Thank you for choosing Marshall Orthopaedics! We will make every effort to ensure that your experience with our office is exemplary.

Enclosed you will find new patient information forms. Please fill this paperwork out at your convenience and bring it with you to your appointment. In addition to this completed paperwork, please also bring the following with you:

1) Unless taken at Cabell Huntington Hospital, please bring any relevant X-Rays, MRIs or CT scans on a disc or film
2) Please also bring a current list of all your medications and current insurance cards so that we may make a copy of them for your medical chart

The failure to bring this information with you may result in the rescheduling of your appointment.

Please try to arrive approximately 15 minutes before your scheduled appointment time. This will help avoid delays for you and other patients as our office strives to provide quality care and to best meet all patients’ needs.

**Directions to Marshall Orthopaedics – MUSOM Huntington Office**

**Driving WEST on Interstate 64:** In Huntington, take Exit 11 and remain right when driving down the exit ramp. You will drive through two traffic lights and once you come to the third traffic light, you will see Cabell Huntington Hospital and the Marshall University Medical Center on the right. You may park in the main patient parking lot or have your car parked valet.

**Driving EAST on Interstate 64:** In Huntington, take Exit 11 and turn left once you drive to the traffic light at the end of the ramp. After turning left, you will go through three traffic lights, once you come to the fourth traffic light, you will see Cabell Huntington Hospital and the Marshall University Medical Center on the right. You may park in the main patient parking lot or have your car parked valet.

The Marshall University Medical Center entrance is on the right side of the building under a large white awning. As you come through the main entrance doors, Marshall Orthopaedics is located on the right side of the ground floor.
Thank you for choosing Marshall Orthopaedics as your healthcare provider. We are committed to providing you with compassionate care with the best possible results. It is important that you have a clear understanding of your financial responsibility. Please read below regarding financial expectations.

Co-payments: Co-payments are required on the date of service. Many co-pay amounts will be displayed directly on your insurance card. We accept cash, check and credit cards.

Co-insurance/Deductibles: Depending on your insurance plan, you as the patient may owe a portion of the fee for your surgery. In these cases, pre-payment for surgery is required. An employee from our billing office will be in contact with you to arrange for payment.

Insurance: Please bring all insurance cards to each appointment as we will verify your insurance information at each visit.

Uninsured Patients: All non-urgent appointment requests will require payment prior to or on the date of service in order to see a physician. If you are unable to make the entire payment up front, payment plans with our billing office are available. To speak with our billing office, please call 304-691-8586.

Insurance Forms: Because of the time requirements placed on our physicians and support staff, a fee will apply for some types of insurance forms. Please see fee schedule below for form requests:

- Workers Compensation Forms – Free
- Insurance Pre-Authorization – Free
- Return to Work/School – Free
- Family Medical Leave Act - $25
- Short Term Disability Forms - $25

Signature Date
Name (printed): ____________________________________  Date of Birth: ________  Age: ________

Family Doctor: ____________________________________  Referring Doctor: ____________________________________

**Chief complaint** (reason for visit – be specific):

Which side of your body is affected?

For how long have you had your symptoms?

Was there an accident/fall associated with it?

Are you right or left-handed? (circle one)

What kind of symptoms are you experiencing?

---

On a scale of 1-10, rate your **pain**

Describe (circle) the quality of the pain

Does the pain radiate (shoot down or up)?

When is it worse?

Does it wake you up from a sound sleep

Does anything else make it worse?

What makes the pain better?

What type of treatments have you tried?

---

Have you had any **imaging**?

What activities is this stopping you from doing?

What expectations do you have from treatment?

Please draw out your symptoms.

Use “X” for pain and “O” for numbness (use arrows to show shooting pain)
**MEDICAL HISTORY**

Patient Name: ____________________________________________ Date of Birth: ____________________

Have you **ever** had the following problems? (*circle* all that apply)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Other Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer (tumor) – What kind?</td>
<td>High Blood Pressure</td>
</tr>
<tr>
<td>Hay Fever /// Asthma</td>
<td>Heart attack /// Heart failure /// Rhythm Trouble</td>
</tr>
<tr>
<td>Emphysema /// COPD /// Tuberculosis /// Pneumonia</td>
<td>High Cholesterol</td>
</tr>
<tr>
<td>Unusual bleeding /// Anemia (low blood)</td>
<td>Hepatitis /// Cirrhosis /// Other Liver Problems</td>
</tr>
<tr>
<td>DVT (blood clot in the leg) /// PE (blood clot in the lungs)</td>
<td>Gallstones /// Other Gallbladder Problems</td>
</tr>
<tr>
<td>Diabetes (sugar)</td>
<td>Stomach Problems /// Reflux (heartburn) /// Ulcers</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Kidney Trouble /// Bladder Trouble</td>
</tr>
<tr>
<td>Epilepsy (fits/seizures/convulsions) /// Stroke</td>
<td>Anxiety /// Depression /// Other Emotional Problem</td>
</tr>
<tr>
<td>Arthritis (osteoarthritis) /// Rheumatism /// Lupus /// Gout</td>
<td>Reaction To Anesthesia – What kind?</td>
</tr>
</tbody>
</table>

Please list all **surgeries** you have had:

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Date</th>
<th>Where</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Please list all the **medicines** you are currently taking (including over the counter medicines)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
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</thead>
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</tbody>
</table>

**MEDICATION ALLERGIES:** ____________________________________________
Patient Name: ___________________________________________ Date of Birth: ________________

SOCIAL QUESTIONS
Do you currently smoke or chew? Y N __________ packs/cans per day and for__________ years
Did you ever smoke or chew? Y N When did you quit? ___________________________________
Do you drink alcohol? Y N How often? _________________________________________
What do you do for a living?
Do you exercise? How often?

