Robert W. Piston, M.D.
Board Certified Orthopaedic Surgeon

Fellowship in Hand and Microsurgery
Fellowship in Total Hip
and Knee Replacement Surgery

3120 Highland Road
Hermitage
Pennsylvania 16148
724.342.2663 Bus.
724.342.8988 Fax

Dear_____,

This letter confirms your office appointment with _____. Enclosed is a Patient Information Sheet. Please take the time to complete the enclosed forms before your visit, and bring it with you.

You are required to bring **ALL OF YOUR INSURANCE INFORMATION** with you. This includes **INSURANCE CARDS and SUBSCRIBER INFORMATION WITH THE PATIENT INFORMATION SHEET.** If you have a liability claim (Workmen's Comp, Auto, etc;), **YOU MUST BRING YOUR CLAIM NUMBER and INSURANCE BILLING ADDRESS. If your coverage requires a referral, you must obtain the referral from your PCP prior to your appointment. IF THE REQUIRED INSURANCE INFORMATION IS NOT PROVIDED, YOUR APPOINTMENT WILL BE RESCHEDULED.**

Please call your insurance carrier to answer any questions you may have regarding your insurance coverage. Payment for Non-covered Services, Co-Pays, Deductibles, and/or Co-Insurance is expected at the time of service**.** For your convenience **we accept: CHECKS, DEBIT/BANK CARDS, VISA, MASTERCARD, DISCOVER,** and **CASH. IF YOU DO NOT HAVE THE REQUIRED AMOUNT FOR YOUR CO-PAY, YOU WILL BE RESCHEDULED.**

Also, please bring your medication bottles so that we may accurately record the dosage and frequency of each by referring to the labels on the bottles.

We are here to build a lasting relationship; therefore, we encourage you to feel free to call us if you have any questions or concerns. We look forward to meeting you.

Thank you,

Robert Piston, M.D.
Morgan Hall, PA-C
Cortney Ifft, PA-C

Appointment Information

Date:_____

Time:_____

Insurance
Carrier(s):_____

New Patient Expectations

In order to ensure an efficient and pleasant office visit, the following information will be necessary for review at the time of your initial evaluation:

Billing Information

Specialty Orthopaedics, P.C. has an in-house billing department and we will be more than happy to submit your claims for the care that you received from us. However, we must have all of your insurance information to submit the claim properly. It is also important for you to know that **we do not participate with all insurance plans** and it is your responsibility to verify that we are in network with your plan. We can also accommodate you in setting up a payment plan and will be more than happy to answer any questions you have.

If you are being seen:

1) and your insurance requires a referral, you are responsible for obtaining the referral and bringing it with you or verifying that your PCP has sent it to us prior to your visit. If you have a co-pay, you must pay it at the time of service. We prefer checks, credit cards, or money orders, but will accept cash if you have exact change.
2) for an auto accident, you must bring the insurance company's name and billing address, as well as the claim number and where the accident occurred (city and state).
3) for a PA Workmen's Compensation claim, you must check to see if we are on your company's WC panel. If not, we cannot see you within the first 90 days after your injury. Otherwise, you must bring the billing information and claim number. We will also need to have your health insurance card(s). For Ohio Comp, if you have already been treated by another physician, you must obtain approval to be seen by a provider at Specialty Orthopaedics, P.C.

If you do not have your insurance information, referral, and/or co-pay, you will be rescheduled.

Health Information

We have no information regarding your health issues until we receive test results or information from you. With this in mind, please make sure to have the following information available at the time of your visit:

1) a listing of all of your medication and the dosages. If you are unsure of the names or dosages, please bring your medication bottles so we can obtain the information from them.
2) a list of any allergies including medication, food, and skin allergies. i.e. latex, betadine, etc;
3) previous testing results. X-rays, MRI's, EMG's, etc; are not automatically sent to our office. It is your responsibility to make sure all test results are sent to us prior to your visit, or you can bring them yourself. The provider must be able to review the films in order to treat you. **If we do not have the reports <u>and</u> films at the time of your visit, you will be rescheduled.**

WE LOOK FORWARD TO BUILDING A LONG LASTING RELATIONSHIP WITH YOU. IF YOU HAVE ANY QUESTIONS AT ANY TIME REGARDING ANYTHING, PLEASE FEEL FREE TO CALL US AT 724.342.2663.

