Appt________ Arrival __________ X-ray __________/____________ Room __________ Rack __________ Exam________

480 East Jefferson Street
Suite B
Butler PA 16001
724-968-5300

Initial Patient Health Assessment

Name: ______________________________ Age: ________ Date of Birth: ______________

Primary Care Physician: ____________________ Insurance: ______________________

Did a doctor refer you to us? □ Yes □ No **Referring Physician:** ______________________

Reason for Visit: Please specify □ Right □ Left □ Both Right and Left (Bilateral)

BODY PART AFFECTED: ____

Prior Treatment relating to today's problem:

Have you had?

Joint injection	□ Yes	□ No	If so, did it help? □ Yes	□ No
Medication treatment	□ Yes	□ No	If so, did it help? □ Yes	□ No
Physical Therapy	□ Yes	□ No	If so, did it help? □ Yes	□ No

Testing relating to today's problem:

Have you had?

CT Scan □ Yes □ No MRI □ Yes □ No Ultrasound □ Yes □ No

Current Occupation: ______________________ **Is this worker's comp injury?** □ Yes □ No

Are you? □ Right Hand Dominant □ Left Hand Dominant □ Ambidextrous

Medical History (List those conditions you are presently being treated for or have been treated for in the past)

____

____

____

Women only: Any chance of pregnancy? □ Yes □ No □ Uncertain

Surgeries (List all operations you have had)

____

____

Family History

	Living	Age
Mother	Y/N	____
Father	Y/N	____
Brothers	Y/N	____
Sisters	Y/N	____
Children	Y/N	____

Family History (if applicable and please indicate which family member)

Bleeding Disorder __________	Autoimmune Disorder ________
Kidney Disease ____________	Cancer ______________
Heart Disease ____________	Osteoporosis ____________
Liver Disease ____________	Hypertension ____________
Diabetes ______________	Arthritis ______________

Initial Patient Health Assessment Questionnaire – page 2

Social History:

Do you smoke? ____Yes ____ No How many packs/day? __________

Have you ever smoked? ____Yes ____ No How long did you smoke? ________

When did you quit? ____________

Do you chew tobacco/snuff? ____Yes ____ No

Do you use illicit drugs? ____Yes ____ No

Do you drink alcohol? ____Yes ____ No How many drinks/week? ________

Do you drink caffeine? ____Yes ____ No How many cups/day? __________

Have you ever been treated for substance abuse? ____Yes ____ No

High risk for HIV? ____Yes ____ No

Do you wear seatbelts? ____Yes ____ No

Do you exercise? ____Yes ____ No How often? ______________

List all current medications:

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

______________________________ Dose: __________ Times/Day ________

List any allergies and the reaction:

______________________________ reaction: ______________________

______________________________ reaction: ______________________

______________________________ reaction: ______________________

______________________________ reaction: ______________________

Preferred Pharmacy: ______________________________ Phone: ______________

Patient Name: ______________________________ Birthdate: ______________

BUTLER MEDICAL PROVIDERS
PHYSICIAN DIVISION

PATIENT REQUEST FOR DISCLOSING VERBAL INFORMATION

PATIENT NAME:______________________________________ DATE OF BIRTH:________________

PRACTICE NAME:____

I do ☐/do not☐ consent for detailed messages to be left on my voicemail.
Phone:____________________________

Please list any person(s) whom you allow this office to discuss your medical care with (such as parents/spouse/ children, etc.)
Name:______________________________ Relationship:________________ Phone ________________

Name:______________________________ Relationship:________________ Phone ________________

Name:______________________________ Relationship:________________ Phone ________________

Name:______________________________ Relationship:________________ Phone ________________

Special Instructions or Limitations:____

____

As an extra measure of security, before any member of our office staff will discuss any aspect of your care or information, including but not limited to, appointment dates and times, test results, medication lists, etc., with you or any person listed above, you or that person must know the unique password that you create with this office. Please choose any word that is easy to remember for you and the listed members. For example: pet's name, favorite vacation, favorite food, favorite color, etc. Be sure to notify all person's listed above of your password.

Secure Password:____

Password Hint:____

We will continue to rely on the information on this form when communicating with you, family members, or others involved in your care unless you request changes. Please promptly notify our office in writing if you wish to alter the designations above. With my signature, I am aware that BMP Physician Division encompasses many different Physician Specialties within Butler Health System. Any of those offices may have access to my medical records.

____ ________________
Signature of Patient/Legal Representative: Date/Time:

Relationship to Patient:____

This authorization hereby revokes any previous authorizations.
To revoke this authorization, please send a written request to our office.

Reviewed. No changes.

Initials____________	Date__________	Initials____________	Date__________
Initials____________	Date__________	Initials____________	Date__________

BHS Orthopedic Associates

Privacy Practice Notice and Acknowledgement

I acknowledge that the office has a new Notice of Privacy Practices and the notice has been made available to me.

Patient Name ____
Print Name

Date of Birth ____________________________

____ ______________

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

BHS Orthopedic Associates

Welcome to BHS Orthopedic Associates with Dr Clark. Thank you for selecting us to provide you with high quality, personal care for your orthopedic needs. Please take a few minutes to review a few of our policies which will help us serve you better.

Please notify us of any changes to your address, personal information or insurance coverage.

You will be asked to present your photo ID and insurance card at each visit.

All co-pays are due at the time of service.

Please note that we want to see you when you need care. Calling in prescriptions without examining you is not good practice. We will work with you to find an appointment time to accommodate your schedule as well as ours.

Please provide our staff with a minimum of three business days to generate a referral for all routine services.

Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment please notify us at least 24 hours ahead of time to reschedule or cancel. If you do not notify us, you may be charged a $20 No Show Fee. If appointments are repeatedly missed, we may discharge you from the practice.

For Insurance/FMLA/Disability Forms: There is a $10 form fee which is expected to be paid when an insurance or FMLA form is completed. This excludes forms presented at the time of an office visit.

BHS may request previous medical and/or prescription records so that we may have the best understanding of your medical history.

For the uninsured, we offer a 15% discount if payment in full is made at the time of the visit. Not everyone may be able to pay the entire amount at one time. If you need financial assistance with your medical bills, we offer payment plans and a program called Charity Care for which you may qualify based on income guidelines. Please call Patient Accounts Representative at 724-284-4022 for a confidential discussion of your financial needs.

Any patient under the age of 18 must be accompanied by a parent/legal guardian, or must have written consent from parent/legal guardian authorizing treatment. We reserve the right to call that parent/legal guardian to confirm the validity of the written consent.

Again, thank you for choosing BHS Orthopedics for your healthcare needs. We are committed to providing you excellence in healthcare.

Patient Acknowledgment: I have read and understand my responsibilities as outlined above.

______________________________________ ____________________

Patient Signature Date