❑ NEW PATIENT ❑ UPDATE DR: ____________________

DATE: ____________ PATIENT ACCOUNT #: ____________

Patients **Legal** Name:

(First)____________ (Middle)________ (Last)____________ Sex: M F

Social Sec. #____________ DOB:________ Age: ______ Marital Status: M S W D

Address:____________ City, State and Zip: ____________

Home Phone:____________ Cell Phone:____________ Work Phone:____________

Employer:____________ Occupation:____________

School Name (if student):____________

Religious Preference:____________

Primary Physician Name and Phone: ____________

EMERGENCY CONTACT

Name ____________ Phone# ____________ Relationship____________

RESPONSIBLE PARTY If the patient is a minor, person responsible for billing account

Name: ____________ Relationship to patient: ____________ Sex: M F

Address: ____________ DOB: ____________

City, State and Zip: ____________ Social Security # ____________

Phone: ____________ Employer: ____________

PRIMARY INSURANCE

Insurance Company: ____________ Primary Insured Person: ____________

Claim Address: ____________ Insured Address: ____________

Group #: ____________ Insured Phone #: ____________

Member I.D. #: ____________ Social Security #: ____________

Effective Date: ____________ DOB: ____________ Sex: M F

SECONDARY INSURANCE/ WC/ MVA

Insurance Company: ____________ Primary Insured Person: ____________

Claim Address: ____________ Insured Address: ____________

Group #: ____________ Insured Phone #: ____________

Member I.D. #: ____________ Social Security #: ____________

Effective Date: ____________ DOB: ____________ Sex: M F

DOI: ____________

THIRD INSURANCE/ OTHER

____

How were you referred to us?

- ❑ Referring Physician
- ❑ Friend/Relative/Former Patient (circle one)
- ❑ HMO/PPO
- ❑ Employer
- ❑ Hospital
- ❑ Case Manager
- ❑ School
- ❑ Seminar/Screening
- ❑ Yellow Pages
- ❑ Television
- ❑ Radio
- ❑ Newspaper
- ❑ Other
- ❑ Workers Compensation

____

Name Address Phone

PLEASE READ:

Some insurance companies will not pay your bill if you do not select one of their participating doctors. It is the patient's responsibility to determine if our doctor participates in your plan. Payment or co-payment is due at the time of service. The patient or guardian is responsible for any portion of the bill that is not covered by insurance. In the event of legal action for collection, patient agrees to pay all costs of collection, including reasonable attorney's fees. By signature below, the parent or guardian agrees that the jurisdiction and venue for said action shall be the County of St. Louis and State of Missouri. Any balances due from patients or guardians that are outstanding for over 90 days will have an automatic monthly finance charge of 1.5% (18% annual rate).

SIGNED (Patient or Guardian) ____________ DATE____________

AUTHORIZATION AND ASSIGNMENT

I authorize The Orthopedic Center to release information regarding my treatment to my insurance company, to health care providers who have referred me to The Orthopedic Center and to parties who are involved in my treatment if I have a work-related injury. I also authorize my insurance benefits to be paid directly to The Orthopedic Center. This is an authorization for medical treatment of a minor if signed by a parent or guardian. In addition to the above and in the event The Orthopedic Center is served with a Subpoena for production of records, the undersigned authorizes The Orthopedic Center to produce such records under a Business Records Affidavit without the necessity of attendance at a deposition. This above Authorization can only be withdrawn or revoked by written notification to The Orthopedic Center.

SIGNED (Patient or Guardian) ____________ DATE____________

David M. Brown, M.D.
Matthew F. Gornet, M.D.
Lyndon B. Gross, M.D., Ph.D.
John O. Krause, M.D.
Paul S. Lux, M.D.
Mark D. Miller, M.D.
Michael J. Milne, M.D.
George A. Paletta, Jr., M.D.
Mitchell B. Rotman, M.D.
Brett A. Taylor, M.D.

Consent to Release Information

I, ______________________________, authorize The Orthopedic Center of St. Louis staff to discuss my medical treatment and any billing issues with the following people: (Please list any family members, friends or legal counsel that we are allowed to discuss your treatment or billing issues with.)

______________________________ Relation: ____________________

______________________________ Relation: ____________________

______________________________ Relation: ____________________

Patient Signature: ______________________________ Date: ______________

(Parent or Guardian Signature if a minor)

14825 N. Outer Forty Rd. • Suite 200 • Chesterfield, MO 63017 • (314) 336-2555 • Fax (314) 336-2557

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Dear Friends and Patients,

Welcome. Thank you for choosing **the Orthopedic Center of St. Louis.**

The Orthopedic Center of St. Louis constantly strives to provide the highest quality comprehensive care for you and your family.

