STL ORTHOPEDICS, LTD. PATIENT DATA SHEET

Primary Care Physician_____ **Referred by** _____

PATIENT_____

ADDRESS_____

Street **City** **state** **zip**

HOME PHONE__(_____)_____ **CELL PHONE**_(_____)_____ **WORK PHONE**_(_____)_____

DATE OF BIRTH_____ **SEX: Male Female Transgender**

MARITAL STATUS: Single Married Separated Divorced Widowed **STUDENT STATUS: Full Time Part Time N/A**

EMPLOYMENT STATUS: Full Time Part Time Retired Unemployed **PATIENT'S EMPLOYER**_____

EMERGENCY CONTACT:_____**PHONE NO.**_____ **REL. TO PATIENT**_____

RESPONSIBLE PERSON

PERSON RESPONSIBLE FOR BALANCE_____ **THEIR DATE OF BIRTH**_____

THEIR ADDRESS_____ **THEIR SOC. SEC. NO.**_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ **SECONDARY INSURANCE**_____

NAME OF INSURED_____ **NAME OF INSURED**_____

INSURED'S DATE OF BIRTH_____ **INSURED'S DATE OF BIRTH**_____

INSURED'S SOC. SEC. NO._____ **INSURED'S SOC. SEC. NO.**_____

ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS/RELEASE OF MEDICAL INFORMATION: I hereby authorize STL ORTHOPEDICS, LTD. to administer / perform any medical and/or surgical procedure deemed necessary, and authorize release of information needed to secure payment. I authorize that all benefits by my insurance company be paid directly to STL ORTHOPEDICS, LTD, and I understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. In addition, I hereby authorize the release of all applicable medical information including & without limitation copies of all records and test results produced to the designated attending, referral, and/or follow-up physicians and such other health care practitioners or organizations who/which will be providing subsequent monitoring of care or treatment in connection with care provided by STL ORTHOPEDICS, LTD..

SIGNATURE OF RESPONSIBLE PARTY_____ **DATE**_____

STL ORTHOPEDICS, Ltd. PATIENT DATA SHEET

ePRESCRIBING CONSENT:

ePrescribing is defined as a Physician's ability to send electronically an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that that ability to send prescriptions electronically is an important element in improving the quality of Patient Care. ePrescribing greatly reduces medication errors and enhances Patient safety. The Medicare Modrenization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe Program. These include:

Formulary and benefit transactions—Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions—Provides the Physician with information about medications the Patient is already taking to minimize the number of adverse drug events.

Fill status notification—allows the prescriber to receive an electronic notice from the pharmacy telling them if the Patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that STL ORTHOPEDICS, LTD. can request and use your prescription medication history from other healthcare Providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to STL ORTHOPEDICS ORTHOPEDICS, LTD. to enroll me in the ePrescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

PRINT PATIENT'S NAME_____ **DATE OF BIRTH**_____

SIGNATURE OF PATIENT (OR GUARDIAN)_____ **DATE**_____

RELATIONSHIP TO PATIENT (if not patient signing)_____

LOCAL PHARMACY_____ **PHONE NUMBER**_____

MAIL ORDER PHARMACY_____ **PHONE NUMBER**_____

eMESSAGING SERVICES

Our practice will now be sending notifications to our Patients using an electronic reminder system through our Electronic Health Records. If you would like to be web-enabled, please give us your email address.

EMAIL ADDRESS_____

MORE DEMOGRAPHIC INFORMATION

RACE: (Circle one) Asian Black or African American Native Hawaiian other Pacific Islander

American Indian or Alaska Native White Hispanic Other race Unreported/refused to report

ETHNICITY: Hispanic Non-Hispanic Refused to Report **PREFERRED LANGUAGE**_____

ACKNOWLEDGMENT OF PRIVACY PRACTICE AND PATIENT RIGHTS

A copy of STL ORTHOPEDICS, LTD. Notice of Privacy Practice has been made available to me.

A copy of my Patient Rights has been made available to me.

SIGNATURE OF PATIENT (OR LEGAL REPRESENTATIVE)_____**DATE**_____

STL Orthopedics, Ltd.

Patient (Last, First, MI)_____ **Date**_____

Reason for visit today_____

When did it start:_____ **Is it job related?**_____ **Reported?**_____

Medications you are taking:_____

_____

Medical History: (Circle those you have.)

Diabetes Hypertension Cancer Stroke Heart Disease

Arthritis Gout Seizures Bleeding Problems Infections Lung Disease

Other Medical Problems:_____

Are you pregnant? Yes No

Drug Allergies: _____

Previous Surgeries and Hospitalizations:

_____

Family History:

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)
Diabetes						
Hypertension						
Heart Disease						
Stroke						
Arthritis						
Cancer						
Status (Alive or Deceased)						

Social History: **Are you a** (Circle one) current smoker former smoker nonsmoker

When did you start_____ When did you quit_____ Cigarettes per day_____

Are you (Circle one) A) ready to quit B) thinking about quitting C) not ready to quit

Occupation_____ **Do you drink alcohol**? Yes No

Date of your last flu shot_____

Height(in inches)_____ **Weight** (in pounds)_____ **Blood pressure**_____

Patient Name: _____

Review of Systems

General/Constitutional		
Fever	O Yes	O No
Fatigue	O Yes	O No
Headache	O Yes	O No
Weight gain	O Yes	O No
Weight loss	O Yes	O No
Ophthalmologic		
Blurred vision	O Yes	O No
Diminished visual acuity	O Yes	O No
ENT		
Sore throat	O Yes	O No
Sinus pain	O Yes	O No
Nosebleed	O Yes	O No
Respiratory		
Cough	O Yes	O No
Shortness of breath at rest	O Yes	O No
Wheezing	O Yes	O No
Cardiovascular		
Chest pain at rest	O Yes	O No
Chest pain with exertion	O Yes	O No
Dizziness	O Yes	O No
Gastrointestinal		
Abdominal pain	O Yes	O No
Diarrhea	O Yes	O No
Nausea	O Yes	O No
Blood in stool	O Yes	O No
Genitourinary		
Blood in urine	O Yes	O No
Difficulty urinating	O Yes	O No
Frequent urination	O Yes	O No
Musculoskeletal		
Pain in shoulder(s)	O Yes	O No
Painful joints	O Yes	O No
Swollen joints	O Yes	O No
Weakness	O Yes	O No
Neurologic		
Dizziness	O Yes	O No
Memory loss	O Yes	O No
Seizures	O Yes	O No
Tingling/Numbness	O Yes	O No