PATIENT INTAKE FORM
BEACON ORTHOPAEDICS & SPORTS MEDICINE

Full Name: _____ D.O.B: _____Date: _____

Male/Female: _____ Home Phone: _____ Cell Phone: _____ Email: _____

Height: _____ feet _____ inches Weight: _____

How did you find us? □ Internet Search □ Social Media □ Radio/TV □Event □Beacon Physician □Other Physician □Friend/Family Referral

Referring Physician Name/Phone/Address

_____

Primary Physician Name/Phone/Address

_____

Are you here for an injury? Yes □ No □ Date of Injury_____
Auto Accident Claim: Yes □ No □ **Worker's Compensation Claim:** Yes □ No □

(1) Please describe briefly the primary reason/problems for your visit:
_____
(2) What is the number of weeks/months/years you have had this problem? _____
(3) Location of Problem (check all that apply): **Left** Foot □ Ankle □ Leg □ **Right** Foot □ Ankle □ Leg □
(4) If both sides bother you, which side is worse? Left □ Right □
(5) Check all that apply: Pain □ Numbness □ Feel unstable on your feet □
(6) Is the problem getting: Better □ Worsening □ Staying the same □
(7) What makes the problem better? _____
(8) What makes the problem worse? _____
(9) What does this problem limit you from doing? (Daily activities, tennis, work, etc) _____
(10) Rate your pain when it's at its worst on the following scale by circling a number below.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Possible Pain**

(11) How far can you walk without stopping? Unlimited □ 5-10 blocks □ 1-5 blocks □ Less than 1 □
(12) Have you been using or tried in the past an assist device? None □ Splint or Cast from the ER □ Arch Supports □ Custom Foot Orthotics □ Special Shoes □ Ankle or Leg Brace □ Crutches □ Cane □ Walker □ Wheelchair □ Knee Walker □ Other:_____
(13) Fill in the therapies you have tried for your problem:
   a. Medication by mouth: Yes □ No □
   b. Steroid Injection: Yes □ No □ How many _____ Date of most recent _____
   c. Did symptoms improve with last injection? Yes □ No □ For how long did symptoms improve? _____
   d. For this problem have you tried acupuncture? Yes □ No □ Chiropractic? Yes □ No □
   e. Physical Therapy? Yes □ No □ For how many weeks? _____
(14) Other Therapy? _____

Medical History – Check all that apply

__ AIDS/HIV	__ Connective tissue disorder	__ Heart Failure	__ Lymphoma, malignant	__ Seizures
__ Alzheimer's/Dementia	__ COPD/Emphysema	__ Heart Beat Irregularity	__ Other Tumor, malignant	__ Sleep Apnea
__ Anemia	__ Depression	__ Hemiplegia/Nerve injury	__ Other Tumor, metastatic	__ Stress Fractures
__ Aneurysm	__ Diabetes	__ Hepatitis/Liver Disorder	__ Lyme Disease	__ Thyroid Disease
__ Asthma	__ Diverticulitis	__ High Blood Pressure	__ Migraines	__ Tuberculosis
__ Autoimmune Disorder	__ Fibromyalgia	__ High Cholesterol	__ MRSA Infection	__ Ulcerative Colitis
__ Bleeding/Clotting Disorder	__ Gastric Reflux/Peptic Ulcer Disease	__ Irritable Bowel Syndrome	__ Neuropathy	__ Urinary Problems
__ Blood Clots History	__ Glaucoma	__ Kidney Disease	__ Osteoarthritis	__ Peripheral Vascular Disease
__ Cancer	__ Gout	__ Kidney Stones	__ Osteopenia, Osteoporosis	__ Cerebrovascular Disease/Stoke
__ Chron's Disease	__ Hearing Loss	__ Lupus	__ Rheumatoid Arthritis	__ Other
__ Concussion	__ Heart Attack	__ Leukemia	__ Seronegative Arthritis	__ No Medical Conditions

