New Hip Patient Packet

Dr. Thomas P. Gross, MD

Welcome to Midlands Orthopaedics & Neurosurgery. To be established as a patient and considered as a candidate for surgery, ALL materials in this packet must be submitted to our office. **Out-of-state patients** should submit the full packet including x-ray CD and insurance card scan by mail or secure upload. **Local patients** may complete these forms at your initial office visit or bring completed forms with you to your appointment.

Your Packet Must Include:

1. **Insurance Card (front & back)** (Page 2)
   Scan or photograph both sides of your insurance card.

2. **Patient Information Form** (Page 3)
   Complete all personal, contact,and insurance fields.

3. **Authorization & Acknowledgement Forms** (Pages 4–6)
   Sign and date the HIPAA authorization, consent, and financial policy forms.

4. **Medical History Form** (Pages 7–10)
   Complete general, medical, social, and family history sections.

5. **New Hip Questionnaire** (Pages 11–13)
   Complete the hip-specific questionnaire, including clinical function score.

6. **X-Rays** (Page 14)
   See x-ray order and obtain images (from local radiology facility or our clinic).
   If you have x-rays from the past 6 months, exclude the x-ray prescription page.

7. **MRI Report (Optional)**
   If a nMRI of the hip was performed within the last year, include the written report ONLY - NOT the images or CD.

Mail completed packet to:
Thomas P. Gross, MD | Midlands Orthopaedics & Neurosurgery, PA
1910 Blanding St., Columbia, SC 29201 | Phone: (803) 256-4107

OR

Email completed packet to:

evelyn.washington@midorthoneuro.com

Insurance Card

FRONT of Insurance Card

Scan or photograph and attach here

BACK of Insurance Card

Scan or photograph and attach here

If submitting by mail, please include a photocopy of both sides. If submitting digitally, attach a clear photograph of each side. Copies of insurance cards are required - your submission will be incomplete without them.

Patient Information Form

PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **MI:** ___

Date of Birth (MM/DD/YYYY): _____ **Gender:** _____

Mailing Address: _____ **City:** _____

State: _____ **ZIP Code:** _____ **Language:** _____

Home Phone: _____ **Mobile Phone:** _____ **Work Phone:** _____

Email Address: _____ **Consent to text?** ☐ Yes ☐ No

Contact preference: ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Mail ☐ Portal

Race (or Decline to Answer): _____ **Emergency Contact / Relationship:** _____

Ethnicity (or Decline to Answer): _____

Marital Status: _____

Emergency Contact Phone: _____ **Referring Doctor (or Self):** _____

Employer: _____ **Occupation:** _____

GUARANTOR (IF PATIENT IS A MINOR)

Last Name: _____ **First Name:** _____ **Relationship:** _____

DOB: _____ **Home Phone:** _____ **Mobile Phone:** _____

Address: _____

INSURANCEINFORMATION (INSURANCE CARD COPIES REQUIRED)

PRIMARYINSURANCE

Insured's Name: _____

Relationship to Patient: _____

SS# of Insured (if different): _____

Date of Birth of Insured: _____

Insured's Employer: _____

SECONDARY INSURANCE

☐ Same as primary **Insured's Name:** _____

☐ Same as primary **Relationship to Patient:** _____

☐ Same as primary **SS# of Insured (if different):** _____

☐ Same as primary **Date of Birth of Insured:** _____

☐ Same as primary **Insured's Employer:** _____

I acknowledge that by providing insurance information, I have asked and promised to pay for services provided. I assign to Midlands Orthopaedics & Neurosurgery, PA, all health insurance benefits available for services provided to me. Fees for services are my responsibility and I agreeto pay any balance left unpaid by any insurance company.

Patient/Guarantor Signature: _____ **Date:** _____

Authorizations & Acknowledgements

1. Acknowledgement of Receipt of Privacy Policies

I have received a copy of the Midlands Orthopaedics & Neurosurgery, PA (MON) Notice of Privacy Policies detailing how my protected health information (PHI) may be used and disclosed as permitted under federal and state law. MON may disclose my PHI without my authorization to facilitate treatment, payment, and health care operations.

2. ePrescribe Consent

I understand that MON utilizes electronic health record software incorporating ePrescribing technology, and may access and use my prescription history for purposes of providing appropriate treatment.