FAMILY HISTORY
Back Problems/Scoliosis Y N ____________________ High Cholesterol Y N ____________________
Cancer Y N ____________________ Diabetes Y N ____________________
Heart Disease Y N ____________________ Lung Disease Y N ____________________
High Blood Pressure Y N ____________________ Reaction to Anesthesia Y N ____________________
Bleeding or Blood Clotting Disorder Y N ____________________

Have you experienced any of the following within the past 6 months? (circle all that apply)

<table>
<thead>
<tr>
<th>Unintentional Weight Loss</th>
<th>Frequent Rectal Bleeding /// Tar-like Stool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent Fevers /// Sweats /// Chills</td>
<td>Frequent Nausea /// Vomiting</td>
</tr>
<tr>
<td>Serious Problems with Eyes</td>
<td>Frequent Pain or Problems Urinating</td>
</tr>
<tr>
<td>Serious Problems with Ears</td>
<td>Persistently Swollen Glands</td>
</tr>
<tr>
<td>Difficulty Swallowing</td>
<td>Skin Problems /// Skin Sores</td>
</tr>
<tr>
<td>Frequent Cough /// Wheezing</td>
<td>Redness of Joints /// Swelling in Joints</td>
</tr>
<tr>
<td>Shortness of Breath at Rest /// Shortness of Breath With Activity</td>
<td>Unusual or Persistent Back Pain</td>
</tr>
<tr>
<td>Racing Heart (palpitations)</td>
<td>Excessive Stress from Home or Work</td>
</tr>
<tr>
<td>Chest Pain at Rest /// Chest Pain With Activity</td>
<td>Persistent Swelling the Legs or Ankles</td>
</tr>
<tr>
<td>Frequent Constipation /// Frequent Diarrhea</td>
<td>Frequent Headaches</td>
</tr>
</tbody>
</table>

The information provided in this form is accurate to the best of my knowledge.

________________________________________________________________________________________
Patient’s Signature Date

I have personally reviewed the information in this form with the patient.

________________________________________________________________________________________
Physician’s Signature Date
INSURANCE INFORMATION

Primary Medical Insurance: ___________________________ Phone: ___________________________
Policy Holder Name: ___________________________ Date of Birth: ___________________________
Address: __________________________________________

STREET: __________________________________________
CITY: ___________________________ STATE: ___________________________ ZIP: ___________________________
ID Number: ___________________________ Group Number: ___________________________
Plan Number: ___________________________ Effective Date: ___________________________ Expiration Date: ___________________________

Secondary Medical Insurance: ___________________________ Phone: ___________________________
Policy Holder Name: ___________________________ Date of Birth: ___________________________
Address: __________________________________________

STREET: __________________________________________
CITY: ___________________________ STATE: ___________________________ ZIP: ___________________________
ID Number: ___________________________ Group Number: ___________________________
Plan Number: ___________________________ Effective Date: ___________________________ Expiration Date: ___________________________

Other Medical Insurance (Worker’s Comp., Medicare Supplement, Etc.):
Medical Insurance: ___________________________ Phone: ___________________________
Policy Holder Name: ___________________________ Date of Birth: ___________________________
Address: __________________________________________

STREET: __________________________________________
CITY: ___________________________ STATE: ___________________________ ZIP: ___________________________
ID Number: ___________________________ Group Number: ___________________________
Plan Number: ___________________________ Effective Date: ___________________________ Expiration Date: ___________________________

If Patient is Under 18 Years of Age, Please List Other Children in the Household.

Child’s Name (Please list name child prefers): ___________________________ Child’s Birth Date: ___________________________
1. ___________________________ □ Male □ Female: ___________________________
2. ___________________________ □ Male □ Female: ___________________________
3. ___________________________ □ Male □ Female: ___________________________
4. ___________________________ □ Male □ Female: ___________________________
5. ___________________________ □ Male □ Female: ___________________________

How did you choose University Physicians & Surgeons?

