American Health Network
Part of Optum®

bone & spine

Travis Clegg, MD
Board certified American Academy of Orthopaedic Surgeons

Welcome to American Health Network Bone & Spine

☐ 2108 State Street
New Albany, IN 47150

☐ 2300 Market St.
Charlestown, IN 47111

Dear New Patient:

We would like to take this opportunity to welcome you to our practice and thank you for entrusting us with your medical care. We want to share with you some information about our standard processes that we hope will be helpful to you throughout your care.

Refill Requests

Please allow 72 hours for your refill request to be processed. Our office will call you when your prescription is ready to be picked up from our office. Please bring your photo ID with you to pick up prescription.

FMLA & Disability Paperwork

In order for us to accurately and thoroughly complete your paperwork for FMLA and/or disability, please allow us 14 business days to complete this paperwork. If for some reason you have waited longer than 14 business days, please contact our office to inquire about the status of your paperwork.

AHN Bone & Spine will charge a one-time fee of $40 for FMLA/Disability paperwork per episode of care. Please note, additional fees that may be billed are:

- returned checks $25;
- copying of medical records (fees are set by Indiana statute; amount varies based on number of pages)

Arrival Time

If you have recent X-Rays please arrive **15 minutes early** and bring your paperwork along with your current insurance card(s). If you DO NOT have recent X-Rays please arrive **30 minutes early** for X-Rays and registration. **If you have had any recent X-rays, MRIs, or CT scans pertaining to your visit with us you are responsible for bringing the images to your appointment.** You will also be asked to show your picture ID (driver's license, student ID card, Indiana ID card.) Anyone under the age of 18 years old must have a parent (or guardian) present. Also if you are under the age of 18 without a picture ID your parent (or guardian) must present their picture ID at the visit.

Insurance Card(s)

Please be prepared to present your insurance card(s) and pay any co-pay at each visit. Co-pays may be paid by cash, check, or credit card. We accept most credit cards and also accept Health Savings Account (HSA) cards. If you do not have insurance, we require a minimum payment of $100.00 at the time of the service for each office visit. If you do not have insurance and pay in full for all charges at the time of service, you'll receive a 15% discount.

If you have any questions regarding payment please contact our office in advance. Please check with your insurance provider to be sure they have your doctor listed.

Cancellations: Appointment & Surgery

If you are unable to make your appointment time please contact our office at least 24 hours in advance to reschedule or cancel. There will be a $250 fee for patient cancelling a surgery within 10 business days of the scheduled surgery. Three reschedules of the same surgery will be deemed as a cancellation.

Again, thank you for choosing American Health Network Bone & Spine for your health care needs. We look forward to treating you.

Sincerely,

Dr. Travis Clegg and Staff

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AMERICAN HEALTH NETWORK
MEDICAL HISTORY SCREENING FORM orthopaedics

Date: _____

Name: _____ Family Physician: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Hand Dominance (Right or Left): _____

Reason for Visit: _____

Email: _____

How did you hear about us? _____

Physical Therapy: ☐ Yes ☐ No; If yes, how long? _____ Medication for Pain: _____

Have you had any of these treatments? ☐ Injection ☐ Brace

Have you ever had surgery for this problem? ☐ Yes ☐ No; If yes, surgery date(s)/Physician(s)/Procedure(s):

_____

Location of Pain: _____ Duration of Pain: _____ Work Related? _____

Did pain begin after a specific activity/injury? _____ ☐ Gradual ☐ Sudden Date/Length of injury: _____

Injury was due to: ☐ Sport/Exercise:(type) _____ ☐ Auto Accident ☐ Work Related ☐ Other: _____

What activities worsen pain? _____

What activities improve pain? _____

Pain Scale *(circle one)*: 0 (No Pain), 1 2 (Mild) , 3 4 5 6 7 (Moderate), 8 9 10 (Severe)

Your pain is: ☐ Constant ☐ Intermittent Does your pain wake you from your sleep? ☐ Yes ☐ No

What best describes your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning

What makes your symptoms worse? _____

☐ Standing ☐ Walking ☐ Running ☐ Getting Up Stairs ☐ Twisting ☐ Kneeling ☐ Squatting

☐ Lifting ☐ Reaching ☐ Gripping

If you are having knee pain: ☐ Catching ☐ Instability ☐ Swelling

Since your problem started, it is: ☐ Getting better ☐ Getting worse ☐ Unchanged

REVIEW OF SYSTEMS

- ☐ Fever
- ☐ Fatigue
- ☐ Loss of Appetite
- ☐ Current Illness
- ☐ Sleep Apnea
- ☐ Shortness of Breath
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Arthritis
- ☐ Poor Balance
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Numbing
- ☐ Swelling
- ☐ Deformities
- ☐ Abdominal Pain
- ☐ Gerd
- ☐ Nausea
- ☐ Vomitting
- ☐ Bladder Infection
- ☐ Insomnia

PAST MAJOR MEDICAL HISTORY

- ☐ Aids
- ☐ Anemia
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blood Clots/DVT
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gerd/Reflux
- ☐ HIV
- ☐ Gout
- ☐ Heart Attack when: _____
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Ulcers
- ☐ Respiratory Issues
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Strokes/TIA's
- ☐ Thyroid Disorder
- ☐ Ulcers (Stomach)
- ☐ MRSA
- ☐ Depression/Anxiety
- ☐ Strokes
- ☐ TIA's
- ☐ Epilepsy
- ☐ Other:

_____

_____

_____

PAST MAJOR SURGICAL HISTORY

- ☐ Back or Neck Surgery (Fusions, Etc.)
- ☐ Other _____
- ☐ CAGB (Bypass) when: _____
- ☐ Gastric Bypass
- ☐ Pacemaker
- ☐ Stents
- ☐ None
- ☐ Arthroscopy
- ☐ Joint Replacement by who/what/when:

_____

- ☐ Other:

_____

ALLERGIES

_____

_____

_____

_____

PERTINENT FAMILY HISTORY

_____

_____

_____

_____

_____

SOCIAL HISTORY

Occupation:

_____

_____

- ☐ Currently Working
- ☐ Retired
- ☐ Disabled
- ☐ Unemployed

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

Alcohol:

☐ Yes ☐ No

If yes, how much:

_____

Illegal Drug Use:

☐ Yes ☐ No

If yes, drug:

_____

Tobacco:

☐ Yes ☐ Chew ☐ Cigarettes

Packs/Cans Per Day:

_____

How Many Years:

_____

- ☐ No
- ☐ Quit (when)_____

PLEASE LIST ALL MEDICATIONS AND DOSAGES (Prescription and Over-the-Counter) or provide a list
If your PCP is an AHN Provider you do not need to list meds.

_____

_____

_____

_____

_____

Are you currently receiving or plan to apply for: ☐ Workmen's Comp ☐ Unemployment ☐ *FMLA/STD

* A $40 fee will be charged accordingly for any FMLA or Short Term Disability paperwork submitted to us by you or your employer.

I HAVE RECEIVED A COPY OF THE BONE & SPINE WELCOME LETTER AND AGREE TO PAY CHARGES AS INDICATED:

Patient Signature: _____ Date: _____