Describe or List type of checked selections: _____
_____

Imaging/Test
Have you had any studies/imaging/tests for your problems? Yes □ No □
If yes, list the date of studies you have had: X-Ray _____ CT Scan _____ MRI _____ Bone Scan _____ EMG/Nerve Study _____
Ultrasound _____ Other _____

Diabetic History: Answer if you have had diabetes

Have you ever had a foot ulcer? Yes □ No □

How long have you been diagnoses with diabetes? _____

Have you lost sight, been on dialysis, neuropathy, or had other medical problems due to diabetes? Yes □ No □

Who is managing your diabetes? _____

What is your HbA1C level? _____ Date: _____

Past Surgical History for this Problem

Have you had surgery for this problem? Yes □ No □ Date: _____ Surgeon: _____ Complication (if any): _____

Other Surgical History (Please list all surgeries/hospitalizations you have had) _____

_____

Month/Year of Surgery? _____

I have had no surgeries/hospitalizations in the past □

Social/Employment History

Occupation: _____ Currently Working? Yes □ No □

If no, are you a student? Yes □ No □

If no, are you disabled? Yes □ No □

Do you smoke? Yes □ No □ If yes, how many packs per day? _____ For how many years? _____

Do you drink alcohol? Yes □ No □ How many drinks per week? _____

History of substance abuse? Yes □ No □ If yes, describe _____

Relationship Status: Single □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Do you live: Alone □ With others □

What do you do for exercise? _____

If you have surgery, do you have people that can assist you/drive you while you are recovering? Yes □ No □

For Women Only:

Are you or could you be pregnant? Yes □ No □

Have you reached menopause? Yes □ No □

Family History – Check all the apply

	Parents	Grandparents	Sibling		Parents	Grandparents	Siblings
Asthma/COPD	Yes ___ No___	Yes ___ No___	Yes ___ No___	High Blood Pressure	Yes ___ No___	Yes ___ No___	Yes ___ No___
Autoimmune Disorder	Yes ___ No___	Yes ___ No___	Yes ___ No___	Liver Disease	Yes ___ No___	Yes ___ No___	Yes ___ No___
Bleeding Disorder	Yes ___ No___	Yes ___ No___	Yes ___ No___	Lupus	Yes ___ No___	Yes ___ No___	Yes ___ No___
Blood Clots	Yes ___ No___	Yes ___ No___	Yes ___ No___	Mental Illness	Yes ___ No___	Yes ___ No___	Yes ___ No___
Bunions	Yes ___ No___	Yes ___ No___	Yes ___ No___	Osteoarthritis	Yes ___ No___	Yes ___ No___	Yes ___ No___
Cancer	Yes ___ No___	Yes ___ No___	Yes ___ No___	Rheumatoid Arthritis	Yes ___ No___	Yes ___ No___	Yes ___ No___
Diabetes	Yes ___ No___	Yes ___ No___	Yes ___ No___	Strokes	Yes ___ No___	Yes ___ No___	Yes ___ No___
Flat feet	Yes ___ No___	Yes ___ No___	Yes ___ No___	Thyroid Disease	Yes ___ No___	Yes ___ No___	Yes ___ No___
Heart Disease	Yes ___ No___	Yes ___ No___	Yes ___ No___	Vascular Disease	Yes ___ No___	Yes ___ No___	Yes ___ No___