Robert W. Piston, M.D.
Board Certified Orthopaedic Surgeon

Fellowship in Hand and Microsurgery
Fellowship in Total Hip
and Knee Replacement Surgery

3120 Highland Road
Hermitage
Pennsylvania 16148
724.342.2663 Bus.
724.342.8988 Fax
www.specialtyorthopaedics.com

Patient Financial Responsibility Disclosure Statement

Effective 8-1-17

Your signature below forms a binding agreement between Specialty Orthopaedics, P.C. , Specialty Orthopaedics Rehabilitation Center, Fitness 'n' Physique Wellness Center (the providers of medical/surgical, rehabilitation and/or wellness services) and the patient who is receiving those services, or the responsible party for minor patients (those patients under 18 years old).

The responsible party is the individual who is financially responsible for payment of all bills for services performed by Specialty Orthopaedics P.C. or any of its affiliates which include Specialty Orthopaedic Rehabilitation Center and Fitness n' Physique Wellness Center.

ALL CHARGES FOR SERVICES RENDERED ARE DUE AND PAYABLE AT OR BEFORE THE TIME OF SERVICE.

THIS INCLUDES, CO-PAYS, DEDUCTIBLES, CO-INSURANCE AND ANY OTHER PAYMENTS FOR THE MEDICAL/SURGICAL/REHABILITATION OR WELLNESS SERVICES PROVIDED.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are financially responsible for payment if your insurance company declines to pay for any reason.

The person signing on behalf the patient, or the patient them self as the responsible party **MUST:**

- Inform Specialty Orthopaedics, P.C.(or any of its affiliates) of the current address and phone number for the patient and the responsible party;
- Present all current insurance cards and form of identification at time of office visit or prior to surgery;
- Verify at each office visit that the information is current ;
- Pay any required co-pay, deductible or co-insurance at time of visit;
- Upon receipt of Specialty Orthopaedics, P.C. (or any of its affiliates) billing statement, the patient or responsible party agrees to pay any remaining balance within 5 days.

Retuned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC) or Refer to Maker (RTM), the patient or the patient's responsible party will be responsible for the original check and a $30.00 Service Charge. Once notice is received of the returned check, Specialty Orthopaedics, P.C. (or its affiliates) will contact you notifying you of the returned check. If you do not send in a new check, plus the $30.00 service charge, your account will be turned over to a collection agency and their fee will be added to your outstanding balance. It is expected that you will send in a new check with the service charge added within 5 business days of us contacting you.

Specialty Orthopaedics, P.C.
3120 Highland Road
Hermitage, PA 16148
(724) 342-2663

Financial Policy

INSURANCE

Your insurance policy is a contract between you and your insurance company. We will gladly submit the medical bills to your insurance carrier if you have given us all of the required information. If your insurance company has not paid your account in full within a reasonable time frame (45 days), the balance of your account will become your responsibility. Please be aware that some of the services provided may be "non-covered" services according to your policy. You are still responsible for payment at the time of service.

OUT OF NETWORK PATIENTS

Specialty Orthopaedics **DOES NOT participate with every insurance plan**. Therefore, if you elect to have care by one of our providers and we are **Out of Network or not a Participating Provider, you will be responsible for any balances left by your insurance.**

SELF-PAY

If you have no insurance coverage, full payment will be required the day services are rendered. We accept Debit/Bank Cards, Credit Cards and Checks. There will be a $25 fee for any check returned to us unpaid by your bank.

BILLING

A billing statement for personal balances owed will be mailed to you on a monthly basis. If you have a financial problem, please contact the billing department. If a payment plan is agreed upon, we require monthly payments or the account will be turned over to a credit agency. If you have a collection balance, you will be required to pay your previous collection balance prior to being seen as well as the charge for the current visit.

CANCELLATION POLICY **Effective April 1, 2014**

Time has been specifically reserved for your Orthopedic or Rehab appointment. Please call at least 24 hours ahead of time if you must cancel an appointment. There is a $25.00 charge if you fail to show up for a scheduled appointment or cancel with less than a 24 hour notice. Thank you for your understanding with this Policy.

