



**Medical Director: Kedar K. Deshpande, M.D.,FAAPMR**  
**Michelle Bester, CNP**  
**Physical Therapy: Jim Jenkins, PhD**  
**Psychology Services: Vijay Balraj, PhD**  
**Interventional Spine Specialist**  
**Interventional Pain Management**  
**Physical Medicine & Rehabilitation**

Your appointment with Kedar Deshpande, M.D./Michelle Bester, CNP:

---

Day	Month	Date	Time
(Please arrive <b>30</b> minutes early if paperwork is not completed- thank you)			

**Please bring the following documents with you:**

- Insurance card and photo ID
- MRI films, X-Rays, or CT Scans
- If available, medical records and reports related to your current condition
- New patient history forms to be completed in its entirety. **Your appointment may be delayed if packet is not completed before you arrive for your appointment**
- If time allows, please mail or fax your new patient history forms. Fax to Attn: Referral Coordinator @ 614-468-0208
- BWC patients only: please bring your BWC card along with any other form of health insurance

**Insurance Policy:**

- Insurance copay must be paid at the time of service. If you are unable to pay your co-pay, we reserve the right to reschedule your appointment.

**Medication Policy:**

- **Medications are NOT prescribed at the first consultation**
- Any ongoing medication management is at the physician's discretion

**Cancellation/No Show Policy:**

- Any cancellations **MUST** be made 24 hours in advance of your appointment
- A \$50 no show fee will be charged if the office is not made aware of cancellation
- If two appointments are missed consecutively, your appointment will not be rescheduled
- Please contact our office directly with any questions at **(614) 468-0300**

**1080 Polaris Parkway, Suite 200 Columbus, Ohio 43240**  
**Telephone 614-468-0300 Fax 614-468-0214**

**Take a tour of our facility, interventional treatment demonstrations and details online.**  
**[www.orthopaedicandspinecenter.com](http://www.orthopaedicandspinecenter.com)**

# Orthopaedic & Spine Center – New Patient Demographics

## Patient Information:

Patient Name: \_\_\_\_\_

For Minor Only: Child lives with: Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

May we leave a message at home with other residents? YES NO Answering Machine/Voicemail? YES NO

Name of person we may contact regarding any medical concerns? \_\_\_\_\_

Phone Number(s): \_\_\_\_\_ Relationship? \_\_\_\_\_

## Insurance Information:

**Primary Insurance:** \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Relationship to Policy Holder: \_\_\_\_\_ Date of Birth of Policy Holder: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Still Employed? YES NO

**Secondary Insurance:** \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Relationship to Policy Holder: \_\_\_\_\_ Date of Birth of Policy Holder: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_ Still Employed? YES NO

**Third Insurance:** \_\_\_\_\_ (please give card to receptionist)

## **Is the reason for your visit today the result of:**

Work Injury? YES NO Claim #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Do you have any other active BWC claims? YES NO Claim#: \_\_\_\_\_

Auto Accident? YES NO Date of Accident: \_\_\_\_\_ State Accident Occurred: \_\_\_\_\_

Who was at-fault for accident? Patient Other Party Location of Accident: \_\_\_\_\_

Patient's Auto Insurance Carrier: \_\_\_\_\_ Claim # \_\_\_\_\_

In Litigation?: YES NO Name of Attorney/Phone #: \_\_\_\_\_

Auto Accident Case Settled?: YES NO If yes, when was it settled? \_\_\_\_\_

Other Type of Accident/Injury? YES NO Date of Accident: \_\_\_\_\_ Place of Accident: \_\_\_\_\_

In Litigation?: YES NO Name of Attorney/Phone #: \_\_\_\_\_

Case Settled?: YES NO If yes, when was it settled? \_\_\_\_\_

## Physician Information:

Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*\*\*\*

For office use only: Front Desk Review by \_\_\_\_\_ Date \_\_\_\_\_

Billing Review by \_\_\_\_\_ Date \_\_\_\_\_



# New Patient History

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Today's Date \_\_\_\_\_

Date when pain began: \_\_\_\_\_

Please explain what you were doing and where you were when your pain began. If this pain is a result of an accident or injury, please describe the details of the accident:

---



---



---



---

Do you have pain in your (please circle all that apply):

- Neck      Mid-Back      Low Back  
 Left:    shoulder      upper arm      elbow      forearm      hand  
 Right:    shoulder      upper arm      elbow      forearm      hand  
 Left:    hip      thigh      knee      calf      ankle      foot  
 Right:    hip      thigh      knee      calf      ankle      foot  
 Other: \_\_\_\_\_

Is the pain always there?    YES    NO

Does the pain come and go?    YES    NO

Rate your pain with medication:

No Pain	Mild			Moderate			Moderately Severe		Severe	
0	1	2	3	4	5	6	7	8	9	10

Rate your pain without medication:

No Pain	Mild			Moderate			Moderately Severe		Severe	
0	1	2	3	4	5	6	7	8	9	10

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Circle the words that BEST describe your pain:**