3. Assignment of Benefits

I assign to MON any insurance or other third-party benefits available for health care services provided to me. If benefits are not assigned to MON, I agree to immediately forward all health insurance and third-party payments I receive for services rendered by MON.

4. Medications and Refill Requests

Providers will not address medication requests or refills after regular business hours or on weekends. Requests must be made during the normal business day. After-hours staff do not have access to medical records needed to make such decisions.

5. Paperless Billing

By providing my email address, I am automatically enrolled to receive paperless billing statements in an effort to reduce environmental impact.

6. Consent to Call

I consent to receive calls from MON and any affiliates related to my protected healthcare information at the phone numbers provided, including wireless numbers. Calls may be generated by an automated dialing system. This consent is not required to be accepted as a patient and may be revoked at any time.

I, _____ , acknowledge receipt and understanding of the items described on this form.

Patient/Guardian Signature: _____ **Date:** _____

HIPAA Privacy Authorization

I hereby authorize Midlands Orthopaedics & Neurosurgery, PA, to use and/or disclose the protected health information below to the following individual(s):

NAME	CONTACT INFORMATION

Authorization for Release of Information:

Covering the period of health care from: **Date:** _____ **to:** _____ **OR** ☐ **All past, present, and future periods**

Covering the following protected health information:

☐ I authorize release of my complete health record.

☐ I authorize release of my complete health record except: _____

• I understand I have the right to revoke this authorization in writing at any time, except where action has already been taken in reliance on it.

• My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing this authorization.

• Information disclosed pursuant to this authorization may no longer be protected by federal or state law.

Signature of Patient or Personal Representative: _____ **Date:** _____

Print Name: _____ **Relationship to the Patient** _____

Financial Policy

Thank you for choosing Midlands Orthopaedics & Neurosurgery, PA (MON/MOPA). While we will make every effort to obtain appropriate payment from your insurance carrier, payment for services rendered is ultimately your responsibility. Your insurance plan is a contract between you and your insurer - our office is not a party to that contract.

Payment for Services

Copays are collected at check-in along with any balance due. We will pre-collect the estimated patient responsibility amount for surgeries, procedures, and MRI services.

Insurance Updates

You are required to update your insurance information at least once per year. Notify our office immediately of any changes to your coverage. Failure to do so may result in claim denials making all charges your full responsibility.

Referrals & Authorizations

If your plan requires a referral from your primary care physician, ensure one is provided prior to your appointment.

Uninsured Patients

Payment is due at time of service. A minimum deposit of $100–$300 is required prior to the appointment. We offer a Prompt Pay Discount for patients who pay their entire balance at time of service.

Past Due Balances

Balances not paid within 30 days are considered past-due. Balances unpaid after 90 days will be forwarded to a collection agency. Patients with past-due balances must arrange payment before additional services will be scheduled.

No-Show & Late Cancellation Fees

Appointments must be cancelled at least 24 hours in advance to avoid fees: • MRI appointments: $100.00 • ESI, EMG, Tenex, or surgical procedures: $150.00

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____ **Date:** _____

Medical History Form

Reason for visit today: _____

Was this the result of an accident? ☐ Yes ☐ No If yes, date: _____

Where did injury occur? ☐ Work ☐ Auto ☐ Home ☐ Other

REFERRING PHYSICIAN

Name: _____

Address: _____

Phone: _____

FAMILY PHYSICIAN

Name: _____

Address: _____

Phone: _____

PREFERRED PHARMACY

Name: _____

Address: _____

Phone: _____

MAIL-IN PHARMACY

Name: _____

Address: _____

Phone: _____

Height: _____ **Weight:** _____

Current Pain Scale (circle one):

0 1 2 3 4 5 6 7 8 9 10

No pain — Severe pain

ALLERGIES & REACTIONS (LIST ALLERGIES TO MEDICATIONS, METALS, OR LATEX)

Name of Allergy	Reaction	Name of Allergy	Reaction

FAMILY HISTORY - CHECK ANY THAT HAVE OCCURRED IN BLOOD RELATIVES

- ☐ Blood Clots in Legs or Lungs
- ☐ Osteoarthritis
- ☐ Cancer
- ☐ Aneurysm
- ☐ Nerve Disease
- ☐ Malignant Hypothermia
- ☐ Bleeding Disorder
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Osteoporosis
- ☐ Muscle or Bone Disease
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Lupus