FORM PREPARATION

There is a fee for forms that need to be completed by our office. We try to complete them as quickly as possible, however they may take **up to 10 working days** to complete. **WE WILL CONTACT YOU WHEN THE FORM IS READY TO BE PICKED-UP.**

MINOR PATIENTS

The parent/guardian accompanying the minor child is responsible for full payment. We must have pre-approval from a parent/guardian for an unaccompanied minor. Any child 18 or older is legally responsible for his/her bill. Therefore, we cannot release financial or medical information to a parent/guardian without the patient's written permission.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND BY SIGNING BELOW, I AGREE TO THE OUTLINED TERMS.

_____

Signature of Patient or Responsible Party **Date**

Patient Financial Responsibility Disclosure Statement

Effective 8-1-17

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party understands that Specialty Orthopaedics, P.C. and its affiliates, has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient or the patient's responsible party understands that they are responsible for all costs of collections, including, but not limited to interest due, all court costs, and attorney fees.

Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency may be subject to a collection fee of 33%, which will be added to the total balance due at the time of sending the account to collections.

By singing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Privacy Statement

I am aware that the Privacy Statement is located on Specialty Orthopaedics web site located at www.specialtyorthopaedics.com. I am aware that Specialty Orthopaedics utilizes an outside electronic voice service that includes utilizing auto dialers to inform me: (1) I have an upcoming appointment; (2) If there is an arrears balance; and (3) of other announcements from Specialty Orthopaedics.

Patents Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Name (Please Print)_____

Responsible Party Signature _____ Date_____

SPECIALTY ORTHOPAEDICS, PC Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of SPECIALTY ORTHOPAEDICS, PC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law- enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment and Past Due Balance Reminders. Your health information will be used by our staff or **B**usiness **A**ssociates (**BA**) to send you appointment or balance reminders by telephone, email or text messages.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health- related products and services that we believe may interest you.

Fundraising. Unless you request us not to, we may use your name and other information necessary to support our fundraising efforts. If you do not want to participate in fundraising efforts, please check off the following box.

□ Please do not use my information for fundraising purposes.

Marketing. Unless you request us not to, there are some marketing activities that we may use your name and address for, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please check off the following box:

□ Please do not use my information for marketing purposes

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to opt out of fundraising communications
- The right to restrict certain types of uses and disclosures of your protected health information
- The right to receive a printed copy of this notice

SPECIALTY ORTHOPAEDICS, PC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this "Notice of Privacy Practices."

We also are required to abide by the privacy policies and practices that are outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised, it is our duty to notify you.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
c/o Specialty Orthopaedics, PC
3120 Highland Rd
Hermitage, PA 16148

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practices is:

Privacy Officer
c/o Specialty Orthopaedics, PC
3120 Highland Rd
Hermitage, PA 16148
724.342.5109

Effective Date
This notice is effective on or after 09/23/2013

Revision: 2/19/2024

HIPPA ACKNOWLEDGEMENT

This is to certify that I, the undersigned, hereby consent to and authorize the disclosure of any medical information to the following:

Spouse Child Parent Other: Please Specify: _____

Contact NAME of the authorized person(s):_____

_____

_____

May we* leave a message at the contact number you provided?	Yes	No
May you be called at your place of employment to be informed of your medical information?	Yes	No
May we* contact you utilizing auto dialers to inform you: (1) of an upcoming appointment; (2) for arrears on a balance; and (3) for other announcements?	Yes	No
May we* contact you utilizing other means of electronic communication such as but not limited to: text message (rates may apply), email, EHR Web Portal	Yes	No

If you do not want a certain disclosure made to the above, or to revoke any items, it is your responsibility to notify us. Thank you for your cooperation.

SPECIALTY ORTHOPAEDICS, PC reserves the right to modify the privacy practices outlined in the notice.

I hereby acknowledge receipt of the Notice of Privacy Practices from SPECIALTY ORTHOPAEDICS, PC.

