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CAPITAL
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EXSCRIBE EHR

We are pleased to announce that Capital Ortho has migrated to a new EHR. (Electronic Health Record) It is our goal to make this transition as smooth as possible.

Our new **Patient Portal** is now available. If you have an **appointment scheduled** and have provided an **email address** you will receive an invitation to register on our Patient Portal. Please watch for a Welcome email. **This will significantly reduce your wait time and the amount of paperwork that must be filled out.**

This online tool gives you the flexibility to access your health information and other resources at your leisure – any time of day and from any location! Since the Exscribe Patient Portal is available over the Internet, you can use it from virtually anywhere. You can also use the Exscribe Patient Portal to access information for family members and individuals for whom you provide care, if given permission.

As a patient of Capital Ortho, enrolling in the Exscribe **Patient Portal** is free and will allow you to:

- **Pre-register for Your Visit, fill out all new required paperwork**
- Securely Message with Your Physician/Nurse
- Request Appointments
- Update Personal Information
- Request Prescription Renewals

Also, the Exscribe Patient Portal is completely secure, so you can be confident that your private information is protected. Only you – or an authorized representative – can access your Exscribe Patient Portal. Remember: treat your health information like your banking information and use caution when sharing with others!

We hope this new tool will help you take an active role in your healthcare. For more information, do not hesitate to ask one of our staff members about the details at your next office visit!

If you do not have an email address you can print the paperwork from our website, capitalortho.com or you can pick up a packet from any of our locations.

Thank you,
Capital Ortho

Chart: _____ Date: _____

Name: _____ Social Security #: _____
Last First Middle

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: M___ D ___ S ___ W ___

Address: _____ _____
City State Zip Code

Home Phone: _____ Cell Phone: _____ Day Phone: _____ Work Phone: _____

Email: _____ Place of Employment: _____

Employer's Address: _____

If patient is a minor, current school being attended: _____

RESPONSIBLE PARTY INFORMATION (Skip if same as Patient)

Name: _____ Relationship to above Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Place of Employment: _____ Phone: _____

Social Security: _____ Date of Birth: _____

Spouse: Name: _____ Date of Birth: _____ Social Security #: _____

Spouse Employer: _____ Phone: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's Name: _____

Primary Insurance: _____ Secondary Ins: _____

ID: _____ ID: _____

Insured's DOB: _____ Insured's DOB: _____

Capital Ortho will file a claim with your insurance company for all services rendered by our physicians including office visits, emergency room services, hospital visits and surgery. It is customary to pay for services rendered on the day you are seen.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AND ALL MEDICAL BILLS AT CAPITAL ORTHO.

I CONSENT TO BEING TREATED BY PHYSICIANS OF CAPITAL ORTHO.

It is our policy to collect Deductibles, Co-pays, Co-ins or Account Balances before seeing the physician.

How do you plan to pay for this visit? ____ Check ____ Credit Card ____ Cash ____ Care Credit

Responsible Party, Parent or Guardian's Signature: _____

CAPITAL ORTHO

CHART _____

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Height: _____ Weight: _____

Race: ○ African American ○ Asian ○ Caucasian ○ Native American/Alaskan ○ Pacific Islander ○ Other ○ Unknown ○ Decline to Answer

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unknown ○ Decline to Answer

Preferred Language: ○ English ○ Spanish ○ Chinese ○ Other _____

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Chief Complaint

Dominant Hand: ○ Right ○ Left ○ Ambidextrous

Description of Symptoms: (select only ONE primary symptom and ONE affected area)

○ Pain ○ Numbness/Tingling ○ Fracture ○ Stiffness Other: _____

Shoulder	○ Right	○ Left	Pelvis	○ Right	○ Left	Neck	○	
Upper Arm	○ Right	○ Left	Hip	○ Right	○ Left	Upper Back	○	
Elbow	○ Right	○ Left	Thigh	○ Right	○ Left	Mid Back	○	
Forearm	○ Right	○ Left	Knee	○ Right	○ Left	Low Back	○	
Wrist	○ Right	○ Left	Lower Leg	○ Right	○ Left	Buttocks	○	
Hand	○ Right	○ Left	Ankle	○ Right	○ Left	Tail Bone	○	
Thumb	○ Right	○ Left	Foot	○ Right	○ Left			
Index	○ Right	○ Left	Great Toe	○ Right	○ Left			
Middle	○ Right	○ Left	2nd Digit	○ Right	○ Left			
Ring	○ Right	○ Left	3rd Digit	○ Right	○ Left			
Little	○ Right	○ Left	4th Digit	○ Right	○ Left			
			5th Digit	○ Right	○ Left			

Pain radiates from/to: (ex. from low back to right leg) _____

History of Present Illness

1. Is your problem the result of an injury or accident?

○ No Injury ○ Injury ○ Injury at Work ○ Auto Accident ○ Sport Injury ○ Prior Surgery

How long have the symptoms been present? (ex. 2 days, 4 months) _____

Describe the onset: ○ Acute (sudden) ○ Chronic condition (>3 months)

