Name:
DOB:
Chart:
Age:
Date:

Patient Information

Account # _____ **Patient Name** **Social Security Number**	**Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Address	**Patient Sex**
City, State & Zip Code	**Date of Birth** _____ **Age** _____
FOR MEDICARE PATIENTS ONLY Do you currently reside in a Skilled Nursing Facility? ☐ Yes ☐ No	**Emergency Contact Name & Phone** **Relationship to Patient:**
Employment / Student Status: ☐ Full time employed ☐ Full time student ☐ Part time employed ☐ Part time student ☐ Unemployed ☐ Retired	**Employer Name & Address** **Occupation:**
Referring Physician: **Family Physician:** _____	**Email Address (please print)** **Married** ☐ **Single** ☐ **Other** ☐ **Spouse's Name**
Patient Smoking Status: ☐ **Current Everyday Smoker** ☐ **Current Someday Smoker** ☐ **Smoker, current status Unknown** ☐ **Never Smoker** ☐ **Former Smoker** ☐ **Unknown if ever Smoker** **Ethnicity of Patient:** ☐ **Hispanic Origin** ☐ **Non Hispanic Origin** ☐ **Unknown** ☐ **Declined to answer**	**Race of Patient:** ☐ **American Indian/ Alaskan Native** ☐ **Asian** ☐ **Black/ African American** ☐ **Native Hawaiian/ Other Pacific Islander** ☐ **White** ☐ **Unknown** ☐ **Declined to answer** **Preferred Language of Patient:** ☐ **English** ☐ **Spanish** ☐ **Other** _____
In compliance with the American Recovery and Reinvestment Act of 2009 (ARRA) to demonstrate Meaningful Use, we are required to capture demographic data including your preferred language, race and ethnicity.	

Financially Responsible Person (if different from above)

Full Name **Address** **City, State & Zip Code** **Date of Birth** _____	**Social Security Number** _____ **Home Telephone #** _____ **Work Telephone #** _____ **Cell Telephone #** _____
Employer Name	**Relationship to the Patient (circle one)** Self Spouse Child Parent Other

Date Reviewed _____ Initials _____

Name:
DOB:
Chart:
Age:
Date:

Insurance Company Information

Primary Insurance Company Name		Secondary Insurance Company Name	
Address, City, State & Zip		**Address, City, State & Zip**	
Policy Holder	**Date of Birth**	**Policy Holder**	**Date of Birth**
Policy Holder Employer	**Policy Holder SSN**	**Policy Holder Employer**	**Policy Holder SSN**
Policy Number	**Group Number**	**Policy Number**	**Group Number**
Relationship to the Patient (circle one) Self Spouse Child Parent Other		**Relationship to the Patient (circle one)** Self Spouse Child Parent Other	

Appointment Information:

Patient Name: _____ **Account #:** _____

Name of physician to see today: _____

Name of physician who referred you here today: _____

Body area being seen for today: _____

Problem? ☐ **Yes** ☐ **No** **Date problem began** _____
Injury? ☐ **Yes** ☐ **No** **Date of Injury** _____
Work Injury ☐ **Yes** ☐ **No** **Date of Injury** _____
Auto Accident ☐ **Yes** ☐ **No** **Date of Accident** _____ **State of Accident** _____

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Orthopaedic Specialists of Northwest Indiana, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Signature _____ Date _____

Medicare Patients

If you are covered by Medicare, please read and sign the following:
In Medicare cases, Orthopaedic Specialists of Northwest Indiana, agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Signature _____ Date _____

Workers Compensation

I authorize Orthopaedic Specialists of Northwest Indiana to release medical information regarding my treatment and work status to my employer and / or any persons involved with my case through my employer's worker's compensation carrier. I understand that I am responsible for all fees, including collection, attorney, and any court costs, if the injury is determined to be non-compensable under worker's compensation laws.