- Aching
- Numbing
- Pressing
- Shock-like
- Stabbing
- Throbbing
- Shooting
- Deep
- Continuous
- Bruised
- Abnormal Skin Sensitivity
- Crushing
- Tingling
- Burning
- 
- Cramping

**What makes your pain better?**

---



---

**What makes your pain worse?**

---



---

**Please circle all previously or currently used methods of pain management:**

- Acupuncture
- Homeopathy
- Exercise
- Hypnosis
- Chiropractic
- Medication
- Biofeedback
- Herbal Medication
- Massage
- Physical Therapy
- Injections

Other: \_\_\_\_\_

**Does your pain effect:**

	Always	More than half of the time	Half of the time	Less than half of the time	Never
Trouble falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Need sleep medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble with activities of daily living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daytime fatigue/lack of concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Please list all previous and/or diagnostic studies (i.e. MRI, X-Ray, EMG, CT Scans). Please list additional information on a separate page.**

Date	Test Performed	Facility	Part of Body

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please list all surgeries (even minor procedures). Please list additional surgeries on a separate page.**

Date	Surgery	Part of Body	Physician

**Please list ALL medications you are currently taking (prescription and over-the-counter). Please list additional medications on a separate page:**

Medication Name	Dosage	How Often	Effectiveness

**Do you ever take any of the following:**

	Yes	No	Dose/How often
Vitamin E	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fish Oil, Omega 3, Lovaza	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excedrin, Bayer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Plavix, Pletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coumadin/Warfarin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heparin	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name/Phone # of doctor prescribing any of the above medications: \_\_\_\_\_

**Do you have a pacemaker?** YES NO If yes, name of company: \_\_\_\_\_

**Do you have a defibrillator?** YES NO If yes, name of company: \_\_\_\_\_

Name of Cardiologist managing pacemaker/defibrillator: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please list ALL PREVIOUS medications taken for your pain:**

Medication Name	Dosage	Dates Taken	Reason for Stopping

**Are you allergic to any medication(s)?** YES NO

If yes, please specify:

Medication Name	Date of 1 <sup>st</sup> Reaction	Reaction

**Are you allergic to Latex?** YES NO If yes, what is your reaction: \_\_\_\_\_

**Have you ever had an allergic reaction to shellfish, iodine, or contrast dye?** YES NO

If yes, please specify:

Which One?	Date of 1 <sup>st</sup> Reaction	Reaction

**Please mark if you or anyone in your immediate family have the following conditions:**

	You	Family		You	Family		You	Family
Diabetes			High Blood Pressure			Constipation		
Loss of Bowel Control			Loss of Bladder Control			Heart Disease		
Stroke			Thyroid			Stomach/Ulcer Problems		
Kidney Problems			Liver Problems			Overweight/Obesity		
Depression/Mood Disorder			Cancer			Headaches		
Seizures			Sleep Apnea			Blood Clots		
Arthritis			Seizures			Other:		

**What is your current work status (please circle)?**

- Unemployed
- On Short-Term Disability
- Working Part-Time without Restrictions
- Permanent Disability (SSI)
- On Long-Term Disability
- Working Full-Time with Restrictions
- Temporary Total (TTC/C-84)
- Working Part-Time with Restrictions
- Working Full-Time without Restrictions

If you are off work, who has taken you off work? \_\_\_\_\_

When are you scheduled to return to work? \_\_\_\_\_

If you are working with restrictions, what are your restrictions? \_\_\_\_\_

\_\_\_\_\_

Which physician is writing these restrictions for you? \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Do you smoke?                      YES    NO    If yes, how many packs per day? \_\_\_\_\_

Do you consume alcohol?        YES    NO    If yes, what kind (beer, wine, liquor, etc.)? \_\_\_\_\_

How often?    Daily    Weekly    Monthly    Other: \_\_\_\_\_

Do you have or have you ever had a problem with substance abuse including prescription medication?    YES    NO    If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

.....

**FOR PHYSICAL THERAPY PATIENTS ONLY:**

If your primary insurance is Medicare, do you feel you would benefit from a referral to social services for housing assistance, bill payment assistance, etc?                      **Yes    No**

Are you currently receiving home care services? (i.e. nursing, home health aide, physical therapy, occupational therapy, speech therapy)    **Yes    No**

.....

The information supplied is to the best of my knowledge; I understand that any falsification of information may compromise medical treatment

**Release of Information:** I authorize the release of any medical or billing information that is needed to obtain payment on my account regardless of my diagnosis. **Consent of claim verification:** I give Orthopaedic & Spine Center, LLC. to have any and all information regarding my claim to benefits verified. **Assignment of benefits:** I hereby assign and transfer over to the Orthopaedic & Spine Center, LLC. all of my rights, title and interest of medical reimbursement and all other rights and privileges otherwise payable to me for this service provided by Orthopaedic & Spine Center, LLC. **Agreement to pay for services:** For and in consideration of services rendered or to be rendered for said patient named on this form, I hereby guarantee payment of any and all bills rendered for said patient which are outstanding to include all collection costs, including Orthopaedic & Spine Center, LLC. attorney and legal fees for collection action of delinquent accounts.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
(if patient is a minor)

New Patient History (page 1 to 5) Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Provider