Onset Date: (mm/dd/yyyy) _____

2. Are you represented by an attorney? ○ Yes ○ No

Attorney Name: _____

Will there be any legal actions with respect to this problem? ○ Yes ○ No

3. Have you had a problem like this before? ○ Yes ○ No

Describe: _____

_____

4. Have you been seen in an ER for this problem? ○ Yes ○ No

Treating ER: (ex. St. Luke's Health) _____ Date: (mm/dd/yyyy) _____

 Patient Name: _____

CHART: _____

History of Present Illness (continued)

5. Rate the pain (10 being the most pain):

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

6. Do the symptoms wake you from sleep?

○ Yes ○ No

7. Please describe the symptoms:

○ Sharp ○ Dull ○ Stabbing ○ Throbbing ○ Aching ○ Burning ○ Shooting

8. What is the timing of the symptoms?

○ Constant ○ Intermittent (comes and goes)

9. Is the problem getting better or worse?

○ Getting better ○ Getting worse ○ Unchanged

10. What makes the symptoms worse?

○ Squatting ○ Kneeling ○ Sitting ○ Bending ○ Stairs ○ Twisting ○ Moving ○ Lying in bed
○ Running ○ Walking ○ Athletics ○ Standing ○ Gripping ○ Lifting ○ Reaching Overhead

11. Are there any other symptoms associated with this problem?

○ Redness ○ Bruising ○ Swelling ○ Numbness ○ Stiffness ○ Limping ○ Clicking ○ Locking
○ Popping ○ Tingling ○ Weakness ○ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem?

○ None ○ X-rays ○ MRI ○ CT Scan ○ Nerve Test (EMG/NCV) ○ Bone Scan

Have you had any prior treatment for this problem? ○ Yes ○ No

Type of treatment	Status of symptoms after treatment (select only those that apply)			Date of treatment
Ice	○ Improved	○ Worsened	○ Unchanged	
Heat	○ Improved	○ Worsened	○ Unchanged	
Rest	○ Improved	○ Worsened	○ Unchanged	
NSAIDs	○ Improved	○ Worsened	○ Unchanged	
Muscle Relaxers	○ Improved	○ Worsened	○ Unchanged	
Chiropractor	○ Improved	○ Worsened	○ Unchanged	
Physical Therapy	○ Improved	○ Worsened	○ Unchanged	
HomeExerciseProgram	○ Improved	○ Worsened	○ Unchanged	
Surgery	○ Improved	○ Worsened	○ Unchanged	
Injections	○ Improved	○ Worsened	○ Unchanged	
Bracing	○ Improved	○ Worsened	○ Unchanged	
TENS unit	○ Improved	○ Worsened	○ Unchanged	

Other/Comments: _____

_____

_____

Select all previous hospitalizations/surgeries: ○ None

○ Aneurysm (Brain) Surgery	○ Hysterectomy
○ Aortic Bypass / Vascular Surgery	○ LAP Band / Gastric Bypass Surgery
○ Appendectomy	○ Lumpectomy
○ Cataract (Eye) Surgery	○ Mastectomy
○ Cholecystectomy (Gallbladder)	○ Malignancy/Cancer
○ Heart Surgery	○ Stents
○ Hernia Repair	

Orthopedic on side:	Right	Left
Arthroscopy: Knee	○	○
Arthroscopy: Shoulder	○	○
Carpal Tunnel Release	○	○
Rotator Cuff Repair	○	○
Total Hip Replacement	○	○
Total Knee Replacement	○	○
TotalShoulderReplacement	○	○
Spinal Surgery - Indicate Level: _____		

Other Surgery

_____

_____

_____

Other Orthopedic Surgery

_____

_____

_____

Medical Questions

Mark all that currently apply:

○ Metal in body ○ Claustrophobic ○ Pregnant ○ Sleep Apnea ○ Uses a CPAP ○ Snores

Are you taking blood thinners? ○ Yes ○ No

Review of Systems

Please indicate if you have experienced any of the following symptoms in the last 6 months?

○ None for all

				None	Comments
1) CON	○ Weight Loss	○ Loss of Appetite	○ Fatigue	○	_____
2) EYE	○ Blurred Vision	○ Double Vision	○ Vision Loss	○	_____
3) ENT	○ Hearing Loss	○ Hoarseness	○ Trouble Swallowing	○	_____
4) CV	○ Chest Pain	○ Palpitations		○	_____
5) RS	○ Chronic Cough	○ Pneumonia	○ Shortness of Breath	○	_____
6) GI	○ Heartburn, Ulcers	○ Nausea, Vomiting	○ Blood in Stool	○	_____
7) GU	○ Painful Urination	○ Blood in Urine	○ Kidney Problems	○	_____
8) SK	○ Frequent Rashes	○ Skin Ulcers	○ Lumps ○ Psoriasis	○	_____
9) NEU	○ Frequent Falls	○ Loss of Coordination	○ Numbness	○	_____
	○ Change in Bowel	○ Change in Bladder	○ Dizziness		
10) PSY	○ Depression/Anxiety	○ Drug/Alcohol Addiction	○ Sleep Disorder	○	_____
11) ENDO	○ Fever	○ Heat or Cold Intolerance	○ Night Sweats		
12) HEM	○ Easy Bleeding	○ Easy Bruising	○ Anemia	○	_____