Review of Symptoms – Mark all that apply currently or have in the past

General	HEENT	Chest/CV	Derm	GI
___ Weight Loss	___ Ringing in ears	___ Cough	___ Hives	___ Difficulty Swallowing
___ Weight Gain	___ Dizziness/Balance	___ Shortness of breath	___ Rash	___ Heartburn
___ Loss of appetite	___ Fainting	___ Chest Pains	___ Eczema	___ Nausea/Vomiting
___ Chronic Fatigue	___ Vision changes	___ Heart Palpitations	___ Ulcers	___ Chronic abdominal pain
___ Decreased hearing	___ Headaches	___ Leg Swelling	___ Skin Color Change	___ Change in bowel habits
___ Cold Intolerance	___ Nose Bleeds	___ Lew cramping with waling	___ Itching	___ Constipation
	___ Sinus Troubles			___ Diarrhea
	___ Sore Throat			___ Bloody/Tarry stools
	___ Hay Fever/ allergies			
Heme	GU	MSK	Neuro/Psych	
___ Abnormal bruising	___ Urinary Problems	___ Joint Pain	___ Memory Loss	
___ Abnormal bleeding	___ Incontinence	___ Leg Pain	___ Difficulty concentrating	
	___ Urethral discharge	___ Tremors, hand shaking	___ Anxiety	
		___ Muscle weakness	___ Insomnia	
		___ Numbness/tingling	___ Nervousness	
		___ Back pain	___ Depression	
		___Cold/numb feet		

Patient Signature _____ **Date** _____

Reviewed By _____ **MD** **Date**_____

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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:_____

Dr. Miller Pain Medication Policy

The purpose of this agreement is to prevent misunderstanding about the distribution of medications from Dr. Adam Miller, M.D. We believe that it is important that patients understand that there are risks and responsibilities with taking some medications, especially opioids/narcotics and commit to work with you to ensure your pain is managed effectively and safely.

The goal of opioids/narcotics is to decrease pain and improve function. The use of these medications may not completely eliminate your pain but is meant to make you more comfortable. The use of these medications in an unauthorized regimen could be dangerous and these prescriptions must be followed. You may experience other side effects from the use of these medications; commonly they are nausea, vomiting, itching, drowsiness and constipation. Please contact the office if you are concerned about the any side-effects you may experience.

By signing the bottom of this form, you agree to the following:

- I understand that Dr. Miller will be the only physician prescribing any narcotic pain medication while under his care, unless a written agreement between providers has been made. Dr. Miller reserves the right to deny patients medication if a patient seeks prescription from another source while under his care.
- I understand that Dr. Miller only prescribes pain medication in situations where he feels it is warranted.
- I understand that Dr. Miller uses prescription monitoring software to verify pain medication use.
- Dr. Miller 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.
- I understand that if my pain requires use of narcotic medications for a longer period of time, Dr. Miller may refer to a pain management specialist.
- I will be in charge of keeping medications safely in my care. Lost or stolen medication may not be replaced.
- If prescribed narcotic medications while under Dr. Miller's care, I agree to take them as prescribed. If I take them more often than prescribed without his authorization, I understand that I may not have pain medication for a period of time.
- I agree that 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 notice for all refill authorizations so as to ensure arrangements can be made.
- Refill requests MUST be made by calling the main line at 513-354-3700, and cannot be made at the front desk.

I, _____, understand the guidelines that are described above and agree to follow the above outlined policy.

_____

Patient Signature Date

_____

Patient Printed Name Date of Birth

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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.*

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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:_____

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Directions to Beacon

Northern Kentucky

600 Rodeo Drive, Erlanger KY, 41018

(513) 354-3700

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

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Directions to Beacon East

463 Ohio Pike

Cincinnati, OH 45255

513-354-3700

From South of Cincinnati: I-75/I-71 North

- Take I-71/75 North to I-275 East
- Take the Beechmont Avenue exit 65 and turn left. Stay in the left hand lane.
- Turn left onto Hamblen Road (Bob Sumerel Tire and Olive Garden will be to the left)
- Parking is available on the side and front of the building

From Northern Cincinnati: I-75/I-71 South

- Take I-71/I-75 South to I-275 East
- Take the Beechmont Avenue exit 65 and turn right. Stay in the left hand lane
- Turn left onto Hamblen Road (Bob Sumerel Tire and Olive Garden will be to left)
- Parking is available on the side and front of the building.

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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.

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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