



bone
&
spine



Brian L. Badman, MD
*Board certified in
Orthopaedics (ABOS)*

Jenna Nowlin, PA-C



Welcome to American Health Network Bone & Spine

AVON
8607 East U.S. 36
#100
Avon, IN 46123

CARMEL
12188-B N. Meridian St.
Suite 330
Carmel, IN 46032
*Signage on building says
Franciscan St. Francis*

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.

Phone Hours

In order to most efficiently handle patient care, we utilize a centralized call center. Our call center hours are Monday-Friday 8:00am to 4:30 pm. Our phone number is (317)208-3866. If you have an urgent medical need outside of our normal business hours, the provider on call can be reached by calling our office; the answering service will contact the provider on call and have them call you.

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

Please arrive **15 minutes early** and bring your paperwork along with your current insurance card(s). **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. Brian L. Badman, Jenna Nowlin and Staff





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&
spine

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: _____ Occupation: _____

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

Have you had any of these treatments? Injection Brace Crutches Sling

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

Is your skin sensitive to costume jewelry/nickel? Yes No

Are you currently under the care of a Pain Management physician? Yes No; If yes, Who? _____

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: _____

Explain injury: _____

Have you noted any arm or leg weakness/numbness? _____

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

What makes your symptoms better? _____

If you are having knee pain: Catching Instability Swelling

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

ANY RECENT IMAGING (with Dates and Location of Imaging)

Xray: _____

CT Scan: _____

MRI: _____

EMB/NCV: _____

CT Myelogram: _____

Bone Scan: _____

Other: _____

REVIEW OF SYSTEMS

- Fever
- Fatigue
- Loss of Appetite
- Current Illness
- Sleep Apnea
- Shortness of Breath
- Pneumonia
- Wheezing
- Arthritis
- Poor Balance
- Joint Pain
- Stiffness
- Numbness
- Swelling
- Deformities
- Abdominal Pain
- Diarrhea
- Constipation
- Gerd
- Ulcers
- Nausea
- Vomitting
- Bladder Infection
- Kidney Disease
- Retention
- Easy Bleeding
- Easy Bruising
- Clotting Disorder/Blood Clots
- Strokes
- TIA's
- Epilepsy
- Anxiety
- Depression
- Insomnia
- MRSA History
- Latex Allergy

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
- Respiratory Issues
- Rheumatoid Arthritis
- Seizure Disorder
- Strokes/TIA's
- Thyroid Disorder
- Ulcers (Stomach)
- Other:

PAST MAJOR SURGICAL HISTORY

- Back or Neck Surgery
(Fusions, Etc.)
- Other _____
- CABG (Coronary 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)

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.

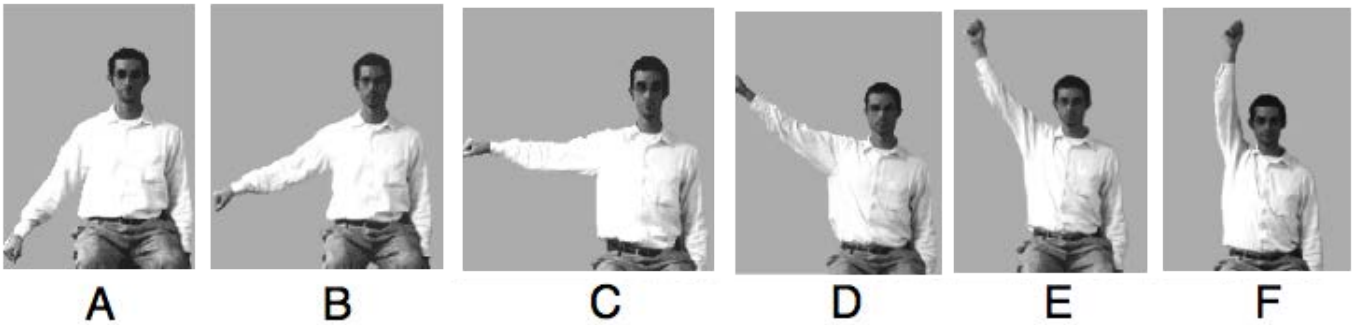
I HAVE RECEIVED A COPY OF THE BONE & SPINE WELCOME LETTER AND AGREE TO PAY CHARGES AS INDICATED:

Patient Signature: _____ Date: _____

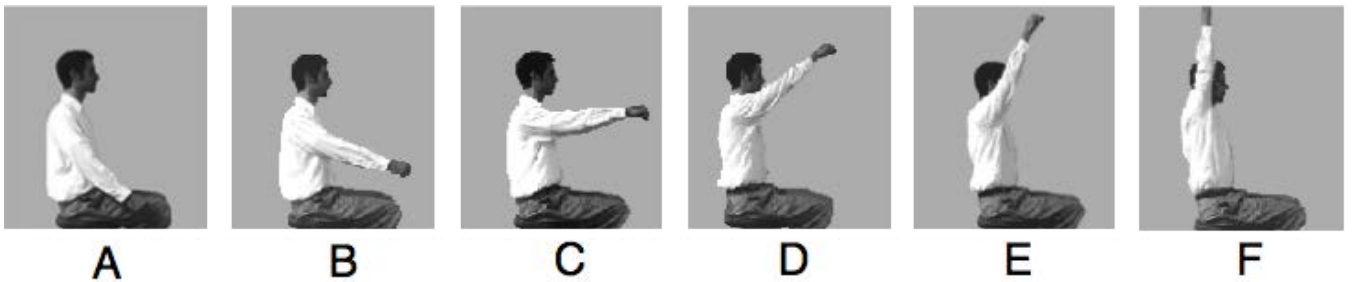
Range of Motion

Please circle the picture which most closely represents your current motion.

ABDUCTION



FORWARD FLEXION



INT ROT