Witness:

_____
Please Print

Date:_____

Patient:

_____
Please Print

Patient Signature: _____

Date:_____

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient

*SPECIALTY ORTHOPAEDICS, PC or one of our contracted vendors working on our behalf

(Rev. 2/2018)

Specialty Orthopaedics, P.C.

#_____

Date/Time Appt: _____ __Dr. P__MH__CI

Patient Information

Last Name:_____First:_____Middle:_____Birthdate:___-___-_____

SS#:_____-_____-_____ Age:_____ Sex: M or F Marital Status: M S W D Other

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

Language:_____Race:_____Ethnicity:_____

Cell Phone # for appointment reminders: ( )_____

Home Phone: ( )_____Email:_____

Employer:_____ Occupation:_____

Work Phone: ( )_____

Emergency Contact:_____ Phone:_____

Nearest Relative:_____ Phone:_____

Primary Care/Family Physician:_____ Referring Doctor:_____

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

Pharmacy Name and Address:_____City:_____ State:_____Zip:_____

Person Responsible for bill (Self if over age 18, legal guardian if under age 18)

Last Name:_____First:_____Middle:_____Birthdate:___-___-_____

SS#:_____-_____-_____ Age:_____ Sex: M or F

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

Cell Phone: ( )_____ Work Phone: ( )_____

Employer:_____ Occupation:_____

Relationship to Patient (only if different):_____

Additional Information

Reason for visit:_____

Any X-Rays? If so, where?:_____

Any MRI, EKG or other testing? If so, where?:_____

When did the injury occur?:_____

Where (home, store, etc;) did the injury occur?:_____

Is this an Auto, Liability or Worker's Compensation claim?_____

Are you currently involved in any litigation cases?_____

Primary Insurance (Please present card for verification)

Insurance Name:_____Co-Pay for Specialists:_____

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

Subscriber Name:_____ Sex: M or F Birthdate:____-____-_____

Subscriber Address:_____ Phone #:_____

Insurance ID#:_____ Group #:_____Effective Date:_____

SS #:_____-____-_____ Relationship to patient:_____Employer:_____

Secondary Insurance (Please present card for verification)

Insurance Name:_____Co-Pay for Specialists:_____

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

Subscriber Name:_____ Sex: M or F Birthdate:____-____-_____

Subscriber Address:_____ Phone #:_____

Insurance ID#:_____ Group #:_____Effective Date:_____

SS #:_____-____-_____ Relationship to patient:_____Employer:_____

Auto/Liability/Worker's Compensation Claims

Injury Description:_____

Accident Date/Injury Date:_____Type of Claim: WC Auto Liab.

State of Accident:_____ WC/Auto/Liab. Claim #:_____

Insurance Name:_____ Phone #:_____

Contact Person/Agent's Name:_____

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

Responsible Employer (WC only):_____Employer Phone #:_____

Assignment of Benefits: I hereby assign all medical and or/surgical benefits to which I am entitled, including Major Medical, Medicare, Commercial Insurance and any other health plan benefits to Specialty Orthopaedics, P.C.(Robert W. Piston, M.D., P.C.). This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance**. I hereby authorize said assignee to release all information via manual claims and/or electronic submission as necessary to secure payment. **Payment is expected at the time services are provided. Patients under eighteen (18) must be accompanied by an adult.**

Patient Signature:_____ Date:_____

Robert W. Piston, M.D.
Board Certified Orthopaedic Surgeon

Fellowship in Hand and Microsurgery
Fellowship in Total Hip
and Knee Replacement Surgery

3120 Highland Road
Hermitage
Pennsylvania 16148
724.342.2663 Bus.
724.342.8988 Fax

SPECIALTY ORTHOPAEDICS
Patient Medical Information Sheet

Please ask for assistance if you have any questions about entering your medical history on this sheet.

Today's Date:_____ **Date of office visit:**_____

Name_____ **Age**____ □ Male □ Female

Date of birth ___/___/___ **Who referred you? (friend, doctor, other)** _____

Release to: PCP or Referring Name:_____

Why are you seeing the doctor today?