We have organized this building to include providers that complement our services so that you can get the care you need in one convenient location. This includes:

- 10 Fellowship Trained Orthopedic/Plastic & Reconstructive Surgeons with subspecialty training in specific areas.
- Digital xrays and electronic medical records in our state of the art facility
- High resolution digital MRI and MR Arthrograms on the 1st floor at **Imaging Partners of Missouri**
- **CT Partners of Chesterfield** provides state of the art CT scanning on the 1st floor
- Electrodiagnostic testing on the 3rd floor at the **Neurological & Electrodiagnostic Institute**
- **ProRehab** on the 3rd floor provides physical therapy and custom splinting, often the same day as your appointment at **The Orthopedic Center of St. Louis**
- Medical Equipment (DME) is available on-site through our office and the **Corner Pharmacy** delivers medications to each of the following surgical facilities to save you a trip to the drugstore after surgery.

If surgery is required, **Timberlake Surgery Center** is located on the 1st floor. The **St. Louis Spine and Orthopedic Surgery Center** and **Advanced Surgery Center** are located nearby and provide additional locations for outpatient surgeries, spine patients, and patients who require an overnight stay. These facilities are staffed with experienced nurses and staffs that work closely with our physicians to provide the highest quality specialized care in an efficient and personalized fashion.

Financial Disclosure

Some of the individual physicians at the Orthopedic Center of St. Louis have ownership in some of the surgical and imaging facilities listed above as permitted by both state and federal law.

You have complete freedom of choice as you select your providers and facilities.

Our physicians and staff are happy to provide you with the names of other service providers and will help coordinate your appointments with your provider of choice.

For more information, visit our website **www.TOC-STL.com**

We appreciate the opportunity to serve you and your family.

Signed: ______________________________ Date: ____________________

Printed Name: ____________________________ TOC: ____________________

14825 N. Outer Forty Rd. • Suite 200 • Chesterfield, MO 63017 • 314.336.2555 • Fax 314.336.2557

The Orthopedic Center of St. Louis
Notice of Health Information Practices

This notice describes how your medical information may be used or disclosed and how you can access this information. Please review it carefully.

Uses and Disclosures:
We will use and disclose elements of your protected health information (PHI) in the following ways.

- Basis for planning your care and treatment
- Communication among the health professionals who may contribute to your care
- Legal document describing the care you receive
- Means that you, your insurance company or a third party payor can verify that services billed were actually provided
- Source of data for medical research
- Source of information for public health officials charged with improving the health of the nation
- Source of data for facility planning
- Source we can assess our data to improve the care we render and the outcomes we achieve
- In emergency situations or to avert serious health/safety situations
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties
- To organ, tissue and other donations organization, upon or proximate to your death, if we have no indication on hand about your donation preferences
- To use an automated telephone system to use my name, address, and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights:

- Request a restricted access to all or part of your private health information as provided by 45 CFR 164.522, if we are unable to abide by this request we will notify you
- Inspect or receive a copy of your medical record as provided by 45 CFR 164.524
- To get updates or reissue of this notice, at your request
- To request a list of disclosures of your medical records as provided by 45 CFR 164.528
- To receive correspondence of confidential information by alternate means or location as long as the request in reasonable
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken

Our duties:
We are required by law to maintain the privacy of your private health information. We must abide by the terms of this notice or any update of this notice. If this notice is updated we will notify you by mail to the address you've supplied us.

To obtain more information or report problems please contact The Orthopedic Center of St. Louis's HIPAA Compliance Officer at 314-336-2555. **Full explanation of notice is posted in our waiting room. To request your own copy, please see our receptionist.**

If you believe your privacy rights have been violated, you can file a complaint with the administrator or operations manager. If, after contacting, The Orthopedic Center of St. Louis, you are not satisfied with the response you may contact the U.S. Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Effective date of this notice is April 14, 2003.