Relationship (for "family history" items checked above):

Medical History Form

SOCIAL HISTORY

Smoking status: ☐ Current Smoker ☐ Non-Smoker ☐ Former Smoker

Cigar/pipe use: ☐ Yes ☐ No

Alcohol use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Tobacco years of use (current/former): _____

Number of children: _____

Occupation: _____

Employer: _____

Diet: ☐ Regular ☐ Vegetarian ☐ Gluten-free ☐ Low carbohydrate ☐ Cardiac ☐ Diabetic

SURGICAL HISTORY & MEDICATIONS

SURGICAL HISTORY / HOSPITALIZATIONS

ALL DAILY MEDICATIONS / VITAMINS / SUPPLEMENTS

PAST MEDICAL HISTORY - CIRCLE ALL THAT APPLY

AIDS/HIV	Anemia	Anxiety	Asthma
Atrial Fib	Bladder Disease	Blood Clots	Bronchitis
Cancer	Cardiac Stents	Depression	Diabetes
Eating Disorder	Fracture	Gallbladder	Glaucoma
Gout	Heart Attack	Heartburn/GERD	Hepatitis B/C
Hernia	High Blood Pressure	High Cholesterol	Irritable Bowel
Kidney Disease	Kidney Stones	Liver Disease	Lupus
Migraines	MRSA/VRE	Multiple Sclerosis	Osteoarthritis
Osteoporosis	Pacemaker/AICD	Pulmonary Embolism	Rheumatoid Arthritis
Seizure Disorder	Sickle Cell Anemia	Sleep Apnea	Stroke
Thyroid Disorder	Tuberculosis	Fibromyalgia	

Sleep apnea? If yes, use C-PAP or Bi-PAP? ☐ Yes ☐ No

Device settings: _____

Cardiac stents? If yes, date(s): ☐ Yes ☐ No

Pacemaker or AICD? If yes, date: ☐ Yes ☐ No

REVIEW OF SYSTEMS - CIRCLE ALL THAT APPLY

Constitutional: fever, night sweats, weight gain, weight loss, difficulty exercising
Eyes: dry eyes, irritation, change in vision
Ears: difficulty hearing, ear pain
Nose: frequent nosebleeds, sinus problems
Mouth/Throat: sore throat, bleeding gums, snoring, dry mouth, mouth ulcers
Cardiovascular: chest pain, arm pain on exertion, shortness of breath, palpitations, heart murmur
Respiratory: coughing, wheezing, shortness of breath, coughing up blood
Gastrointestinal: abdominal pain, vomiting, loss of appetite, diarrhea
Genitourinary: incontinence, difficulty urinating, blood in urine, increased frequency

New Hip Questionnaire

SECTION I -ABOUT YOUR HIP

1. This questionnaire is for my: ☐ LEFT hip ☐ RIGHT hip

2. I have had problems with my: ☐ LEFT hip ☐ RIGHT hip ☐ BOTH hips

3a. The most pain is in my: ☐ LEFT hip ☐ RIGHT hip

3b. When does this joint hurt? (check all that apply) ☐ Sitting ☐ Resting ☐ On stairs ☐ Walking ☐ At night ☐ Standing

4. How long have you had this pain? (years/months): _____

5. What activities cause this joint to hurt?: _____

7. Pain location (check all that apply): ☐ None ☐ Groin ☐ Side of hip ☐ Buttock ☐ Front of thigh ☐ Side of thigh ☐ Lower back

☐ Other (describe): _____

8. PREVIOUS MEDICATIONS FOR PAIN

Over-the-counter: _____

Prescription: _____

9. CURRENTMEDICATIONS FOR PAIN

Over-the-counter: _____

Prescription: _____

10. Number of physical therapy sessions for this issue: _____

11. Have you had hip injections? ☐ Yes - how long did it help? No

12. Previous surgeries on this joint: _____

13. Other treatments tried and their success: _____

14. Activities stopped due to hip pain: _____

15. Activities now difficult due to hip pain: _____

16. Is pain worse with certain movements? Explain.: _____

17. Two daily activities that cause pain: _____

18. Has any orthopedic surgeon recommended surgery? ☐ Yes ☐ No

19. What prompted you to contact us?: _____

20. Additional notes: _____

New Hip Questionnaire (continued)