_____

Did you have an injury? □ Yes □ No

If yes, where did it happen and please describe the detail of how the injury happened_____

Date of Injury? ___/___/___ **Was it work related?** □ Yes □ No □ Not sure □ Auto Accident

Where are you having pain? _____

When did it start?_____

Describe your pain by checking any of these words that apply: □ Dull □ Sharp □ Cramping □ Mild □ Moderate □ Severe □ Burning □ Stinging □ Tingling □ Grinding □ Throbbing □ Aching

What makes your pain better?

_____

What makes your pain worse?

_____

Have you had any testing for this problem? □ X-RAY □ MRI □ EMG (nerve test)

□ Other _____

When did you have your test done? _____ **Where** was it done? _____

Have you had a bone density exam or screening for osteoporosis? □ Yes □ No If yes, when?_____

Height _____ **Weight** _____ □ **Right-handed** □ **Left-handed**

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY – Please check any that you have currently today or all of the time

GENERAL
___Unusual weight loss/gain
___Fever or chills
___Night sweats
___Swollen glands

HEENT
___Glaucoma
___Cataracts
___Severe headaches
___Hearing loss
___Wear hearing aides
___Ringing in the ears
___Sinus problems
___Wear dentures
___Glasses/contacts
___Loose teeth/bridge

PULMONARY
___Wheezing
___Asthma
___Frequent cough
___Shortness of breath
___Cough up blood
___Cough up phlegm
___Ankles swell
___History tuberculosis
___COPD

ENDO
___Severe itching
___Persistent rash
___Psoriasis
___Diabetes
___Thyroid problem

CARDIAC
___High blood pressure
___History heart attack
___Heart murmur
___Mitral valve Prolapsed
___Heart Disease
___Artificial heart valve
___Stents
___Rheumatic fever
___Heart disease
___High cholesterol
___Irregular heartbeat
___Pacemaker
___Chest pain
___ History of Coronary Bypass /Open heart surgery

GI
___Hiatal hernia
___Ulcers
___Frequent heartburn
___Reflux disease
___Liver disease
___Nausea/ Vomiting
___ Gallstones
___Rectal bleeding
___Diarrhea
___Constipation

GU
___Kidney stones
___Kidney disease
___Urinary frequency
___Blood in urine
___Enlarged prostate
___Painful urination

NM
___Muscle weakness
___Arthritis
___Joint pain
___Frequent back pain
___Polio
___Muscle disease

HEMO
___Sickle cell disease
___History of Blood Clot
___Phlebitis
___Anemia
___Bleeding disorder
___Use blood thinner
___History hepatitis
___Lyme's disease
___High risk for AIDS
___ HIV

NEURO
___History of Epilepsy/Seizure
___History of stroke
___Dizziness
___Balance problems
___Fainting
___Numbness/tingling
___Depression
___Anxiety
___Bipolar disease
___Memory Loss
___Excess bleeding after surgery

___**Trouble with Anesthesia in the past**?
Describe;

_____

_____

History of Cancer?

□ Yes □ No

What type of Cancer?_____

MEDICATIONS / VITAMINS/ AND ANY OVER THE COUNTER MEDICATION TAKEN DAILY OR AS NEEDED □ None

Name of medicine/herb	Dose/MG	How many times a day	Side effects

ALLERGIES TO MEDICATIONS □ **None**

Name of medication	What happens when you take this?

PAST SURGICAL HISTORY □ **None**

Surgeries/Hospitalizations	Date of Surgery	What Doctor did the surgery?

FAMILY HISTORY

Has anyone in your family had □ Cancer □ Diabetes □ Heart Disease □ Stroke
□ Rheumatoid Arthritis □ Lupus □ high blood pressure □ death before the age of 50

Mother: □ Living □ Deceased
What health problems?_____

Father: □ Living □ Deceased
What healh problems?_____

How many sisters? _____ **How many living**?_____ **How many desceased**?_____
What health problems?_____

How many Brothers?_____ **How many living**?_____ **How many deceased**?_____
What health problems?_____

PAST MEDICAL HISTORY

Please explain how long you have had condition, and treatment given:

Diabetes	Yes	No	
Heart disease	Yes	No	
Hypercholesterolemia	Yes	No	
Stroke	Yes	No	
Peptic ulcer disease	Yes	No	
Blood clots	Yes	No	
High blood pressure	Yes	No	
Asthma	Yes	No	
Hepatitis B or C	Yes	No	
Tuberculosis (TB)	Yes	No	
HIV (AIDS)	Yes	No	
Other_____			
Other_____			

SOCIAL HISTORY

Marital status: □ Single □ Married □ Divorced □ Separated □ Widowed

Do you have children? □ Yes □ No If yes, how many? ____

Do you live alone? □ Yes □ No

Are you: □ Employed Occupation_____ Where?_____
□ Full-time □ Part-time

If you are not working Please check one of the following?