Acknowledgement:

Signature: ______________________________ Date: ________________

Print the name of the Patient: ______________________________

If you are signing as the patient's representative:

Print your name: ______________________________

Describe your authority: ______________________________

The Orthopedic Center of St. Louis
John O. Krause, M.D.
Orthopedic Surgery; Surgery of the Knee, Ankle, Foot

NEW PATIENT INFORMATION

Name: ______________________ **Age** ______________
Referring Doctor: ______________________ **Date of Birth:** ____ / ____ / ____
How did you hear about Dr. Krause? ______________________ **Phone #** ______________
Primary Care Physician:____________ **Address:** ________________**Phone #**________

Chief Complaint: ______________________________
Date of Accident/Onset: _____ / _____ / _____ **Which side is your problem on?** ❑ Right ❑ Left
Please describe the recent events that brought on this orthopaedic problem: ______________________
____
How long has it been a problem? ______________________________
How often do you have pain? ______________________________
What makes it worse? ________________ What makes it better? ________________
Have you had prior treatment for this injury? ❑ Yes ❑ No What Treatment? When?________________
______________________By Whom?______________________

Occupation____________ Employer ____________ Hours____________
Do you smoke? ❑ Yes ❑ No Cigarettes / Cigars / Other ____________ Quit? _____ Yr________
How many packs per day? ____________ How many total years have you smoked? ____________
Do you use chew tobacco? ❑ Yes ❑ No Do you consume alcohol? ❑ Yes ❑ No How much/often? ________
List any activities that you participate in on a regular basis outside of work (sports, gardening, weight lifting, musical instruments, etc.) ______________________________
Are you here for a work-related injury? ❑ Yes ❑ No If yes, please complete page 3
Do you have an attorney regarding this injury? ❑ Yes ❑ No If yes, who?____________________
Do you regularly attend religious services? ❑ Yes ❑ No
How important is religion/spiritual issues in your life? ❑ Very ❑ Moderately ❑ Somewhat ❑ Not important

HEALTH HISTORY

Height____________ Weight____________ Shoe Size____________

Question			Question		
Do you have diabetes?	❑ Yes	❑ No	Do you have fibromyalgia?	❑ Yes	❑ No
Do you have rheumatoid arthritis?	❑ Yes	❑ No	Do you have lupus?	❑ Yes	❑ No
Do you have a thyroid problem?	❑ Yes	❑ No	Do you have gout?	❑ Yes	❑ No
Do you have any heart problems?	❑ Yes	❑ No	Do you have any lung problems?	❑ Yes	❑ No
Have you ever had a heart attack?	❑ Yes	❑ No	Do you have stomach ulcers?	❑ Yes	❑ No
Do you have high blood pressure?	❑ Yes	❑ No	Do you have or have you had hepatitis?	❑ Yes	❑ No
Do you have depression?	❑ Yes	❑ No	Do you have any other mental illness?	❑ Yes	❑ No
Do you have any bleeding disorders?	❑ Yes	❑ No	Do you have any kidney trouble?	❑ Yes	❑ No
Do you have seizures?	❑ Yes	❑ No	Do you have cancer?	❑ Yes	❑ No
Have you ever had a stroke?	❑ Yes	❑ No	Do you have anemia?	❑ Yes	❑ No
If you are a woman, are you pregnant?	❑ Yes	❑ No	Have you ever had a blood transfusion?	❑ Yes	❑ No
Have you ever had a blood clot in your legs or lungs?	❑ Yes	❑ No	Do you have HIV/AIDs?	❑ Yes	❑ No

Explain all yes answers and list any other medical problems: ______________________________
____

PAST SURGICAL HISTORY: (List all surgeries you have had)

TYPE OF SURGERY	DATE (or approx. date)	WHERE	NAME OF SURGEON
______________________	_____ / _____ / _____	____________________	______________________
______________________	_____ / _____ / _____	____________________	______________________
______________________	_____ / _____ / _____	____________________	______________________
______________________	_____ / _____ / _____	____________________	______________________

MEDICATIONS: (List all medications you are currently taking, including vitamins, OTC meds, herbal medications)

MEDICATION	STRENGTH	HOW OFTEN

ALLERGIES:

Are you allergic to Latex? ❑ Yes ❑ No

Have you ever had an allergic reaction to a medication? ❑ Yes ❑ No If yes, please list:	
MEDICATION	**REACTION**

Have you ever had a bad reaction to aspirin or a non-steroidal anti-inflammatory type medication?(i.e. Motrin, Ibuprofen)
❑ Yes ❑ No If yes, what was the name of the medication and what happened? ______________________________
____

FAMILY MEDICAL HISTORY:

Do any of your relatives (mother, father, brothers, sisters, aunts, uncles, grandparents) have any of the following medical problems?

