

Name:

Chart:

TOS Health Questionnaire

Date:

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_

Main Reason for Medical Evaluation \_\_\_\_\_

Date of Injury/Length of symptoms: \_\_\_\_\_ Where did injury occur? \_\_\_\_\_

Is this a work related problem? Y N Are you right or left handed? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

What treatment have you received for this problem? \_\_\_\_\_

1. Medications: \_\_\_\_\_ 2. Physical Therapy (location): \_\_\_\_\_

3. Injections (when): \_\_\_\_\_ 4. Surgery: \_\_\_\_\_

4. X-rays (where & when): \_\_\_\_\_ 6. MRI (where & when): \_\_\_\_\_

7. Brace/Walking Aids: \_\_\_\_\_ 8. Other: \_\_\_\_\_

Have you ever been diagnosed with any of the following conditions: Check all that apply.

- Alcoholism, Asthma, Anemia, Anesthesia Problems, Bleeding Tendencies, Blood Clots, Cancer, Colitis, Diabetes, Epilepsy, GI Bleeding, Heart Disease, Hepatitis, High Blood Pressure, Kidney Disease, Lung Disease, Migraines, Osteoarthritis, Osteoporosis, Rheumatoid Arthritis, Sickle Cell Disease, Sleep Apnea, Stomach Ulcers, Stroke, Thyroid Disease, Tuberculosis, Other

Are any other physicians treating you for ANY health problems? \_\_\_\_\_

If yes, whom? \_\_\_\_\_

Have you had any heart testing? Y N if yes, when and where? \_\_\_\_\_

Have you ever had Blood Clots? \_\_\_\_\_

Did you have any adverse reaction to anesthesia? \_\_\_\_\_

Smoking Status? Never smoker, Current everyday smoker, Current some day smoker, Former smoker

Do you drink alcohol: None, Beer, Liquor, Wine Amount: \_\_\_\_\_

Marital status: S M D W Hobbies: \_\_\_\_\_

- Has anyone in your family had: High Blood Pressure, Heart Disease, Cancer, Arthritis, Blood Clots, Diabetes, Bleeding Problems, Lung Disease, Reaction to Anesthesia, Other

Have you recently had any of the following problems/symptoms: Check any which apply.

- Abdominal pain, Alcohol addiction, Balance problems, Blood in stool, Blood in urine, Breathing difficulties, Chest pain, Chronic cough, Constipation, Depression, Dizziness, Drug addiction, Easy bleeding, Easy bruising, Excessive thirst, Fainting spells, Fever or chills, Gait disturbance/Walking changes, Headaches/Migraines, Hearing Loss, Heartburn, Hoarseness, Hot or cold intolerance, Loss of appetite, Loss of control of bladder, Loss of control of bowels, Lumps/Masses, Nausea or vomiting, Numbness/Tingling/Weakness, Other joint symptoms, Pain burning with urination, Palpitations, Rectal bleeding, Sexual disfunction, Shortness of breath, Skin rashes or sores, Trouble swallowing, Unexplained weight loss, Vision Problems

Name:

Chart:

**TOS Health Questionnaire**

Date:

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Please list any current prescriptions and non-prescription medication and dosages:

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Please list any allergies:

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Please list any surgeries you have had and dates:

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

Physician Review \_\_\_\_\_ Date \_\_\_\_\_

Name:  
Chart:  
Date:

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Ashok Biyani, MD  
Spine  
Toledo Orthopaedic Surgeons

Patient questionnaire

Please answer all questions as directed to help us evaluate and treat your problem.