□ Unemployed looking for work □ Unemployed not looking for work □ Retired □ Unable to work □ Disabled □ Student: grade/level____

Education level: □ High school □ College □ Graduate education □ Other_____

Live in a: □ house □ apartment □ townhouse □ mobile home □ other □ one story □ two story

Do you exercise? □ Daily □ Weekly □ Rarely □ Never Type of exercise_____

Do you smoke? □ Yes □ No □ Cigarettes - __ packs per day □ Cigars-__ per day
□ Pipe □ Snuff

Have you smoked in the past? □ Yes □ No Previously smoked ___ packs per day for ___ years.
When did you stop smoking? _____

Do you use any Illegal Drugs? □ Yes □ No

Do you drink alcohol? □ Daily-___ drinks per day □ 1-2/week □ 1-2/month □ 1-2/year □ Never
(Please circle)Do you drink coffee/tea/soda **with caffeine**? □ No □ Yes-___cups/day

HEALTH MAINTENANCE

Date of last Flu Shot_____
Date of last Pneumonia Shot_____
Date of last Colonoscopy_____
Date of last Mammogram_____
Date of last Pap Smear_____

Patient signature:_____ **Date:** _____

Local Driving Directions

From areas NORTH of Hermitage:

Take **PA-18 South** toward **HERMITAGE**

Turn Ⓡ on **HIGHLAND RD ****

From areas SOUTH of Hermitage:

Take **PA-18 North** toward **HERMITAGE**

Turn Ⓛ on **HIGHLAND RD ****

From areas EAST of Hermitage:

Take **US-62 WEST**

Turn Ⓡ on **PA-18 North** (North Hermitage Rd.) toward Greenville

Turn Ⓛ on **HIGHLAND RD ****

From areas WEST of Hermitage:

Take **US 62 BUS EAST** (East State Street) toward **HERMITAGE**

Turn Ⓛ on **PA-18 North** (North Hermitage Rd.) toward Greenville

Turn Ⓛ on **HIGHLAND RD ****

****** Highland is the intersection at Hickory High School

Go approximately 75 yards; on the left is the Highland Professional Center sign

Specialty Orthopaedics is located in the last building on the right in the development

Arrive at **3120 HIGHLAND RD, HERMITAGE**

Distant Driving Directions

From areas NORTH (Erie) and SOUTH (Pittsburgh) of Hermitage:

* **PA-60 NORTH** is also an alternate route from Pittsburgh; start at step # 4

Take **I-79 SOUTH** (from Erie) or **I-79 NORTH** (from Pittsburgh).
Take exit **#116B** onto **I-80 WEST** toward **SHARON**
Take exit **#4B** onto **PA-60 NORTH** toward **SHARON-HERMITAGE**
Take the **PA-18** exit onto **HERMITAGE RD [PA-18]** toward **SHARON/HERMITAGE/W MIDDLESEX**
Turn on **HIGHLAND RD** **

From areas EAST (Clarion) and WEST (Austintown) of Hermitage:

Take **I-80 EAST** (from Austintown) or **I-80 WEST** (from Clarion)
Take exit **#4B** onto **PA-60 NORTH** toward **SHARON-HERMITAGE**
Take the **PA-18** exit onto **HERMITAGE RD [PA-18]** toward **SHARON/HERMITAGE/W MIDDLESEX**
Turn on **HIGHLAND RD** **

****** Highland is the intersection at Hickory High School
Go approximately 75 yards; on the left is the Highland Professional Center sign
Specialty Orthopaedics is located in the last building on the right in the development
Arrive at **3120 HIGHLAND RD, HERMITAGE**