

New Knee Patient Package

ALL materials in this packet must be submitted to us for you to be established as a patient and candidate for surgery. Please complete each section and return the full package as directed below.

YOUR NEW PATIENT PACKET SHOULD INCLUDE:

- 1 Copy of your insurance card, front + back
- 2 Patient information form
- 3 Patient authorization forms
- 4 Medical history form
- 5 New knee questionnaire
- 6 Recent x-rays (prescription included)
 - X-rays must be within past 6 months.
 - Exclude the x-ray prescription from your submitted package.

HOW TO SUBMIT

Local patients: These materials are available in our clinic at your initial visit, or you may bring completed forms to your appointment.

Out-of-state patients: Submit this packet in its entirety, including x-ray CD and scan of insurance card:

Thomas P. Gross, MD
ATTN: New Patient Package
Midlands Orthopaedics & Neurosurgery
1910 Blanding Street, Columbia, SC 29201

QUESTIONS? Contact our follow-up team:

Phone: (803) 933-6127 Email: evelyn.washington@midorthoneuro.com Office: (803) 256-4107

**PLEASE SCAN A COPY OF YOUR INSURANCE CARD
INCLUDING FRONT AND BACK**
(Mail or email a scan or photocopy)

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: _____

INSURANCE INFORMATION (INSURANCE CARD COPIES REQUIRED)

PRIMARY INSURANCE

Insured's Name: _____
 Relationship to Patient: _____
 SS# of Insured (if different): _____
 Date of Birth of Insured: _____
 Insured's Employer: _____

SECONDARY INSURANCE

☐ Same as primary
☐ Same as primary
☐ Same as primary
☐ Same as primary
☐ Same as primary
 Insured's Name: _____
 Relationship to Patient: _____
 SS# of Insured (if different): _____
 Date of Birth of Insured: _____
 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 agree to 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: _____

PREFERRED PHARMACY

Name: _____

Address: _____

Phone: _____

Height: _____ Weight: _____

Current Pain Scale (circle one):



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

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	

Do you have sleep apnea? ☐ Yes ☐ No

If yes, do you use C-PAP or Bi-PAP? Yes / No Device Settings: _____

Do you have cardiac stents? ☐ Yes ☐ No

If yes, please list date(s): _____

Do you have a pacemaker or AICD? ☐ Yes ☐ No

If yes, please list dates: _____

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 Knee Questionnaire

Patient name: _____

SECTION I. INTRODUCTION

1. This questionnaire is for the evaluation of my (side) knee: ☐ Left ☐ Right ☐ Both

2. I have had problems with my (side) knee(s): ☐ Left ☐ Right ☐ Both

3a. The most pain is in my (side) knee: ☐ Left ☐ Right

3b. When does this joint hurt? (check all that apply):

☐ Resting ☐ Sitting ☐ Walking ☐ On stairs ☐ At night ☐ Standing

7. Please indicate location of pain. (Check all that apply):

☐ No knee pain ☐ Inside Knee ☐ Back of Knee ☐ General/all-over ☐ Outside Knee ☐ Above Knee ☐ Knee Cap

☐ Other knee pain: _____

4. How long have you had this pain? Years: _____ Months: _____

5. What activities cause this joint to hurt? _____

6. Have you had any previous injuries affecting this joint? ☐ No ☐ Yes - please explain: _____

8. PREVIOUS medications for pain:

a. Over-the-counter: _____

b. Prescription: _____

9. CURRENT medications for pain:

a. Over-the-counter: _____

b. Prescription: _____

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

11. Have you had knee injections to treat your pain? ☐ No ☐ Yes: how long did it help? _____

12. List any previous surgeries on your problematic joint: _____

13. List other treatments you've tried and how successful: _____

14. What activities have you stopped due to knee pain? _____

15. What activities are now difficult due to knee pain? _____

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

17. Please list two daily activities that cause pain: _____

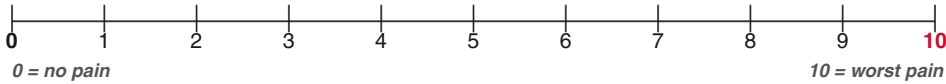
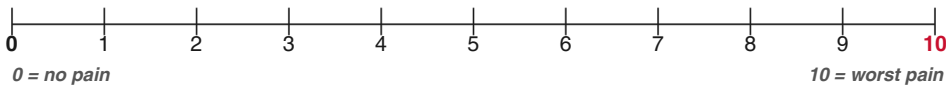
18. Has any orthopaedic surgeon recommended surgery? _____

19. What prompted you to contact us for evaluation? _____

20. Please list any additional notes here:

SECTION II. CLINICAL FUNCTION SCORE**1. My overall pain level:**

- ☐ None / insignificant
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Disabled

2a. Circle your REGULAR pain level:**2b. Circle your HIGHEST pain level:****3. Please indicate your use of support, if any:**

- ☐ None required
- ☐ Use of a cane
- ☐ Use of two canes
- ☐ Use of two crutches or a walker

4. I am able to walk _____ without a break:

- | | |
|---|--|
| ☐ Over 1 mile / unlimited | ☐ <5 blocks / 10–20 minutes |
| ☐ ~10 blocks / 45 minutes | ☐ <1 block |
| ☐ 5–10 blocks / 30 minutes | ☐ Bed and chair only |

5. Which of the following describes how you take the stairs?

- ☐ Normally, foot-over-foot, no railing needed
- ☐ Normal up; require railing going down
- ☐ Require railing going up or down
- ☐ Up with rail; need assistance going down
- ☐ Unable to take stairs even with assistance

SECTION III. ACTIVITY SCORE**1. Choose your current activity level (circle one number):**

- 1** Wholly inactive; dependent on others, cannot leave residence
- 2** Mostly inactive, or restricted to minimum activities of daily living
- 3** Sometimes participates in mild activities (e.g. walking, limited shopping)
- 4** Regularly participates in mild activities
- 5** Sometimes participates in moderate activities (e.g. swimming, unlimited shopping)
- 6** Regularly participates in moderate activities
- 7** Regularly participates in active events, such as bicycling
- 8** Regularly participates in very active events, such as bowling or golf
- 9** Sometimes participates in impact sports (e.g. jogging, tennis, skiing)
- 10** Regularly participates in impact sports

New Knee 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
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PATIENT INFORMATION (Please complete before visiting the radiology facility)

Patient Name:		Date of Birth:	
Address:		Date:	

Please choose/circle ONE section (either 1, 2, or 3) to ensure the appropriate x-rays are obtained from the patient's radiology facility.

1. LEFT
- Osteoarthritis (OA) of the knee - M17.12

Knee pain - M25.562
2. RIGHT
- Osteoarthritis (OA) of the knee - M17.11

Knee pain - M25.561
3. BILATERAL
- Osteoarthritis (OA) of the knee - M17.0

Knee pain - M25.569

Views Required (please obtain each of the following):

1. AP
2. Lateral
3. Sunrise
4. 45° flexion

HOW TO SUBMIT

PREFERRED: Nuance PowerShare (electronic)

Ask the radiology facility to send images via Nuance PowerShare.
Search: Midlands Orthopaedics & Neurosurgery, 1910 Blanding St, Columbia SC 29201

ALTERNATIVE: Mail a CD

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