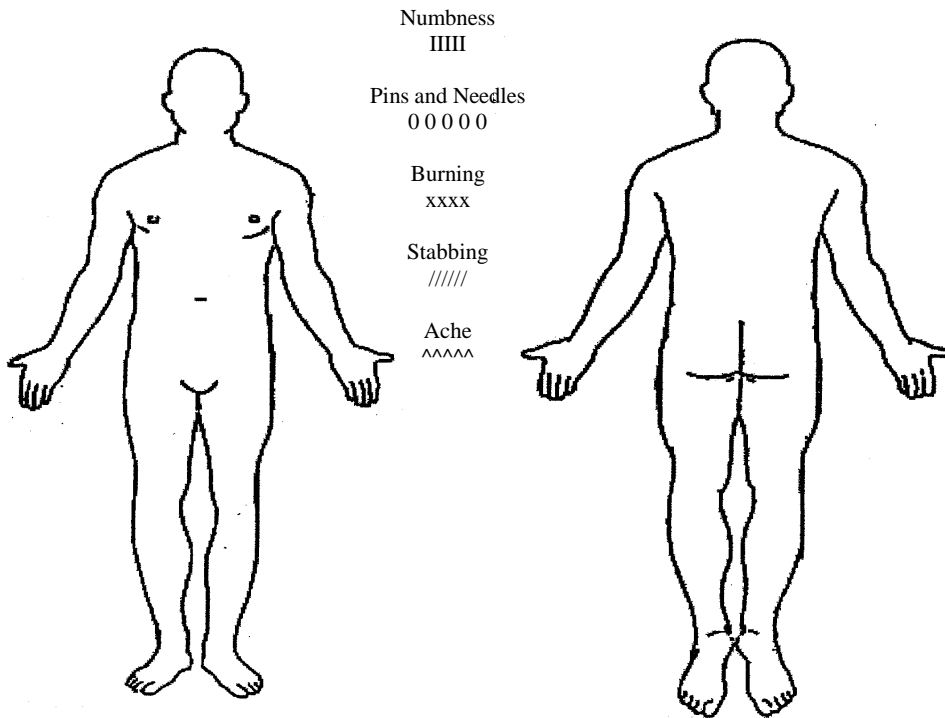
---

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

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Mark these drawings according to where you hurt (if the back of your neck, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



Name:

Chart:

Date:

How did your pain start? (check appropriate box)

- |  |   |  |  |                                  |
|--|---|--|--|----------------------------------|
| <input type="checkbox"/> Suddenly          | <input type="checkbox"/> Gradually                | For how long _____                       |  |                                  |
| <input type="checkbox"/> Pulling           | <input type="checkbox"/> Lifting                  | <input type="checkbox"/> Twisting        | <input type="checkbox"/> Fall                  | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Injured at work   | <input type="checkbox"/> Injured in auto accident | <input type="checkbox"/> Hit from behind | <input type="checkbox"/> Injured during sports |                                  |
| <input type="checkbox"/> No apparent cause |   |  |  |                                  |

**Back pain** \_\_\_\_\_ **Neck pain** \_\_\_\_\_

Severity of pain at its worst \_\_\_\_\_ at its best \_\_\_\_\_ (1-10, 10 being the worst)

- Progress:  Improving  Same  Getting worse  
 Nature:  Sharp  Dull  Burning  Numbness  Pins and needles

What affects your pain?

- |              |                                   |                                    |                                  |                                 |  |
|--------------|-----------------------------------|------------------------------------|----------------------------------|---------------------------------|--|
| Worse with   | <input type="checkbox"/> standing | <input type="checkbox"/> walking   | <input type="checkbox"/> sitting | <input type="checkbox"/> laying | <input type="checkbox"/> no difference |
| Better with  | <input type="checkbox"/> standing | <input type="checkbox"/> walking   | <input type="checkbox"/> sitting | <input type="checkbox"/> laying | <input type="checkbox"/> no difference |
| Worse with   | <input type="checkbox"/> coughing | <input type="checkbox"/> sneezing  |                                  |                                 |  |
| Worse in the | <input type="checkbox"/> morning  | <input type="checkbox"/> afternoon | <input type="checkbox"/> evening | <input type="checkbox"/> in bed |  |

Pain in the leg \_\_\_\_\_ R / L / both Pain in the arm \_\_\_\_\_ R / L / both

Severity of pain at its worst \_\_\_\_\_ at its best \_\_\_\_\_ (1-10, 10 being the worst)

Radiation

- |          |   |  |                                  |
|----------|---|--|----------------------------------|
| Leg pain | <input type="checkbox"/> to the hips/thighs | <input type="checkbox"/> below the knees | <input type="checkbox"/> toes    |
| Arm pain | <input type="checkbox"/> to the shoulder    | <input type="checkbox"/> elbow           | <input type="checkbox"/> fingers |

Weakness in legs / arms \_\_\_\_\_

How far can you walk? \_\_\_\_\_ block(s), \_\_\_\_\_ mile(s)

Can you sleep well at night? \_\_\_\_\_

Bowel or bladder problems \_\_\_\_\_

Have you had back or neck pain in the past? Yes / No. When \_\_\_\_\_

Have you had any treatment so far?  Yes  No If yes, answer the following:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> rehab           | <input type="checkbox"/> aqua therapy |
| <input type="checkbox"/> chiropractic     | <input type="checkbox"/> pain management |                                       |