□ Advertisements □ Referred by a Friend □ Telephone Directory
□ Referred by a Physician (Name): ___________________________ □ Other: ___________________________
PATIENT INFORMATION

Patient Name ____________

Date of Birth ____________

Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed

Social Security Number ____________

Preferred Language: □ Arabic □ English □ Hindi □ Spanish
□ Chinese □ German □ Russian □ Other:

Race:
□ African American □ Asian □ Hispanic/Latino □ Pacific Islander
□ Alaska Native □ Caucasian/White □ Native American □ Declined

Ethnicity:
□ Hispanic/Latino □ Non-Hispanic/Latino □ Declined

Patient Address

STREET ____________

CITY ____________ STATE ____________ ZIP ____________

Driver's License Number ____________

Home Phone ____________ Work Phone ____________ Mobile Phone ____________

Employer Name ____________

Employer Address

STREET ____________

CITY ____________ STATE ____________ ZIP ____________

Primary Care Provider ____________

If under 18, who is parent or legal guardian?

Guardian Name ____________ Date of Birth ____________

Responsible Party (Person who will be responsible for any amount not covered by insurance.)

<table>
<thead>
<tr>
<th>Relationship to Patient</th>
</tr>
</thead>
</table>

Social Security Number ____________ Date of Birth ____________

Address

STREET ____________

CITY ____________ STATE ____________ ZIP ____________

Home Phone ____________ Work Phone ____________ Mobile Phone ____________

Employer Name ____________

Employer Address

STREET ____________

CITY ____________ STATE ____________ ZIP ____________

Spouse’s Name/Other Parent if under 18 ____________

Employer Name ____________ Work Phone ____________

In case of an emergency, notify (friend or relative not in your home):

Name ____________ Phone ____________

Relationship to Patient
PATIENT’S AGREEMENT
Please Read Carefully

I consent to care and treatment
I consent to examination, treatment and testing as advised by the physicians and other providers of Joan C. Edwards School of Medicine ("the School") and Marshall Health. I understand that Marshall Health is associated with a university. I give permission for health care professionals in training to observe and participate in my care and treatment under the supervision of licensed health care providers. In addition, I consent to the use or disclosure of my protected health information by the School and Marshall Health to diagnose and treat me, to obtain payment for my bills and to conduct its health care operations and business. I understand I may receive a call or survey from MTC, Inc. asking about my satisfaction with my care and services at Marshall Health.

I further consent to any treatment and testing by Cabell Huntington Hospital, Inc. ("Cabell"), such as laboratory testing and radiology procedures, which may be performed at the request of my physician or other provider. I understand that I may receive a survey by phone, mail, or email from Press Ganey asking about my satisfaction with my care and services provided by Cabell. I understand that the email address provided may be used to invite me to enroll in Cabell’s patient portal. I may also receive calls from Cabell staff to follow up on my care and treatment. I agree that the terms and conditions set forth in this Patient’s Agreement, including the agreement to pay for the cost of care, shall also apply to treatment and testing by Cabell.

I have received the Notice of Privacy Practices
I have received the Notice of Privacy Practices of the School and Marshall Health, which tells how my health information may be used and shared. I understand that these institutions reserve the right to revise the notice at any time, and that I can always get the current copy by asking for it.

I agree that payments can be made directly to Marshall Health
I allow Marshall Health to directly bill and collect payment from my insurance company, Medicare, Medicaid or other person or entity that pays my medical bills. I assign my right to receive payment of any insurance to Marshall Health, including Medicare, Medicaid or other benefits payable from any source. Some insurance companies will not pay for services unless they authorize the service in advance. I understand it is my responsibility to inform Marshall Health if my insurance policy requires such authorization (sometimes it is called pre-certification).

I agree to pay for the cost of care
I accept full responsibility for the cost of all services that Marshall Health provides to me. I promise to personally pay all expenses and charges that are not paid by my insurance company or anyone else, but only to the extent that Marshall Health legally may bill me for such expenses and charges.

I can cancel this agreement
I understand that I can revoke this agreement in writing. This can be done at any time by delivering to Marshall Health a written statement of revocation, except to the extent that the School and Marshall Health have taken action in reliance on this consent, agreement and authorization. I will be financially responsible for any medical services provided before the date of such revocation.

I agree to follow-up calls.
I expressly give my consent that University Physicians & Surgeons, dba Marshall Health ("Marshall Health") and its employees and independent contractors, may deliver or cause to be delivered to me telephone calls, telephone voice messages, and telephone text messages, for any purposes related to my health care that Marshall Health deems appropriate and that are permitted by law, by using an automated telephone dialing system or an artificial or prerecorded voice or message. Such calls and messages may be delivered to me at the following telephone numbers ____________, and at any other telephone numbers I provide to Marshall Health in connection with my patient account at Marshall Health. I understand that I am not required to give this consent to Marshall Health as a condition of being treated or receiving services.

I have read this form and I fully understand what I am agreeing to. (The patient or another responsible party on behalf of the patient must sign this Agreement. Upon signing, the responsible party assumes all liability for the consents, authorizations and financial responsibility discussed above.)

Date ____________________________
Signature of Patient or Legal Representative

STATEMENT OF PATIENT’S LEGAL REPRESENTATIVE OR AGENT
I give the consents and authorizations made above on behalf of the patient and I have the authority to do so. The patient did not sign because he or she is (check one):
☐ A minor (under 18 years of age)
☐ Mentally or physically unable to understand or sign
☐ Other (describe): ____________________________

I am authorized to sign for the patient because: (for example, being a parent or having medical power of attorney)