Signature _____ Date _____

Name:
DOB:
Chart:
Age:
Date:

PATIENT AGREEMENTS AND AUTHORIZATIONS

Please review each statement below and initial next to each, indicating your understanding and agreement with the statement.

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by **Orthopaedic Specialists of Northwest Indiana** (the "Practice"), and its employees or designees. The details of the procedure, including the anticipated benefits and material risks have been explained to me in terms I understand. I have had the opportunity to ask questions regarding my treatment and, if I had any questions, they were answered to my satisfaction. Moreover, alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. _____

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE: I understand and agree that in consideration for the services rendered to me by the physicians or other staff at the Practice, I am obligated to pay the Practice's account in accordance with the regular rates and terms of the Practice. In consideration for the services rendered to me by physicians or other staff the Practice, I hereby transfer and assign the Practice all rights, title and interests in any payment due to me for services described herein. The Practice may disclose all or any part of my record for all or part of the Practice's charge, including but not limited to medical service companies, insurance companies, workers' compensation carriers, welfare funds or my employer. _____

I understand that certain insurance claims may be filed as a courtesy. I certify that I have active and valid insurance coverage and have supplied the Practice with the up-to-date and current insurance information. However, if a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the Practice for services rendered to me. Some companies pay fixed allowances for certain procedures and other pay a percentage of the charges. I understand it is my responsibility to pay any co-payment, deductible, co-insurance, or any other balance not paid for by my insurance or third party payor within a reasonable period of time not to exceed 60 days. I understand that there is a $30.00 fee for returned checks and a late payment charge not to exceed 1.5% applied to any balanced carried forward to the following month's bill. Should the account be referred to an attorney or third party for collections, I agree to pay reasonable attorneys' fees and collection expense. _____

PRIVACY POLICY: I acknowledge having received the Practice's Notice of Privacy Practice ("Notice"). My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Notice. The Notice tells me how the Practice may use my health information for treatment, payment for my treatment, and the Practice's healthcare operations. The Notice explains in more detail how the Practice may use and share my health information for other than treatment, payment, and healthcare operations. I understand and acknowledge that the Practice may use and share my health information as required, or permitted, by law. _____

NAME, ADDRESS, & TELEPHONE NUMBER	PURPOSE OF DISCLOSURE	SPECIFIC INFORMATION THAT MAY BE DISCLOSED	EXPIRATION DATE
	☐ At the request of the patient. ☐ Other:		☐ On a specific date: _____ ☐ Upon the occurrence of a specific event: _____ ☐ None
	☐ At the request of the patient. ☐ Other:		☐ On a specific date: _____ ☐ Upon the occurrence of a specific event: _____ ☐ None
	☐ At the request of the patient. ☐ Other:		☐ On a specific date: _____ ☐ Upon the occurrence of a specific event: _____ ☐ None

Name:
DOB:
Chart:
Age:
Date:

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. I understand that information disclosed under this authorization might be re-disclosed by the recipient and this re-disclosure may no longer be protected by federal or State law. I understand that I may revoke this authorization by written request to the person listed in the Practice's Notice of Privacy Practices, except to the extent that action has already been taken based on this authorization. _____

Patient's Full Legal Name		**Date of Birth**
Signature of Patient/Legal Representative	**Name of Legal Representative, if applicable**	**Date**
Name of Witness	**Signature of Witness**	**Date**

☐ Patient unable to sign. Verbal consent given. The reason for the inability to sign is set forth below:

FOR OFFICE USE ONLY

Documentation of Failure to Obtain Signed Acknowledgement

On _____ (date), _____ (name of Practice Employee) presented this Patient Agreements and

Authorizations Form to _____ (the "Patient"). The Patient refused to initial or provide a signature when requested.

*******Office: Please retain a copy of this form for six (6) years.*******

ORTHOPEDIC SPECIALISTS of Northwest Indiana

MEDICAL HISTORY: INITIAL

PATIENT NAME: _____ **DATE:** _____

OCCUPATION: _____ **DATE OF BIRTH:** _____ **AGE:** _____

CHIEF COMPLAINT: What problem are you being seen for today?

