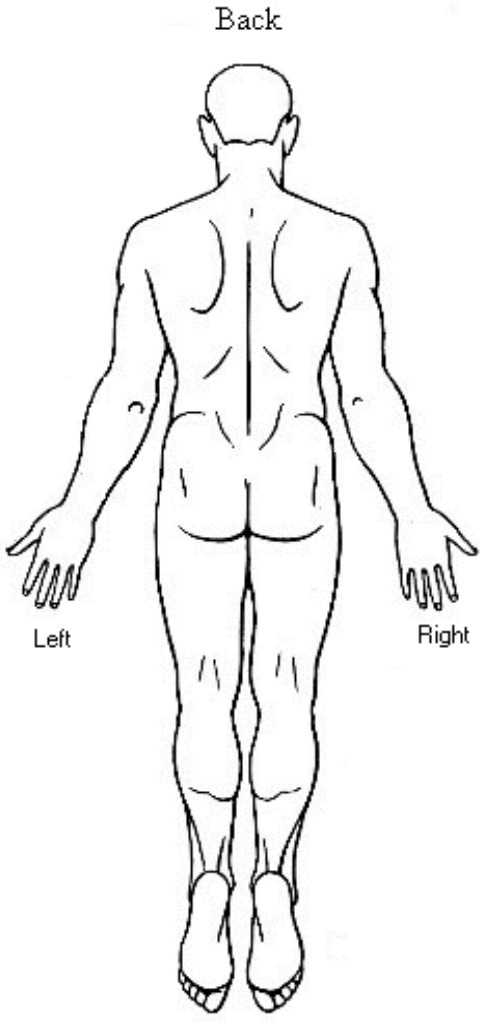
Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.

Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///

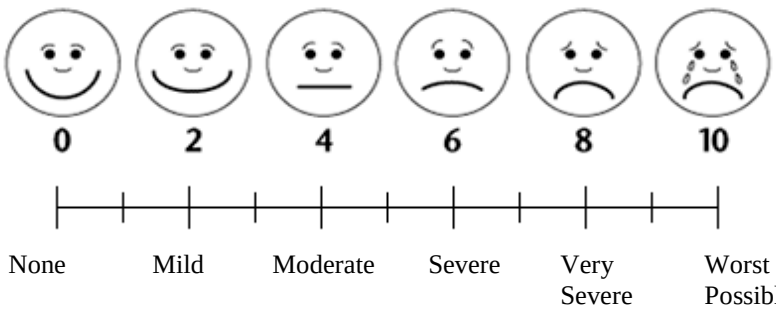
Pins And Needles

≡ ≡ ≡



Grade your overall Pain

Please place an X *on the hash mark* that most accurately describes your overall degree of pain now.



BEACON Orthopaedics & Sports Medicine

Patient Name: _____

Date: _____

Michael T. Rohmiller, M.D.

SF-12v2TM Health Survey

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
☐	☐	☐	☐	☐

2. The following questions are about activities you might do during a typical day. Does your health *now* limit you in these activities? If so, how much?

	Yes, Limited a lot	Yes, Limited a little	No, not limited at all
a. **Moderate activities,** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing **several** flights of stairs	☐	☐	☐

3. During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. **Accomplished less** than you would like	☐	☐	☐	☐	☐
b. Were limited in the **kind** of work or other activities	☐	☐	☐	☐	☐

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. **Accomplished less** than you would like	☐	☐	☐	☐	☐
b. Didn't do work or other activities as **carefully** as usual	☐	☐	☐	☐	☐

5. During the *past 4 weeks*, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Patient Name: _____

Date: _____

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

6. How much of the time during the *past 4 weeks*...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. Did you have a lot of energy?	☐	☐	☐	☐	☐
c. Have you felt downhearted and blue?	☐	☐	☐	☐	☐

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7. During the *past 4 weeks*, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Patient Name: _____

Date: _____

BEACON Orthopaedics & Sports Medicine

Michael T. Rohmiller, M.D.

Oswestry Disability Index 2.0

Could you please complete this questionnaire? It is designed to give us information as to how your spine trouble has affected your ability to manage in everyday life. Please answer every section.
Mark *one box only* in each section that most closely describes you *Today*

Section 1: Pain Intensity
0. ☐ I have no pain at the moment.
1. ☐ The pain is very mild at the moment.
2. ☐ The pain is moderate at the moment
3. ☐ The pain is fairly severe at the moment.
4. ☐ The pain is very severe at the moment.
5. ☐ The pain is the worst imaginable at the moment.

Section 2: Personal Care (Washing, dressing, etc)
0. ☐ I can look after myself normally without causing extra pain.
1. ☐ I can look after myself normally but it is very painful.
2. ☐ It is painful to look after myself and I am slow and careful.
3. ☐ I need some help but manage most of my personal care
4. ☐ I need help every day in most aspects of self-care.
5. ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3: Lifting
0. ☐ I can lift heavy weights without extra pain.
1. ☐ I can lift heavy weights but it gives extra pain
2. ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table.
3. ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed
4. ☐ I can lift only very light weights
5. ☐ I cannot lift or carry anything at all.

