78 Ridgewood Drive Bangor, ME 04401 ● www.downeastortho.com

P. Gregory Askins, M.D.
Surgery of the Hand
Tel: 207.307.8906
Fax: 207.307.8916

Jacob Brooks, D.O.
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Orthopedic/Arthroscopic Surgery
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Tony J. Tsismenakis, M.D.
Adult Reconstructive Surgery
Tel: 207.307.8910
Fax: 207.307.8940

Dear Patient,

Welcome and thank you for choosing Down East Orthopedic Associates, P.A. (DEOA) for your orthopedic care. We look forward to your upcoming visit with us. We know that a healthy body is something many of us take for granted until illness, injury, or the normal aging process threatens to take it away. Your trust in our knowledge and expertise is very important to us and we promise not to take that for granted. At DEOA we provide a full range of orthopedic services to help restore you to your lifestyle. Our goal is to provide you with an accurate assessment and evaluation, coupled with early intervention and the best possible medical care, in a compassionate and caring manner.

Our practice is made up of professionals who work closely together to bring you the highest quality orthopedic care. This includes physicians, physician extenders, and therapists. We work as a team to provide the best possible care as efficiently as possible and look forward to your upcoming visit.

Please take a few minutes to read the enclosed information regarding your upcoming visit, general information, and policies.

Thank you for your trust in DEOA and we look forward to serving you.

Sincerely,

The Physicians and Staff at Down East Orthopedic Associates, P.A.

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Preparing For Your Visit

Enclosed you will find a patient information and medical history form. Please take a moment to complete these forms as this will help us prepare for your visit. If you already have a typed summary of your medical history and medications you may attach this instead. Please return the completed forms in the enclosed envelope. Having this information will help us save time during the registration process on the day of your visit. **If your appointment is less than 1 week away**, please bring the completed forms with you to the appointment.

Please bring the following items with you to appointment:

- Current insurance card(s)
- Photo identification
- Prior surgical pictures, operative notes, and office notes if applicable
- Proper clothing for your appointment (shorts for knee or hip visits; tank top for shoulder visits)
- Imaging studies are typically accessible through the imaging system. However, this is dependent on the facility where the images were taken. For the most reliable service, please bring a copy of all past studies on CD (obtained from the original imaging center). If not possible, we will do our best to access these.

We encourage you to please visit our website www.downeastortho.com and take some time to get to know our practice and also to obtain additional directions to our location.

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Office Hours and Appointments

Our office hours are from 8:00am to 5:00 pm Monday-Thursday and 8:00am to 3:30pm Friday. With this letter, you will find your upcoming appointment date and time. Prior to your appointment you will receive a reminder call from our automated system. If you are unable to keep this appointment, please contact our office as soon as possible to reschedule with the provider's secretary. Please note that our office may not reschedule your appointment if you fail to show.

Your scheduled appointment may vary depending on the provider's rounds and surgery schedule. We believe that everyone's time is valuable and in the event of a delay, we will do our best to notify you in advance. If you need to be seen immediately, we will do our best to accommodate and get you an appointment in a timely manner. Follow-up appointments will be made upon check out.

Please arrive at least 15 minutes prior to your scheduled appointment to allow for check in and x-rays if needed. We understand that your time is important and we do our best to stay on schedule. We also strive to provide the most comprehensive care possible and ensure all concerns are addressed at your visit.

What to Expect During the Visit

Our office is located at 78 Ridgewood Drive in Bangor, Maine, off Stillwater Avenue in the Oak Ridge Business Park. Upon arrival, you will be greeted by our staff and your registration information will be confirmed. If your plan requires a copayment, we will ask for that amount at the time of check in. DEOA accepts cash, personal check, or credit/debit cards as forms of payment. Self-pay patients should come prepared to pay the predertimined amount upon check in. Our accounts receivable department will be happy to assist you with any questions regarding services and billing concerns. You may contact them at (207) 947-8381 and select option 4.

If you have not had recent imaging of your affected limb/joint, we may obtain x-rays in the office. You may be asked to change into shorts or a gown to allow for appropriate examination by your provider. Upon check out our secretaries will assist you in scheduling follow-up appointments, further testing, surgery, or referral if needed.

DOWN EAST ORTHOPEDIC ASSOCIATES, P. A.
78 RIDGEWOOD DRIVE BANGOR, ME 04401

Patient Information

First Name: _____ M.I.: _____ Last Name: _____

Parent/Guardian name (If minor/student): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: (____)____-_____ Cell: (____)____-_____ Work: (____)____-_____

Sex: M F SSN: _____-_____-_____ Date of birth: _____/_____/_____

Email address: _____
(by providing your email, you are allowing Down East Orthopedics to contact you via your email)

Marital status: Single Married Divorced Widowed

Employer: _____

Employer's address: _____

Employer's phone number: _____ Occupation: _____

Emergency contact person: _____ Relationship: _____

Emergency contact phone number(s): _____

Primary care physician:_____ Referred by:_____

Reason for Visit

Describe problem:_____

Location: Right Left Bilateral

Auto Accident? Yes No Work Related: Yes No

If work related, has there been a claim filed with employer: Yes No

Date of accident/injury: _____

Attorney (if applicable): _____ Phone number: _____

Insurance Information

Primary insurance: _____

Insurance ID: _____ Group: _____

Policy holder: _____ Relationship to patient: _____

DOB: _____ SSN: _____-_____-_____

Secondary insurance: _____

Insurance ID: _____ Group: _____

Policy holder: _____ Relationship to patient: _____

DOB: _____ SSN: _____-_____-_____

Workers' Compensation Information

Insurance company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Case adjuster:_____

Claim number: _____ Date of injury:_____

Employer's name: _____

Employer's Address: _____

Phone number: (_____)_____-_____ Contact person: _____

I hereby authorize Down East Orthopedic Associates, P.A. to release medical information to my primary care physician, my referring physician, my current treating physicians, and to my insurance carrier. I understand this medical information may be sent electronically or via facsimile. I further authorize direct payment to Down East Orthopedic Associates, P.A. for the services rendered. I understand I am financially responsible for the charges related to these services. I authorize any holder of medical or other information about me to release to the Social Security Administration or Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
You must be 18 years of age or legal guardian to sign.

