SHOULDERMD

PAUL B. ROACHE, M.D.

BOARD CERTIFIED ORTHOPEDIC SURGEON

Patient Demographics and Insurance: Please Review, Edit and Complete all required fields.

***First Name: _____ *M.I.: _____ *Last Name: _____**

***Male/Female: _____**

***Date of Birth: _____ *Social Security Number: _____**

***Address: _____**

City: _____ State: _____ Zip: _____

***Email Address: _____**

***Mobile Phone: _____**

***Home Phone: _____**

***Emergency Contact Name: _____ Phone: _____**

Relationship: _____

***PCP: _____**

***Referring Source: _____**

***Preferred Pharmacy: _____**

***Preferred Physical Therapy location: _____**

Insurance: Please complete the sections that apply to you.

PRIMARY INSURNACE:

***Insurance Name: _____**

***Subscriber ID: _____ *Group Number: _____**

***Insurance address: _____**

City: _____ State: _____ Zip: _____

***Customer Service Number: _____**

***Guarantor's Name** (if subscriber is other than you): **_____**

***Copay amount: _____**

SECONDARY INSURNACE:

***Insurance Name: _____**

***Subscriber ID: _____ *Group Number: _____**

***Insurance address: _____**

City: _____ State: _____ Zip: _____

***Customer Service Number: _____**

***Guarantor's Name** (if subscriber is other than you): **_____**

***Copay amount: _____**

WORKERS COMP:

***Date of Injury: _____ *Claim Number: _____**

***Employer's Name: _____**

***Employers Address: _____**

City: _____ State: _____ Zip: _____

***Adjuster's Name: _____*Phone number: _____**

***Insurance Name: _____**

***Case Manager's Name: _____ *Phone number: _____**

***Attorney Name or Company: _____ *Phone number: _____**

Today's Date:

- ❑ New Patient
- ❑ 2nd opinion

- ❑ Need for Surgery
- ❑ Need for MRI
- ❑ Need for Injections
- ❑ Need for referral

Patient Name:

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1) What is Your Age Today? _____

2) Dominant hand:

- ❑ Right hand
- ❑ Left hand
- ❑ Both hands

3) Are you:

- ❑ male
- ❑ female

4) **Height: _____Feet _____Inches**

5) Weight: _____Lbs

6) What is your Occupation?

_____

7) What Body Part Was injured?

_____

8) What is your chief complaint today?

_____

_____

_____

9) What date did your injury begin? _____

10) Have you ever had any injury to this area before?

- ❑ No
- ❑ Yes

If Yes, When?_____

Describe:_____

_____

11) How did the injury start?
(Mark all that apply to how the problem started)

- ❑ Slipped and fell
- ❑ Twisted
- ❑ Strained while lifting
- ❑ working on the computer
- ❑ Driving
- ❑ Other: Briefly describe how the injury started:

_____
_____
_____

Treatments:

12) Have you had any of the following treatments for this problem?

Surgery
- o No
- o Yes, date? _____

Oral Pain/NSAIDS Medications
- o No
- o Yes, which meds are you taking? _____

Cortisone Injections
- o No
- o Yes, # of Injections _____
  Date of Last Injection? _____

Physical Therapy
- o No
- o Yes, # of Sessions? _____
  Date of Last Session? _____

Other treatments: (mark all that apply)
- ❑ None
- ❑ home or gym exercise program
- ❑ Rest or activity modification
- ❑ Acupuncture
- ❑ Casting/Splinting
- ❑ Orthotics
- ❑ Hospitalization?
- ❑ Other _____

13) Have any treatments you received helped you get better?

- ❑ not helped
- ❑ maybe helped
- ❑ helped some
- ❑ helped a lot.
- ❑ Other: describe:_____

14) Have you had X-ray, MRI, or EMG for your problem?

- ❑ None
- ❑ EMG/NCS
- ❑ X-ray
- ❑ MRI

  Date: _____Name of imaging facility: _____

<u>General Medical History</u>

15) Do you take any of the following Types of medications? (mark all that apply)

- ❑ Coumadin/Warfarin/Blood thinners
- ❑ Aspirin
- ❑ Motrin/ibuprofen or any NSAIDs types
- ❑ Blood Pressure
- ❑ Diabetes pills
- ❑ Diabetes injections of insulin
- ❑ Thyroid Medication
- ❑ Narcotic Pain medication
- ❑ Other

16) List Meds:

_____
_____
_____
_____

17) **Allergies to Medication** (mark all that apply)

- ❑ ***No***
- ❑ **Yes, (please mark below**)
- ❑ Penicillin
- ❑ Sulfa drugs
- ❑ Codeine
- ❑ Morphine
- ❑ Other_____

