NOMS ACCESS ORTHOPAEDICS

HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Referred By: _____ Family Doctor: _____

What doctor are you seeing today? ☐ Pocos ☐ Powers ☐ Shine ☐ Brown

When did the symptoms begin? ☐ Gradually ☐ Suddenly, without injury ☐ After an injury / accident

When did the injury of accident occur? *Write a date:* _____

How did the injury or accident occur? Write clearly and in complete sentences below.

_____

_____

Was the injury work related? ☐ No ☐ Yes Date reported to employer: _____

List all allergies that you have.

Type of Allergy	Reaction

List all other medications you are taking.

☐ IF YOU HAVE A LIST OF ALL YOUR MEDS PLEASE JUST CHECK THIS BOX AND ATTACH

Name of Drug	Strength	Frequency Taken

List all of your pharmacies here

	Pharmacy Name	City
Primary Pharmacy		
Secondary Pharmacy		
Other Pharmacy		

Indicate all medical conditions you've had in the past.

☐ Arthritis ☐ Blood Clots ☐ Depression

☐ Diabetes ☐ Fibromyalgia ☐ Gout ☐ Heart Disease ☐ High Blood Pres. ☐ Intestinal Disease

☐ Kidney Disease ☐ Lung Disease ☐ Lyme Disease ☐ MRSA ☐ Osteomyelitis ☐ Osteoporosis

☐ Rheum Arthritis ☐ Stomach Ulcers ☐ Stroke ☐ Thyroid Disease ☐ TIA ☐ No Significant History

☐ Cancer - Type: _____ ☐ HIV ☐ Hepatitis ☐ Other: _____

Have you had any surgeries? *If yes, please list below:*

Year	Surgery Performed	Hospital

Please circle in the column below any problems you currently have:

1) Constitutional Symptoms: Fever, Weight Loss, Sweats

2) Eyes: Glasses, Blurred Vision, Visual Loss

3) Ears, Nose, Mouth, Throat: Dentures, Hoarseness, Swallowing Difficulties, Hearing Loss, Ear Infections, Nose Bleeds

4) Cardiovascular: High blood pressure, Chest Pain, Irregular heart beat, Heart murmur

5) Respiratory: Short of breath, Cough, Wheeze, Asthma

6) Gastrointestinal: Nausea, Vomiting, Diarrhea, Constipation, Blood in stool, Change in bowel habits, Hepatits, Abd Pain

7) Genitourinary: Kidney stones, urine infection, difficulty passing urine

8) Musculoskeletal: Pain, Weakness

9) Skin: Changing moles, Skin rash, Skin lumps

10) Neurological: Seizures, Epilepsy, Headaches

11) Psychiatric: Emotional or psychatric problem

12) Endocrine: Thyroid problems, Diabetes

13) Hematology/Lymphatic: Bleeding problems, Anemia, Blood clots, Transfusions

14) Allergy-Immunology: Swollen lymph nodes/glands, IV drug abuse

Any other problems not mentioned? _____

Do you smoke tobacco? ☐ Former ☐ Current ☐ Non/Never

If yes, how many packs per day? ☐ Less than one ☐ One ☐ Two ☐ More than three

Do you drink alcohol? ☐ Former ☐ Current ☐ Non/Never

If yes, how frequently? ☐ Rarely ☐ Socially (2-3 per week) ☐ Daily

Do you drink caffeinated beverages? ☐ No ☐ Yes

If yes, list the type and number per day: _____

Family History (Check the box of any of the following conditions your blood relatives has had)

Family Member	Alive / Deceased	Diabetes	High BP Hypertension	Heart Disease	Stroke	Heart Disease	Other (Write In Please)
Father	A / D						
Daughter(s)	A / D						
Son(s)	A / D						
Mother	A / D						
Paternal Grandparents	A / D						
Maternal Grandparents	A / D						
Siblings	A / D						

NOMS HEALTHCARE

2500 Strub Rd
Sandusky, Ohio 44870

Patient: _____

Patient Date of Birth: _____

Patient Acknowledgment

I hereby permit Northern Ohio Medical Specialists to release any information acquired throughout the course of my examination and treatment as needed to process any claims on my behalf.

HIPAA Notice of Patient Privacy Practices

I hereby agree, in accordance with HIPAA regulations, that I have been advised of Northern Ohio Medical Specialists privacy policy. I permit NOMS to release or obtain any information throughout the course of my examination and treatment as needed to process any claims on my behalf. I permit Northern Ohio Medical Specialists to send me any information via email or by calling the telephone number (s) I have authorized, regarding my account, treatment, appointments and/or any advertisements or specials offered by the offices. In the event that I cannot be reached directly, I give my consent for Northern Ohio Medical Specialists to leave a message on my voicemail, answering machine or with any individual who answers any of the telephone numbers I've provided.

I give permission For:

(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)
(name)	(relationship)	(phone number)

to receive my medical information.