SECTION II - CLINICAL FUNCTION SCORE

1. My overall pain level: ☐ None/insignificant ☐ Regularly slight ☐ Mild ☐ Moderate ☐ Severe ☐ Disabled

2a. Circle your REGULAR pain level:

0 1 2 3 4 5 6 7 8 9 10

0 = no pain 10 = worst pain

2b. Circle your HIGHEST pain level:

0 1 2 3 4 5 6 7 8 9 10

0 = no pain 10=worst pain

3. Limp severity: ☐ None ☐ Slight ☐ Mild ☐ Moderate ☐ Severe ☐ Disabled

4. Use of walking support:

- ☐ None required
- ☐ Cane/stick almost always
- ☐ Two crutches or a walker
- ☐ Cane/stick for long walks or high activity only
- ☐ One crutch almost always
- ☐ Unable to move across the room

5. Walking distance without a break:

- ☐ Over 1 mile / unlimited
- ☐ ~2–3 blocks / 10–15 minutes
- ☐ Bed and chair only
- ☐ ~6 blocks / 30 minutes
- ☐ Indoor walking only

6. Taking stairs:

- ☐ Normally, foot-over-foot, no railing needed
- ☐ One step at a time, leading with non-painful hip
- ☐ Normally, using the railing
- ☐ Cannot take the stairs

7. Putting on socks/shoes:

- ☐ With ease
- ☐ Unable without help
- ☐ With difficulty

8. Sitting comfortably:

- ☐ Any chair / 1+ hour
- ☐ Unable to sit comfortably
- ☐ High chair / 30 minutes

9. Getting in/out of a vehicle without help? ☐ Yes ☐ No

SECTION III - ACTIVITY SCORE

1. Choose your current activity level (circle one number):

1 - Wholly inactive; dependent on others
2 - Mostly inactive; minimum daily activities only
3 - Sometimes participates in mild activities (walking, limited shopping)
4 - Regularly participates in mild activities
5 - Sometimes participates in moderate activities (swimming, unlimited shopping)
6 - Regularly participates in moderate activities
7 - Regularly participates in active events (cycling)
8 - Regularly participates in very active events (bowling, golf)
9 - Sometimes participates in impact sports (jogging, tennis, skiing)
10 - Regularly participates in impact sports

Patient First Name: _____ **Last Name:** _____

Hip X-Ray Order

Bring or present this form to any local hospital or freestanding radiology facility.

ORDERING PHYSICIAN
Thomas P. Gross, MD
Midlands Orthopaedics & Neurosurgery

Rx

Digitally signed: Thomas P. Gross, MD
Date: 2026.JUN.30

PATIENT INFORMATION (Please complete before visiting the radiology facility)

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Date:** _____

STEP 1 - Select all that apply

LEFT HIP

- ☐ Osteoarthritis: M16.12
- ☐ Hip pain: M25.552
- ☐ Presence of left artificial hip joint: Z96.642

RIGHT HIP

- ☐ Osteoarthritis: M16.11
- ☐ Hip pain: M25.551
- ☐ Presence of right artificial hip joint: Z96.641

BILATERAL

- ☐ Osteoarthritis: M16.10
- ☐ Hip pain: M25.559
- ☐ Presence of artificial hip joints, bilateral: Z96.643

STEP 2 - X-Ray Views Required (Obtain ALL)

View 1: AP Pelvis - STANDING
Label as "STANDING" - Weight-bearing, upright position

View 2: AP Pelvis - SUPINE
Label as "SUPINE" - Lying down, non-weight-bearing

View 3: Frog-Leg Lateral / Cross Table
- Standard lateral view

View 4: "False Profile" View
- Anterior coverage assessment

STEP 3 - Send X-Ray Images to Dr. Gross

PREFERRED: Nuance PowerShare (electronic)
Ask the radiology facility to send images viaNuance PowerShare.
Search: Midlands Orthopaedics & Neurosurgery, 1910 Blanding St, Columbia SC 29201

OR

ALTERNATIVE: Mail a CD
Request a CD with digital DICOM image files and mail to:
Midlands Orthopaedics & Neurosurgery, ATTN: Gross MD New Hip
1910 Blanding Street, Columbia, SC 29201