18) Other Allergies (mark all that apply)

- ❑ *None*
- ❑ *Latex*
- ❑ *shell fish*
- ❑ *iodine*
- ❑ Other:_____

19) Have you ever had any surgery? (List with dates)

_____
_____
_____

20) <u>Do you have any of the following common medical conditions?</u>

- ❑ **None**
- ❑ Diabetes
- ❑ High blood pressure/ Hypertension
- ❑ Heart disease:
  - o Angina
  - o Arrhythmia
  - o Heart attack
- ❑ Blood clots/ DVT/ PE
- ❑ Bleeding problems
- ❑ Stomach ulcers
- ❑ Kidney disease
- ❑ Thyroid disease
- ❑ Lung Problems:
  - o Asthma
  - o Emphysema
  - o other
- ❑ Immunodeficiency/HIV
- ❑ Anemia
- ❑ Cancer
- ❑ Depression
- ❑ Liver disease/hepatitis
- ❑ Nerve or neurological
- ❑ Psychiatric
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Other:_____
- ❑ ***None of the above***

21) Review of Systems:

Do you have any of the following symptoms recently?

- ❑ All Negative
- ❑ General: fever, chills, weight loss
- ❑ Cardiac: chest pain, heart racing,
- ❑ Ear/Nose/Throat: ear pain, sinus drainage, hearing loss,etc
- ❑ Eyes: double vision, pain, eye strain
- ❑ GU: discharge with urination, burning sensation, etc
- ❑ GI: change in bowel or bladder function loose bowel movements, dark stool or blood, bloating
- ❑ Respiratory: shortness of breath, wheezing, chronic cough, etc
- ❑ Neuro: headaches, tremors, seizures,etc
  sleeping habits, feelings of anxiety, nervousness etc
- ❑ Skin: skin rash, lesions, itching, etc.
- ❑ Endocrine: thyroid problems, excess sweat, excess thirst
- ❑ Hematologic: nose bleeding ,easy bruising

22) Smoking History?

- ❑ ***No***
- ❑ **Yes _____**

23) Drinking History?

- ❑ ***No***
- ❑ **Yes, How many per week? _____**

Family and Social History:

24) Have any of your relatives had serious medical problems?

- ❑ ***No***
- ❑ **Yes, (please list and describe)**
  - o Heart problems
  - o Diabetes
  - o Cancer
  - o Other_____

25) Relationship History?

- ❑ *None*
- ❑ *Single*
- ❑ Living with partner
- ❑ Married
- ❑ Divorced
- ❑ Widower

26) Do you have Children?

- ❑ *No*
- ❑ Yes

Reviewed date/ by

(SPQ) Shoulder Patient Questionnaire

SUBJECTIVE ASSESSMENT NUMERIC EVALUATION

How would you rate your shoulder today as a percentage of normal (0% to 100% scale with 100% being normal)?

American Shoulder and Elbow Surgeons questions

MODIFIED ASES QUESTIONNAIRE

Can you throw a ball overhand?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you sleep on your shoulder comfortably ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you put on your coat unassisted ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you wash your back/fasten your bra ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you use toilet tissue ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you comb/wash your hair ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you lift ten pounds (a full gallon container) above the level on your shoulders ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Can you reach a shelf over your head	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Does your shoulder allow you to work full time at your regular job (or regular activities if you not working) ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't
Does your shoulder allow you do your regular sports ?	A) Yes, No Trouble B) Slight Trouble C) Moderate trouble D) No, I can't or I don't play sports
On average, how much shoulder pain have you experienced in the last weeks ?	0 1 2 3 4 5 6 7 8 9 10

The European Shoulder and Elbow Surgeons Questions: (Constant-A)

Do you have pain in your shoulder (normal activities)?

If "0" means no pain and "15" is the maximum pain you can experience, please mark the level of pain in your shoulder. (Mark Scale)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Is your occupation or daily living limited by your shoulder? No Moderate Limitation Severe Limitation

Are your leisure and recreational activities limited by your shoulder? No Moderate Limitation Severe Limitation

Is your night sleep disturbed by your shoulder? No Sometimes Yes, Frequent

State to what level you can use your arm for painless, reasonably activities. Waist Xiphoid(sternum) Neck Head Above head

The European Shoulder and Elbow Surgeons Questions: (Constant-B)

(THIS SECTION FOR DOCTOR USE ONLY - DO NOT FILL OUT)

Forward Flexion 0-30 31-80 61-90 91-120 121-150 151-180

Abduction 0-30 31-80 61-90 91-120 121-150 151-180

Constant ER hah-eb hah-ef hbh-eb hbh-ef iFull Elev. of Arm

IRB 1-Lateral thigh 2-Bullock 3-LS Junction 4-Waist(L3) 5-T12 Interscapular are (T7)

Constant Strength lbs.