PAYMENT AUTHORIZATION

I HEREBY AGREE TO PAY ANY AND ALL CO-PAYS, DEDUCTIBLES, CO-INSURANCE, AMOUNTS OVER UCR, AND/OR EXCLUDED CHARGES FROM INSURANCE COMPANIES WITH WHOM NORTHERN OHIO MEDCIAL SPECIALISTS DOES NOT ACCEPT ASSIGNMENT, AND ANY AND ALL CO-PAYS, DEDUCTIBLES AND CO-INSURANCE WITH THOSE THEY DO ACCEPT ASSIGNMENT.

I hereby request my insurance carrier to pay on my behalf insurance benefits to Northern Ohio Medical Specialists for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if

necessary, a credit bureau report may be obtained. Northern Ohio Medical Specialists cannot be held responsible for collecting my insurance claim(s) nor for negotiating a settlement(s) on a disputed claim(s). Northern Ohio Medical Specialists fees are not established by insurance companies. I am responsible for my account.

No Show Policy

I hereby understand that Northern Ohio Medical Specialists has a posted No-Show Policy and that if I do not cancel an appointment 24 hours prior to the scheduled appointment, I may be subject to the fees associated with said policy.

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Consent for RX Hub Inquiry

I herby provide my consent for Northern Ohio Medical Specialists, LLC to obtain my Rx History using the SureScripts-RxHub network or the Ohio Automated Rx Reporting System (OARRS). I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Imaging Radiation Exposure

Your physician has ordered a procedure, which requires the use of radiation. The radiation exposure enables the radiologist to view the area of interest and then submit a written report to your doctor. By signing below you give consent to have this procedure and any future procedures performed that requires radiation.

Health Information Exchange

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying Human Resources or the IT Department.

Signed _____ Date_____

NOMS HEALTHCARE

Date:_____

Legal Last Name_____ First Name_____ Middle Initial____ Nickname_____

Social Security #_____ Date of Birth____/____/____ Sex: Male ☐ Female ☐

Address_____ Apt_____

City_____ State_____ Zip_____

Marital Status: Married ☐ Single ☐ Legally Separated ☐ Divorced ☐ Widowed ☐

Race_____ Language_____ Ethnicity_____

Home Phone _____ Cell Phone_____ Work Phone_____

Email _____

Primary Care Physician_____ Referring Doctor_____

Pharmacy_____ City, State _____

Employer_____ Employer Address_____

City_____ State_____ Zip_____ Phone Number_____

Occupation_____ Status: Full Time ☐ Part Time ☐ Retired ☐

Are You Homeless? Yes ☐ No ☐ Do You Have Any Special Communication Needs? Yes ☐ No ☐

••

Person Responsible for Any Patient Balance (Head of Household): _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Employer_____ Work Phone_____

••

Spouse's Name_____ Date of Birth____/____/____ SS#_____

Are you covered under your Spouse's insurance: Y N Employer_____ Work Phone _____

••

In case of an emergency who should we contact?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

••

Is this a work related injury? Yes ☐ **No** ☐

MCO:_____ Claim#:_____ Date of injury____/____/____ Time of injury_____

1st Report of Injury complete? **Yes or No** Employer at time of injury_____

Employers Phone _____ Employers Fax _____

Insurance Information:

Primary Insurance_____ Policy Holder Name_____

Check if below policy holder information is same as front ☐ Patient ID Number _____

Date of Birth____/____/____ Sex: M☐ F☐ SS#_____ Relationship to Patient_____

Address_____ City/State/Zip_____ Home Phone_____

Employer_____ Work Phone_____

Address_____ City/State/Zip_____

••

Secondary Insurance_____ Policy Holder Name_____

Check if below policy holder information is same as front ☐ Patient ID Number _____

Date of Birth____/____/____ Sex: M☐ F☐ SS#_____ Relationship to Patient_____

Address_____ City/State/Zip_____ Home Phone_____

Employer_____ Work Phone_____

Address_____ City/State/Zip_____

••

If you are covered under you parents insurance, OR a minor, you MUST complete the following:

Mother's Name_____ Date of Birth____/____/____ SS#_____

Are you covered under your mother's insurance? Y or N Employer_____ Work Phone_____

Check if below is same as above ☐

Address_____ City/State/Zip_____ Home Phone_____

Father's Name_____ Date of Birth____/____/____ SS#_____

Are you covered under your father's insurance? Y or N Employer_____ Work Phone _____

Check if below is same as above ☐

Address_____ City/State/Zip_____ Home Phone_____

In the event that I (or in the case of a minor, the personal representative of said minor) cannot be reached directly to discuss Patient Health Information, NOMS Healthcare is authorized to leave a message by voice mail, answering machine, with any individual listed above as Emergency Contact(s), or with any individual who answers any of the telephone numbers as listed on Page One (I) of this form.

Patient Signature:_____ Date:_____

Parent of Guardian Signature:_____ Date:_____

Initials of person completing the form, if other than the patient: _____