Diabetes	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Rheumatoid arthritis	❑ Yes	❑ No	Bleeding Disorders	❑ Yes	❑ No
Lupus/Gout	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
Heart problems	❑ Yes	❑ No	Lung problems	❑ Yes	❑ No
Anesthetic Reactions	❑ Yes	❑ No	Any other medical problems	❑ Yes	❑ No

Please explain all yes answers: ____

Patient Expectations

Patient Name: ______________________________ Age: ________

Condition being treated: ______________________________________

Please check the box the most appropriately describes your current expectations for treatment.

- ❑ Definitely non-surgical
- ❑ Probably non-surgical
- ❑Not sure
- ❑ Either surgical or non-surgical
- ❑ Probably surgical
- ❑Definitely surgical

Please check off which factors most influence your decision to seek treatment. (Check all that apply)

- ❑ Pain the limits daily activities/work
- ❑ Pain that limits sporting activities
- ❑ Pain that limits shoewear
- ❑ I am unhappy with the appearance
- ❑ Concerns about long term damage to the bones/joint/ligaments
- ❑ Friends/family recommended I seek treatment
- ❑ Directed by workman's comp or an attorney

Review of Systems

(Circle all that apply)

General
Normal
Weight change
Fever / Chills
Fatigue / Malaise
Strength / Weakness
Overall status:________

HEENT
Normal
Headache
Vision: blurred,
Sensitivity to light (photophobia)
Ringing in ears (tinnitus)
Nasal discharge
Bloody nose (epistaxis)
Sore throat / Hoarseness

Cardiopulmonary
Normal
Chest pain, palpitations
Short of breath:
  exertional,
  laying down (orthopnea)
  wake up in middle of night (PND)
Cough, sputum
Wheezing
Dizzy when standing up (orthostasis)
Passing out (syncope)
Leg/calf pain with exercise/walking (claudication)

Hemo-Onc
Normal
Pallor
Bruising / Bleeding

Genito-Urinary
Normal
Blood in urine (hematuria)
Flank pain
Stones / Gravel

Gastro-Intestinal
Normal
Nausea / Vomiting
Heartburn (GERD)
Regurgitation
Vomit blood (hematemesis)
Coffee ground vomit
Abdominal pain
Constipation / Diarrhea
Jaundice

Neurological
Normal
Loss of consciousness
Seizures
Numbness / Tingling

Musculoskeletal
Normal
Weakness
Swelling / Pain
Stiffness (in am)
Back pain
Joint pain

OB/GYN
Normal
Menstrual cycle:
  Normal
  No period (amenorrhea)
  Excessive
  Bleeding
  Spotting
  Menopausal
Breast: pain, masses, lesions, ulceration's

Endocrine
Normal
Neck mass / pain (goiter)
Lethargy / Fatigue
Breasts in males (gynecomastia)
Obesity (truncal, facial)
Flushing

Psychiatric
Normal
Personality disorder:
____
Depression
Anxiety
Schizophrenia
Bipolar
Suicide ideation
Homicide ideation
Drug abuse

Skin
Normal
Eczema
Psoriasis
Atopic dermatitis
Keloids
Rashes / Sores
Pain / Itching

COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR A WORK-RELATED PROBLEM

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible.

WORK HISTORY:

What is your current occupation? ____________________

What company do you currently work for? ____________________

What was your occupation when you developed the problem that you are being seen for? ____________________

What company were you working for when you developed this problem? ____________________

When did you first start working for this company? ____________________

If you are no longer working for this company, when did you last work for this company? ____________________

How many hours a day do you (or did you) work? ____________________

How many hours a week do you (or did you) work? ____________________

Describe your job in detail (the job you were working when you developed your problem):

- What do you do with your hands and arms at work? ____________________
  ____
- How often do you do these activities? ____________________
- How much do you lift? ____________________
- How often? ____________________
- If you do data entry, how many hours a day? ____________________
- Is it continuous or intermittent? ____________________
- If you do something repetitive, how many times an hour do you do it? ____________________

Additional Comments: ____________________

____

____

Do you have a second job? ❑ Yes ❑ No If yes, please describe what you do and list how many hours per day and week you work there: ____________________

____

PAST WORK HISTORY:

Please list the type of work you did before you worked for the company you were working for when you developed this problem:

- Where did you work? ____________________
- How long did you work there? (from when to when) ____________________
- What did you do? ____________________

Additional Comments: ____________________

Are you currently working your regular job? ❑ Yes ❑ No If so, are you on light duty? ❑ Yes ❑ No

Additional Comments: ____________________

If you are on light duty, what are your work restrictions? ____________________

____

Signature: ____________________ Date: ______ / ______ / ______