_____

_____

HISTORY OF PRESENT ILLNESS: NP PT (L2…1), (L3, L4…4); EST. PT. (L2-3…1); (L4…3-4 CHRONIC CONDITIONS)

When did your problem start: (DATE OR MONTH/YEAR)? _____

If there was an INJURY, on what date did it occur? _____ ☐ No Injury

If there was a specific INJURY, please describe what happened: _____

_____

Did your problem OCCUR AT WORK? ☐ YES ☐ NO; I**f yes, is there a workman's comp claim?** ☐ YES ☐ NO

Were you seen in the ER for this problem? ☐ YES ☐ NO; **If yes, which ER?** _____

Did a physician refer you here? ☐ YES ☐ NO **REFERRING PHYSICIAN:** _____

PRIMARY CARE PHYSICIAN: _____ **CARDIOLOGIST:** _____

Other Specialist(s): _____ **Did they evaluate this problem?** ☐ YES ☐ NO

What tests/treatments have you had for this problem? ☐ X-rays ☐ MRI ☐ CT ☐ Bone Scan ☐ Ultrasound ☐ Physical Therapy ☐ Medications ☐ Previous Surgery ☐ Other: _____

Since my problem started it is: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

Has your problem kept you from: ☐ Working ☐ Recreational Activities ☐Activities of Daily Living

I experience: ☐ Pain ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Locking ☐ Locking ☐ Catching ☐ Instability ☐ Swelling ☐ Stiffness ☐ Other: _____

If you have pain, how would you describe the type of pain? ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Burning ☐ Other: _____

On a scale of 1-10 (10 is the worst) how severe is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms WORSE? ☐ Walking ☐ Stairs ☐ Exercising ☐ Twisting ☐ Kneeling ☐ Direct Pressure ☐ Standing ☐ Sitting ☐ Lying Flat ☐ Bending ☐ Lifting ☐ Cough/Sneezing

What makes your symptoms BETTER? ☐ Rest ☐ Limiting Movement ☐ Sitting ☐ Lying ☐ Standing ☐ Exercise/Movement ☐ Elevation ☐ Ice ☐ Heat ☐ Compression ☐ Bracing ☐ Injections ☐ Pain Pills ☐ Other: _____

PAST MEDICAL HISTORY:

List CURRENT MEDICATIONS: (Dose and Frequency) ☐ **NONE; or** ☐ **IF > 10 MEDICATIONS, SEE ADDITIONAL SHEET**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient Name: _____

Date of Visit: _____

_____

List recently DISCONTINUED or UNSUCCESSFUL MEDICATIONS related to current problem:

_____ _____

_____ _____

_____ _____

List ALLERGIES (TO MEDICATIONS):☐ NONE

_____ _____

_____ _____

_____ _____

Other Allergies? ☐ Latex ☐ Food ☐ Seasonal ☐ Other: _____

Have you ever had an ADVERSE REACTION TO ANESTHESIA? ☐ YES ☐ NO

If yes, explain: _____

Do you have a history of any of the following MEDICAL PROBLEMS? (Please "X" all that apply)

If NONE of the below apply, then mark (this): ☐ NONE

BONES/JOINTS
- ☐ Fracture Surgery
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Gout

CIRCULATION
- ☐ Blood Clots/DVT
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Sickle Cell Anemia

LUNG
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Embolism

HEART
- ☐ Heart Disease
- ☐ Stents
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Surgery

DIGESTIVE
- ☐ Heartburn
- ☐ Reflux
- ☐ Ulcers
- ☐ Liver/Hepatitis
- ☐ Colitis

KIDNEY
- ☐ Infection
- ☐ Stones
- ☐ Dialysis
- ☐ Nephrectomy

CURRENT INFECTION
- ☐ Upper Respiratory
- ☐ Pneumonia
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ HIV/Aids
- ☐ Tuberculosis