Section 4: Walking
0. ☐ Pain does not prevent me from walking any distance.
1. ☐ Pain prevents me from walking more than 1 mile.
2. ☐ Pain prevents me from walking more than a quarter of a mile.
3. ☐ Pain prevents me walking more than 100 yards.
4. ☐ I can only walk using a stick or crutches.
5. ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5: Sitting
0. ☐ I can sit in any chair as long as I like.
1. ☐ I can sit in my favorite chair as long as I like.
2. ☐ Pain prevents me from sitting for more than 1 hour.
3. ☐ Pain prevents me from sitting for more than half an hour.
4. ☐ Pain prevents me from sitting for more than 10 minutes.
5. ☐ Pain prevents me from sitting at all.

Section 6: Standing
0. ☐ I can stand as long as I want without extra pain.
1. ☐ I can stand as long as I want but it gives me extra pain.
2. ☐ Pain prevents me from standing for more than 1 hour.
3. ☐ Pain prevents me from standing for more than half an hour.
4. ☐ Pain prevents me from standing for more than 10 minutes.
5. ☐ Pain prevents me from standing at all.

Section 7: Sleeping
0. ☐ My sleep is never disturbed by pain.
1. ☐ My sleep is occasionally disturbed by pain.
2. ☐ Because of pain I have less than 6 hours' sleep.
3. ☐ Because of pain I have less then 4 hours' sleep.
4. ☐ Because of pain I have less than 2 hours' sleep.
5. ☐ Pain prevents me from sleeping at all.

Section 8: Sex life (if applicable)
0. ☐ My sex life is normal and causes no extra pain.
1. ☐ My sex life is normal but causes some extra pain.
2. ☐ My sex life is nearly normal but it is very painful.
3. ☐ My sex life is severely restricted by pain.
4. ☐ My sex life is nearly absent due to pain.
5. ☐ Pain prevents any sex life at all.

Section 9: Social Life
0. ☐ My social life is normal and causes me no extra pain.
1. ☐ My social life is normal but increases the degree of pain.
2. ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc.
3. ☐ Pain has restricted my social life and I do not go out as often.
4. ☐ Pain has restricted social life to my home.
5. ☐ I have no social life because of pain.

Section 10: Traveling
0. ☐ I can travel anywhere without pain.
1. ☐ I can travel anywhere but it gives extra pain.
2. ☐ Pain is bad but I manage journeys over 2 hours.
3. ☐ Pain restricts me to journeys less than 1 hour.
4. ☐ Pain restricts me to short necessary journeys less than 30 minutes.
5. ☐ Pain prevents me from traveling except to receive treatment.

Patient Name_____

DOB_____

Pain Medication Policy
Dr. Michael T. Rohmiller

The purpose of this Agreement is to prevent misunderstanding about the distribution of medications and alterations to work status from Dr. Michael T. Rohmiller. Please initial each line on this form and sign the bottom.

_____ I understand unless receiving written authorization of altered work status, I am able to perform functions required by my employer. If I feel I am unable to perform functions described in my job description I will discuss this with Dr. Rohmiller at the time of evaluation and a determination of work status will be made.

_____ Dr. Rohmiller does **NOT** prescribe long term medication prescriptions to his patients.

_____ Any long term medication use, be it narcotic, non-narcotic, or anti-inflammatory, must be obtained through a Primary Care Physician, Pain Management Physician, or other designated provider.

_____ In the event surgical intervention is performed, Dr. Rohmiller will **only** prescribe narcotic pain medication for up to 90 days post-operatively dependent upon the procedure.

_____ As the patient, please understand medications provided should not be used at a more accelerated rate than originally prescribed, and may result in being without medication for a period of time should violations occur.

_____ I understand that with the use of prescription monitoring software, Dr. Rohmiller may verify pain medication is not being administered by any other source while also being received by him.

_____ I agree refills of prescriptions must be requested during regular office hours. No refills will be given after hours or on weekends.

_____ If a medication will need to be refilled over the weekend, please request the prescription by Thursday.

_____ We request at least 24 hours hour notice for all refill authorizations so as to ensure arrangements can be made.

I, _____ understand these guidelines as described above and agree to follow the policy outlined in this document.

_____ _____

Patient Signature Date

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. 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.**

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: _____

BEACON
Orthopaedics & Sports Medicine

Directions to

Beacon Northern Kentucky

((513)) 354-3700

600 Rodeo Dr.
Erlanger, KY 41018

From I-75/I-71 in Northern Kentucky:

- Take Exit 184 for KY - 236 toward Erlanger
- Follow KY- 236 West
- Turn right onto Houston Road
- Take first left onto Rodeo Dr.
  Beacon NKY will be on your right

From I-275 in Northern Kentucky

- Take Exit 84 for I-75 S/I-71 N toward Lexington/Louisville
- Take Exit 184 for KY-236 toward Erlanger
- Follow KY- 236 West
- Turn right onto Houston Road
- Take first left onto Rodeo Dr.
  Beacon NKY will be on your right

BEACON
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.