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Patient Acknowledgement and Consent Form

On behalf of myself or my minor child or other patient named below, I acknowledge and consent to the statements made in this form.

Consent for Treatment

I, _____ am requesting that health care services be provided to me (or my minor child or the patient named below) at the offices of ShoulderMD, and such other associated physicians, clinicians, and other personnel. I voluntarily consent to all medical treatment and health care-related services that are considered to be necessary for me (or the patient named below). These services may include diagnostic, therapeutic, imaging, and laboratory services. I am aware that the practice of medicine and surgery is not an exact science; no guarantees have been made to me about the results of treatments or examinations.

Patient: _____ Date of Birth:_____

Minor Child: _____ Date of Birth:_____

I understand that if this consent is being signed on behalf of a minor, this consent is valid until the minor turns 18, at which time the minor must consent for services on his/her own behalf.

_____ I understand that offices of ShoulderMD may provide certain services by remote telehealth technology. Such telehealth services involve a health provider who is at a site remote from my location at the time of the service, and, as such, telehealth often involves the transmission of video, audio, images, and other types of data. The remote health provider will determine whether the condition being diagnosed or treated is appropriate for telehealth, and I understand that there is no guarantee of diagnosis, treatment, or prescription. Further, I understand that I may have to travel to see a health provider in-person for certain diagnosis and treatment matters.

_____ I consent to receive, on the cellular phone and/or other telephone number(s) that are provided to the offices of ShoulderMD, text messages and/or telephone calls or other communications. Such text messages and/or telephone calls may be related to any purpose, including those related to my account and/or the care rendered. I understand this consent to communications is not required to receive services, and that data usage and other charges may apply.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

Medical Records Release

_____ I consent to let the offices of ShoulderMD use and disclose health information about me (or the above-named patient). In doing so I consent to the release of my (or the above-named patient's) health information and financial account information to all third-party payers and/or their agents that are identified by the offices of ShoulderMD, its billing agents, collection agents, attorneys, consultants, and/or other agents that represent the offices of ShoulderMD or provide assistance to the offices of ShoulderMD for the purposes of securing payment from all parties who are potentially liable for payment for my (or the above-named patient's) health care.

Patient Acknowledgement and Consent Form

_____ **Workers Comp Patients**: I hereby authorize the offices of ShoulderMD to speak to a rehabilitation specialist, my employer, my insurance carrier or other professionals involved in my care of rehabilitation, regarding my medical records and the treatment I have received or will receive.

Notice of Privacy Policies

_____ The offices of ShoulderMD are committed to protect the privacy of your health and personal information. This information includes both health information and individually identifiable information, such as your name, address, telephone number or social security number. The offices of ShoulderMD protect your personal and health information in electronic, written and oral forms when used throughout our office. We may modify or change our privacy practice when new laws and regulations become effective. Any changes will be effective for all personal and health information we maintain including prior information given to our office.

Financial Information

_____ **Financial Responsibility:** Subject to applicable law and the terms and conditions of any applicable contract between the offices of ShoulderMD and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or the below-named patient), I agree to be financially responsible and obligated to pay the offices of ShoulderMD for any balance not paid under the "Assignment of Benefits/ Third Party Payers" paragraph below.

_____ **Assignment of Benefits/Third-Party Payers:** In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign to the offices of ShoulderMD all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding the offices of ShoulderMD's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third-parties. I consent to any request for review or appeal by the offices of ShoulderMD to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or other third party payer.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

_____	_____
Patient or Legal Representative Signature/Date/Time	Relationship to Patient
_____	_____
Print Patient or Legal Representative Name	Witness Signature/Date/Time

SHOULDERMD

PAUL B. ROACHE, M.D.

BOARD CERTIFIED ORTHOPEDIC SURGEON

Disclosure for Dispensing of Medications Program

Your team at ShoulderMD understands there are several challenges with medications such as cost and convenience. This is why we are proud to offer our Medication Dispensing Program medications at no cost to you or your insurance carrier.

There is no obligation to this Program and we are happy to provide you with an electronic prescription sent to your preferred pharmacy.

Your team will provide an easy to read guide for each medication we dispense to you.

If you have questions or concerns regarding these medications, please let us know prior to picking up your medications.

Please sign below if you elect to receive medications from ShoulderMD and have read/understand the medication guide provided including the potential benefits, risks, common and serious side effects, when to call us, and/or seek emergency help.

Print Name: _____ Date: _____

Signature: _____