Any prior spine surgery \_\_\_\_\_ When and by whom \_\_\_\_\_

Other \_\_\_\_\_

**Previous studies**

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> X-rays    | <input type="checkbox"/> Nerve conduction / EMG | <input type="checkbox"/> MRI / CT scan / myelogram |
| <input type="checkbox"/> Discogram | <input type="checkbox"/> Other                  |  |

Name and signature of person completing the form

Date

Name:

Chart:

Date:

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**Toledo Orthopaedic Surgeons Division  
Notice of Privacy Practices**

**THIS NOTICE, WHICH IS EFFECTIVE AS OF April 14, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

The doctors and staff here at **Toledo Orthopaedic Surgeons Division** believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes your rights concerning our use of your health information.

**We will use and disclose your health information for purposes of treatment, payment and/or health care operations.**

1. **Treatment** means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. *For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.*
2. **Payment** means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. *For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.*
3. **Health Care Operations** includes certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including; quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. *For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary for the reviewer to randomly select and examine patients' medical records.*

**We are permitted or required to disclose limited health information about you, *without your authorization*, in the following circumstances:**

1. **As required by law** so long as it is limited to the relevant requirements of such law.
2. **For public health activities**, including the prevention and control of disease, vital statistics, and public health investigations.
3. For purposes of making required reports about **victims of abuse, neglect or domestic violence**.
4. **Health oversight activities**, including audits, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. **Judicial and administrative proceedings**, in response to court orders.
6. **Law enforcement purposes** (i.e., reports of gunshot wounds; grand jury subpoenas; and information regarding victims of crime).
7. **To coroners, medical examiners and funeral directors** for purposes of identifying deceased persons or determining cause of death.
8. **For organ and tissue donation**, consistent with applicable laws.
9. **Research**, provided the federal regulations governing research activities that insure the privacy of your health information are met.
10. **To avert serious threats to health or safety**.
11. **Specialized government functions** regarding military personnel and military veterans, certain national security purposes, and inmates.
12. **Workers' compensation** to the extent necessary to comply with applicable laws.
13. **Marketing**, for purposes of appointment reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

**Any uses or disclosures other than those noted above require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.**

(over)

Name:

Chart:

Date:

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**You have the following rights with respect to your health information:**

1. The right to request restrictions on certain uses of your health information, **however we are not required to agree to your request.**
2. The right to request, in writing, the manner or method by which we contact you to furnish confidential communications about your health information (i.e., fax, e-mail, voice mail, etc.). You are obligated to notify us, in writing, of any changes to your request.
3. The right to inspect your health information (you are entitled to receive a copy of your health information, except for psychotherapy notes and information compiled in anticipation of or for use in, a civil, criminal, or administrative action or proceeding).
4. In limited circumstances, the right to ask us to amend your health information, **however we reserve the right to deny your request.** If your request to amend is denied, we will provide you with information about the basis of our denial and your right to submit a written statement disagreeing with our denial.
5. The right to receive an accounting of disclosures of your health information, except those disclosures related to treatment, payment or health operations, disclosures that are made to you, disclosures made for national security purposes or to correctional institutions or law enforcement officials, or disclosures that were made prior to the compliance date.
6. The right to receive a copy of this Notice in writing.

**We have the following obligations:**

1. We are required by law to maintain the privacy of your health information, and we are required to provide you with a notice of our legal duties and privacy practices.
2. We are required to abide the terms of the notice.
3. We are required to advise you of any changes we make in the terms of our notice of privacy practices. If any changes are made to notice of privacy practices, we will post the revised notice and make a copy of it available on request.

**Complaints**

If you believe we have violated your privacy rights, you may file a written complaint to our Privacy Officer and/or to the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

If you want more information or you believe your rights have been violated, you can contact Our Privacy Officer at the following address: Toledo Orthopaedic Surgeons Division. 2865 N. Reynolds Rd., Building A. Toledo. Ohio 43615-2100. Attention Privacy Officer. Our telephone number is 419-578-7200. Alternatively, you may wish to contact the federal agency in charge of enforcing patients' privacy rights. That address is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F, HHS Building. Washington, D.C. 20201.