DATE:_____**SIGNATURE**:_____
(Patient, Parent or person legally authorized to sign)

D. THOMPSON McGUIRE, M.D.
KENNETH MORSE, M.D.
CAMERON TRUBEY, M.D.
P. GREGORY ASKINS, M.D.
JOHN I. PYNE, M.D.
P. ALEX GREEN, M.D.
GARRETT R. MARTIN, M.D.
STEPHEN M. WALSH, M.D.
JACOB D. BROOKS, D.O.
TONY J. TSISMENAKIS, M.D.

Please complete this questionnaire to help us provide you with the best possible care. Past and current medical conditions, medications and surgery may have an influence on your current condition or surgical care.

Name: _____ **Birthdate**: _____

Race:
- ☐ Caucasian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Chinese
- ☐ Asian
- ☐ Multiracial
- ☐ American Indian or Alaska Native
- ☐ African American
- ☐ Native American

Preferred Language:
- ☐ English
- ☐ French
- ☐ German
- ☐ Italian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Mandarin

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Other

Hearing Impaired: ☐ Yes ☐ No **Interpreter Needed:** ☐ Yes ☐ No

Past Medical History:

Please **check** any condition that you currently have or have had in the past.

- ☐ Heart attack
- ☐ Chest pain
- ☐ Lung disease
- ☐ Glaucoma
- ☐ Fractures
- ☐ Bleeding disorder
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Epilepsy
- ☐ Childhood diseases
- ☐ Vascular disease
- ☐ Hypertension
- ☐ Liver disease
- ☐ Polio
- ☐ Depression
- ☐ Diabetes

(other) _____

Please list prior hospitilizations/surgeries within the last 5 years:

Date (mm/yy)	Hospital	Physician	Reason (Type of medical problem or operation)

(Please attach a separate list if more space is necessary.)

Have you ever had a blood transfusion? Yes / No If yes, when: _____

Have you had any problems with anesthesia? Yes / No If yes, please explain: _____

Previous EKG: Yes / No If so, where? _____ When? _____

Have you had a previous MRSA or Staph infection? Yes / No If yes, when was your last culture? _____

Do you have a pacemaker? Yes / No

Do you have a defibrillator? Yes / No

List **allergies** to any **medications** or **foods** (and type of reaction, i.e. nausea, hives, ect.):

Allergy	Reaction

List all medications and vitamins you take regularly.

Name of Medication	Strength (i.e. 200mg.)	Directions (i.e. 2 pills 3 times per day)

Pharmacy Name: _____

Pharmacy Telephone: _____

Social History:

Do you smoke? Yes / No If yes, what and how much?_____

If you used to smoke, how many years did you do so and when did you quit? _____

Passive smoke exposure? Yes / No

Illicit Drug use? Yes / No

Alcohol use? Yes / No Type: _____ Drinks per day: 0 <1 2 3 4 4+

Do you follow a special diet? Yes / No (If yes, please specify): _____

Caffeine use (drinks/day): 0 <1 2 3 4 4+

Do you exercise? Yes / No Times per week: _____ Type of exercise: _____

Seatbelt use: ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ 0%

Sun Exposure: ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Remote

Education Level:_____

Family History: (Please list major medical illnesses)

	Current age	Serious illnesses or other medical conditions	If deceased, list cause and age at death
Mother			
Father			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			

Fall Assessment Questionnaire:

Have you had two or more falls in the past year? Yes / No

Do you have trouble getting out of a chair or feel unsteady when you walk? Yes / No

Do you have difficulty getting up from the floor without help? Yes / No

Signature:_____ Date:_____

Down East Orthopedic Associates
78 Ridgewood Drive
Bangor, ME 04401
207-947-8381

PERSONAL RELEASE OF MEDICAL INFORMATION

(This release provides permission to discuss your personal medical record/information with a family member, spouse, etc.)

Patient Name: _____

DOB: _____

I hereby give permission to the staff of Down East Orthopedic Associates to disclose to:

_____/_____
Name of person allowed to receive information Relationship to patient

_____/_____
Address of person allowed to receive information Phone Number

_____/_____
Name of person allowed to receive information Relationship to patient

_____/_____
Address of person allowed to receive information Phone Number

Information obtained and/or contained in my personal medical record as follows:

Check appropriate items:

_____All records contained within my personal medical record, including those listed below
_____Medical problems
_____X-rays
_____Office Notes
_____Medical billing/payment questions and history
_____Other_____

This release will stay in effect for 30 months unless revoked by me in writing before that time.

_____ _____/_____/_____
Patient's Name (PLEASE PRINT) Date

_____ _____
Patient's Signature (Parent if a minor) Witness