Be among the first to know about our newest research studies.

DATABASE RELEASE AUTHORIZATION

The purpose of this Clinical Research Database questionnaire is to provide you with opportunities to participate in clinical research studies. Completing this survey is optional and not intended to replace the relationship you have with your healthcare providers.

Your private information will only be used to notify you of clinical research opportunities. It will not be shared with anyone not affiliated with our site. If at any time you should choose to have your name removed, or your information updated, please contact us at 434-793-4711 ext 349 or marshalla@danvilleortho.com.

I have reviewed and I understand this Authorization allows Danville Orthopedic Clinic, Inc. to enter my private information from this questionnaire into the research database so that I may be contacted with future clinical trial opportunities.

May we contact you about future studies? ☐Yes ☐No
I hereby affirm that the information provided is accurate.

______________________________ __________
Signature of Patient/Guardian **Date**

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I give my permission to be contacted in the following manner (check all that apply):

☐ Home Telephone ____________________

☐ O.K. to leave message with detailed message

☐ Leave message with call back number only

☐ Work Telephone____________________

☐ O.K. to leave message with detailed message

☐ Leave message with call back number only

☐ Cell Telephone____________________

☐ O.K. to leave message with detailed message

☐ Leave message with call back number only

☐ Email/Text Message

☐ (Preferred email)___________________

☐ (Text number)___________________

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures make pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PI disclosures. Information provided below, if complete properly, will constitute an adequate record.

Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency.

_____________________________________ _________________________

Patient Signature Date

_____________________________________ _________________________

Printed Name Date of Birth (mm/dd/yyy)

Personal and Contact Information

Name: ____
First Middle Last

Address: ____
House Number Street Name Apt. #

______________________ __________ ______________
City State Zip Code

Phone Numbers: Home: ______ __________ Work: ______ __________
Area Code Number Area Code Number

Cell: ______ __________ Text Messages : ☐Yes ☐No
Area Code Number

E-mail address: ____________________
Area Code Number

Date of Birth: _____ / _____ / _____ Sex: _____ Race: __________
Month D ay Year

In Case of Emergency contact (Person Not Living in Your Household):

Name: ____________________ Relationship: ______________

Phone Numbers: Home: ______ __________ Cell: ______ __________
Area Code Number Area Code Number

Name of your Primary Physician ______________________________

Primary Physician Address: ______________________________
NUMBER & STREET CITY STATE ZIP CODE

Primary Physician Phone #:____________________

Have you ever been seen or treated by a physician at Danville Orthopedic Clinic? ☐Yes ☐No

Have you ever participated in a clinical research study? ☐Yes ☐No

If Yes, location/Center:______________

Date of the last study completion: ______________________________

Study Indication(s) that you are most interested in:

- ☐ Acute Ankle Sprains
- ☐ Acute and Chronic Pain Conditions
- ☐ Diabetes
- ☐ Dyslipidemia/High Cholesterol
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack Prevention
- ☐ Hypertension
- ☐ Low Back Pain
- ☐ Lupus
- ☐ Migraines/Headaches
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Other:______________

Danville Orthopedic Clinic, Inc

Patient Current Medications/Drug Allergies-Intolerance

Name: ______________________________________DOB: ___________DATE: _____________

DRUG ALLERGIES/INTOLERANCE	REACTION

Name of Current Medication	Dose/Route/Frequency	Start Date	Indication/Medical Condition

SOCIAL HISTORY: ☐ Married ☐Single ☐ Divorced ☐ Separated

Occupation: ________________________Spouse's Occupation: _________________________

SMOKING & DIETARY HISTORY:

Have you ever used any tobacco products? ☐Yes ☐No If yes, how long? ____________

How many per day? ____________ Date you quit (if applicable): __________________

Type used? ☐cigarettes ☐cigars ☐pipe ☐chewing tobacco ☐other, specify____________

Estimate weekly alcohol beverages (beer, wine, mixed drinks) use: _________________

Estimate cups of coffee, tea, and / or colas per day: _________________cups

Are you on a special diet (i.e., low salt, low cholesterol, vegetarian)? ☐Yes ☐No

specify____

REPRODUCTIVE STATUS:

☐Male ***Some studies require that males with spouse/partner that is able to become pregnant, use an effective method of birth control while participating in the study. The study doctor must be informed if the partner becomes pregnant.***

☐ Spouse/Partner is potentially able to bear children

☐ Spouse/Partner is not able to bear children. Specify:_____________________________

☐Female

Are you of child bearing potential? ☐Yes ☐No

If Yes, subject must agree to use systemic contraception (oral contraceptives, depo, implant, trandermally delivered (ortho Evra), IUD, vaginal contraceptive, or diaphragm plus spermicide; diaphragm plus male condom, or male condom plus spermicide). Specify:____

If No, Reason: ☐Non surgical: post-menopausal x _________years

☐ Surgical

☐ Hysterectomy ☐Salpingo-oophorectomy ☐ bilateral tubal ligation

PAST HOSPITALIZATIONS OR SURGERIES:

Surgery/Hospitalization (Reason)	Date	Location

MEDICAL HISTORY

SYSTEM	None (Check Box)	Diagnosis (description of problem)	Start Date	Comment
Allergic/Immunologic	☐			
Cardiovascular (Heart)	☐			
Dermatological (skin)	☐			
Ear, Nose, Throat	☐			
Eyes	☐			
Endocrine (Diabetes)	☐			
Gastrointestinal (Stomach or Intestines)	☐			
Genitourinary (kidney/urinary, genitalia)	☐			
Hematologic (anemia, blood)	☐			
Musculoskeletal (bones, joints, etc)	☐			
Neurological	☐			
Psychiatric (anxiety, depression, bipolar)	☐			
Respiratory (lungs)	☐			
Other, specify	☐			

Danville Orthopedic Clinic, Inc.
Request for Release of Medical Records

Patient Name_________________________________

Date of birth: _________________________________

I, ___________________________, hereby request that my medical records be released to :

Danville Orthopedic Clinic, Inc.
125 Executive Drive, Suite A
Danville, VA 24541
Fax (434)792-5265
Attn: April Marshall, RN, CCRC

Specific documents being requested:

- History & Physical,
- Lab results
- Discharge summary
- Radiology reports
- Other____

____

Patient Signature

____

Date of signature

(Expires 2 years from date of signature)