**Acknowledgment**

I have read the foregoing Notice of Privacy Practices provided to me by Toledo Orthopaedic Surgeons Division, and I have been given the opportunity to discuss the privacy practices at Toledo Orthopaedic Surgeons Division. I understand that the practice may, at its discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. I understand the content of the Notice of Privacy Practices and I have been provided with a copy of same

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Staff initials

If signed by patient's authorized representative, describe the representative's authority:

- Parent of minor child     Guardian     Agent (Health Care Power of Attorney)     Other (describe)

\_\_\_\_\_  
The Notice of Privacy Practices was provided to \_\_\_\_\_, however he/she did not acknowledge receipt for the following reason:     Refused     Did not understand     Other

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

Name:  
Chart:  
Date:

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### Toledo Orthopaedic Surgeons Division

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**I wish to be contacted in the following manner (check all that apply):**

**Oral Communication:**

- |   |   |
|---|---|
| <input type="checkbox"/> Home telephone                                   | <input type="checkbox"/> Work telephone                                   |
| <input type="checkbox"/> O.K. to leave message with detailed information. | <input type="checkbox"/> O.K. to leave message with detailed information. |
| <input type="checkbox"/> Leave message with call-back number only.        | <input type="checkbox"/> Leave message with call-back number only.        |
| <input type="checkbox"/> Other _____                                      |   |

**Written Communication:**

- |   |   |
|---|---|
| <input type="checkbox"/> O.K. to mail to my home address        | <input type="checkbox"/> O.K. to fax to this number _____ |
| <input type="checkbox"/> O.K. to mail to my work/office address | <input type="checkbox"/> Other _____                      |

**Email Communication:**

- My email address is: \_\_\_\_\_
- O.K. to send email regarding Patient Portal to the above email address.

---

**I permit the Practice to discuss my PHI with, and to disclose my PHI to, the following individuals:**

- |  |              |
|--|--------------|
| <input type="checkbox"/> Spouse's name: _____                | Phone: _____ |
| <input type="checkbox"/> Adult child(ren) name: _____        | Phone: _____ |
| <input type="checkbox"/> My parent(s) name: _____            | Phone: _____ |
| <input type="checkbox"/> Personal representative name: _____ | Phone: _____ |

**If checked, the following additional instructions apply:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

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**If signed by patient's authorized representative, describe the representative's authority:**

- Patient is a minor; I am the patient's parent and natural guardian.
- Patient is a minor; I am the patient's guardian, appointed by the \_\_\_\_\_ County Juvenile Court.
- Patient is a ward; I am the patient's guardian, appointed by the \_\_\_\_\_ County Probate Court.
- The patient is deceased. I am the patient's surviving spouse.
- The patient is deceased. I am the executor or administrator of the patient's estate, appointed by the \_\_\_\_\_ County Probate Court.
- I am the patient's attorney in fact, as designated in the patient's Durable Power of Attorney for Health Care.
- Other (describe) \_\_\_\_\_

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

Chart: \_\_\_\_\_

Date: \_\_\_\_\_

**Toledo Orthopaedic Surgeons Patient Data Sheet**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

SS# \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

(Street)

Cell Phone \_\_\_\_\_

(City)

(State)

(Zip Code)

Race: American Indian  Asian  Black  Native Hawaiian  White  Other  Unknown

Ethnicity: Hispanic  Non-Hispanic  Unknown  Preferred Language \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Referring MD \_\_\_\_\_ Primary Care MD \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Guarantor's Name and Address (if different from patient's) \_\_\_\_\_

(City)

(State)

(Zip Code)

Emergency Contact (other than spouse) \_\_\_\_\_

Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**INSURANCE INFORMATION (We will ask to make a copy of your card)**

**Primary Insurance Carrier** \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

**Policy Holder's Identification Number** \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Insurance Carrier** \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_\_\_

**Policy Holder's Identification Number** \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Employer \_\_\_\_\_

**Consent to Release Medical Information / Assignment of Benefits**

**\*\*SIGNATURE REQUIRED\*\***

I hereby consent to the use and disclosure by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, inc. of medical information to carry out medical treatment, payment, and health care operations as defined by applicable law. **Medical treatment** includes the provision, coordination, and management of my health care and related services, including treatment by TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc. and other physicians, hospitals, and providers of medical services and/or their agents to whom I may be referred (and any referring and primary care/family physicians which have been or may be involved in my care and treatment). **Payment** includes all activities relating to the determination of coverage and reimbursement for the provision of health care services, and related claims management and review activities. **Health care operations** include activities of Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. relating to medical care and treatment and related assessment, quality improvement, and management activities.

I agree that Toledo Orthopaedic Surgeons may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I authorize my insurance benefits to be paid directly to TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., realizing that I am ultimately responsible for any allowable portion of the charge not covered by my insurance plans.