 Patient Name: _____ CHART: _____

Family History

Have any direct relatives had any of the following disorders? ○ None for all

Father	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Mother	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			
Sibling	○ None	○ Diabetes	○ Heart Disease	○ Hypertension
	○ Bleeding Problems	○ Epilepsy	○ Connective Tissue	○ Muscular Dystrophy
	○ Stroke	○ Osteoporosis	○ Rheumatoid Arthritis	○ Cancer
	Comments (ex. cancer type) _____			

Social History

Do you smoke tobacco? ○ Current, every day smoker ○ Current, some day smoker ○ Former smoker ○ Never ○ Heavy tobacco smoker ○ Light tobacco smoker

Do you drink alcohol? ○ Daily ○ Occasionally ○ Rarely ○ Never

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partnership

Are you currently working? ○ Yes ○ No ○ Retired ○ Disabled If no, what date did you last work? _____

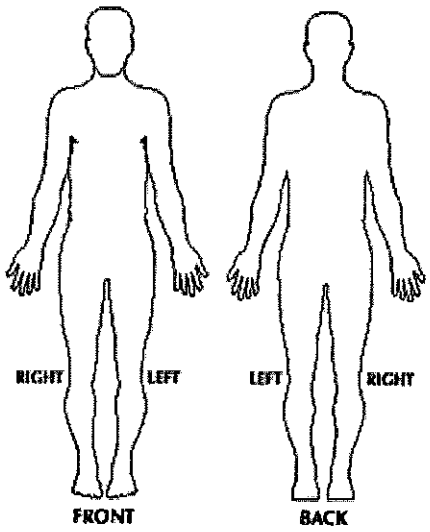
Please list work restrictions, if any: _____

Occupation: _____ Employer: _____ ○ Student

Pain Diagram

On the drawing below, mark an X where the pain is the worst.
Use the symbols below to show where you are having different kinds of pain:

Aching	^^^^
Numbness	====
Pins and Needles	oooo
Burning	xxxx
Stabbing Pain	////



 Patient Name: _____ CHART: _____

Do you have any allergies? ○ Yes ○ No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	Reaction

Latex allergy? ○ Yes ○ No

Please list all medications you take on a regular basis: ○ None

Medication	Dosage and Frequency (e.g. 20 mg, once/day)

Do you have a personal history of any of the following? ○ None

○ Aneurysm Where: _____	○ Emphysema	○ Kidney Disease
○ Angina (Chest Pain)	○ Epilepsy	○ Kidney Stones
○ Arthritis Type: _____	○ Heart Attack	○ MRSA Infection
○ Asthma	○ Hepatitis Type: _____	○ Pacemaker
○ Bone or Joint Infections	○ HIV / AIDS	○ Phlebitis (Blood Clots)
○ Cancer Type: _____	○ High Cholesterol	○ Pulmonary Embolism
○ Chemotherapy / Radiation	○ Hypertension	○ Reaction to Anesthesia Type: _____
○ COPD	○ Hyperthyroidism	○ Seizures
○ Congestive Heart Failure	○ Hypothyroidism	○ Stomach Ulcers
○ Diabetes Type: _____ Last A1C: _____		○ Stroke / TIA
		○ Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

Signature _____ Date

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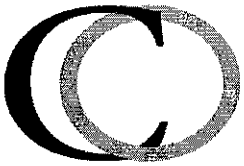

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Financial Policy

Capital Ortho participates in several healthcare networks. It is *your responsibility* to inform us if your insurance program is affiliated with a network and to let us know if a referral or preauthorization is required. You must provide an insurance card so we can determine benefits, and we must know when there are any changes in your coverage. *All portions of any deductible or co-pays are due at the time of service.* If the physician you are seeing is not a member of your network you will be responsible for any portion your insurance does not pay.

SECONDARY INSURANCE POLICIES: We will be happy to file your secondary insurance. However, if we have not received a response from them within 45 days the balance will be transferred to the patient.

Please remember that your insurance policy is a contract between you and your insurance company. We will file you claim(s), but it is your responsibility to follow up and see that the claims(s) are paid in a timely manner. Should problems arise with your insurance company we will gladly assist you in determining what steps need to be taken. *You are always responsible for your account, regardless of insurance coverage.*

We make every effort to work with our patients regarding their account and we encourage you to keep us informed of any special circumstances. However, it is sometimes necessary to rely on an outside agency to assist us with collections. Should it become necessary for your account to be assigned to an agency, a collection fee of 30% will be added to the balance on the account.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED AT CAPITAL ORTHO AND ANY SURGICAL CHARGES THAT ARE INCURRED WITH CAPITAL ORTHO.
I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL STATEMENTS, A 30% COLLECTION FEE AND/OR ANY ATTORNEY FEES THAT MAY BE ADDED TO MY ACCOUNT.

I request that payment of authorized Medicare/Other Insurance company benefits be made to Capital Ortho for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

_____ _____ CHART _____

SIGNATURE OF RESPONSIBLE PARTY DATE