GLANDS
- ☐ Prostrate
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Thyroid

NEURO/PSYCH
- ☐ Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Multiple Sclerosis
- ☐ Drug or Alcohol Abused

EYE & EAR
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retina Disease
- ☐ Hearing Aid

OTHER:

☐ Cancer; if yes, what type? _____

☐ Transplant Surgery; ☐ Sexually transmitted disease; ☐ _____

List all past surgeries and include date (if recent) or year: ☐ NONE; or ☐ IF > 6 PROCEDURES USE ADDITIONAL SHEET

_____ _____

_____ _____

_____ _____

OB/GYN - MENSTRUATING: ☐ YES ☐ NO If NO, ☐ Post-Menopause ☐ Hysterectomy at age: _____ ☐ Pregnant

Patient Name: _____

Date of Visit: _____

REVIEW OF SYSTEMS: NEW PT. (L2…PERT), (L3=2 ...L4=10) EST. PT. (L2 … N/A) (L3…PERTINENT) (L4=2)

Have you recently had any of these symptoms? (Please "X" all that apply)

If NONE of the below apply, then mark (this) ☐ NONE

BONES/JOINTS
- ☐ Osteoporosis
- ☐ Joint Problems
- ☐ Previous Fractures
- ☐ Recent Gout

CARDIAC
- ☐ Chest Pain
- ☐ Irregular Beat
- ☐ Calf Pain
- ☐ Swelling Feet/Ankles

NEURO
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Frequent Falls

KIDNEY/BLADDER
- ☐ Painful Urination
- ☐ Kidney Problems
- ☐ Urinary Infections
- ☐ Incontinence

EAR, NOSE, THROAT
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Difficulty Swallowing
- ☐ Ringing in ears

EYE
- ☐ Blurred Vision
- ☐ Vision Loss
- ☐ Double Vision

BLOOD
- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Anemia

GLANDS
- ☐ Lymph Edema
- ☐ Excessive Thirst
- ☐ Always Hot/Cold

SKIN
- ☐ Frequent Rashes
- ☐ Open Wounds
- ☐ Itchy/Dry

PSYCH
- ☐ Depression
- ☐ Drug/Alcohol Abuse
- ☐ Anxiety

LUNG
- ☐ Short of Breath
- ☐ Wheezing/Asthma
- ☐ Chronic Cough

CONSTITUTIONAL
- ☐ Recent Weight Loss
- ☐ Frequent Fever
- ☐ Loss of Appetite

DIGESTIVE
- ☐ Heartburn/Ulcers
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Constipation

FAMILY HISTORY: NEW PT. (L2…N/A) (L3=1) (L4=3) EST. PT. (L2, L3=N/A) (L4=1)

☐ No significant medical history of any direct relatives. **☐ Adopted & family history is not known**

List any significant medical problems in your family: (examples: Diabetes, heart disease, Cancer, Arthritis, inherited genetic conditions … of your direct relatives)

MOTHER: _____ **FATHER:** _____

GRANDPARENTS, SIBLINGS, CHILDREN: _____

SOCIAL HISTORY: (CODING BULLETS INCLUDE FAMILY HISTORY)

Do you smoke or use tobacco? ☐ YES ☐ NO

If YES, packs/Day: _____ Years: _____ (or) Quit after _____ Years

Alcohol History (circle one): None Rare Social Daily (quantify): _____

Are you currently working? ☐ YES ☐ NO If yes, Job Title: _____

☐ Disabled ☐ Retired ☐ Unemployed Employer: _____

☐ Student at: _____What Grade Level? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed Children: ☐ YES ☐ NO **Number of Children:** _____

_____ _____

Patient Signature **Date**

(The information on this form is accurate to the best of my knowledge)

_____MD/RN Initials