X \_\_\_\_\_  
PATIENT'S (OR RESPONSIBLE PARTY'S) SIGNATURE DATE

**\*\*MEDICARE PATIENT'S ONLY\*\***

I request that payment of authorized Medicare benefits be made to me or on my behalf to the physicians of TOLEDO ORTHOPAEDIC SURGEONS, A Division of The Orthopaedic Network, Inc., for any service furnished to me by the physicians. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine the payments for related services.

X \_\_\_\_\_  
SIGNATURE OF BENEFICIARY DATE



Name:

Chart:

Date:

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## Toledo Orthopaedic Surgeons

### Preferred Pharmacy Information

In an effort to serve you better, we are now able to send prescriptions electronically. This process will help reduce medication errors and reduce the time you have to wait for a prescription to be filled. In order to do this efficiently, please complete the information below. Please know that this form does not obligate you to use this pharmacy; it simply allows us to prepare your chart so that your information is readily available to your physician.

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

Pharmacy Address: \_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_

Name:  
Chart:  
Date:

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**Toledo Orthopaedic Surgeons  
Bureau of Worker's Compensation Declaration  
NON-Work Related Injuries**

**PLEASE READ CAREFULLY.** By signing below, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon physician is treating you *is **not** a work related injury, and that it did not occur while you were on the job or executing a work related activity.*

Further, you understand that we will not support this injury or disease as a work related injury.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**Bureau of Worker's Compensation Declaration  
Work Related Injuries**

**PLEASE READ CAREFULLY:** By signing this form, you are declaring that the injury or disease for which your Toledo Orthopaedic Surgeon is treating you *is a work related injury, and that it occurred while you were on the job or executing a work related activity.*

I hereby declare that my injury is work related and I authorize Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. to submit a claim with complete information to my Workers' Compensation insurance carrier for covered services rendered by my physician at Toledo Orthopaedic Surgeons. I authorize my Workers' Compensation insurance to issue payment directly to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all payable services. I understand that I am financially responsible to Toledo Orthopaedic Surgeons, A Division of The Orthopaedic Network, Inc. for all charges to the extent they are not covered by insurance, unless otherwise prohibited by applicable State of Ohio law.

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

Patient Name \_\_\_\_\_

Claim Number \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer at Time of Injury \_\_\_\_\_

Address of Employer \_\_\_\_\_

Is your employer disputing your claim? \_\_\_\_\_ Is your claim in litigation? \_\_\_\_\_

Description of how injury occurred \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is this a **possible** worker's comp claim? \_\_\_\_\_ Are you filing a claim? \_\_\_\_\_

**\*\*\*Please Note\*\*\* We will need to make a copy of your black and white identification card from BWC, as well as your health insurance card. In the event your claim is disallowed, your health insurance will be billed. Please remember you are ultimately responsible for all payment of all charges.**

Name:  
Chart:  
Date:

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A. Biyani, MD  
Scoliosis  
Toledo Orthopaedic Surgeons

Patient questionnaire

Please answer all questions as directed to help us evaluate and treat your problem.

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Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Please list the name and address of the referring doctor who you would like us to send the letter to. \_\_\_\_\_

When were you diagnosed as having scoliosis or kyphosis? \_\_\_\_\_

Have you seen any physicians in the past for your spine? \_\_\_\_\_

Brace/ surgery advised? \_\_\_\_\_

Do you have any back pain? (Please circle one)

None, occasionally / at night / with activities / always / other

Radiation of pain to the legs yes / no

Weakness or numbness in legs yes / no

Bowel or bladder problems yes / no

Any other medical problems or previous surgeries \_\_\_\_\_

Allergies \_\_\_\_\_

Current medications \_\_\_\_\_

Birth and developmental history

Born at full term/ \_\_\_\_ weeks early/ late

Any problems at birth \_\_\_\_\_

Needed ICU/ more than 3 day hospital stay

Started sitting at \_\_\_\_ months, walking at \_\_\_\_ months.

Periods (girls) started \_\_\_\_ months/years ago, not yet started

Family history:

Anybody else in the family has scoliosis or other orthopedic conditions

\_\_\_\_\_  
Siblings, their ages and height \_\_\_\_\_

Mother's height \_\_\_\_\_ Father's height \_\_\_\_\_

Which grade in school? \_\_\_\_\_

Sports you like to participate in \_\_\_\_\_

Height \_\_\_\_\_

Weight \_\_\_\_\_