

1 PATIENT INFORMATION

Date _____

Patient _____
Last First Middle

Name you go by _____

Address _____

City State Zip

Home Phone _____ Cell Phone _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient Social Security # _____

Responsible Party Information

Occupation _____

Employer _____

Employer Address _____

Employer Phone # _____

Spouse's Name _____

Birthdate _____ Soc. Sec. # _____

Occupation _____

Spouse's Employer _____

3 EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT (Not in same household)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

4 ACCIDENT DETAILS

Date & Time of Accident _____

Place Accident Occurred _____

Is this a Work Related Injury? _____ Auto? _____ Other? _____

Details of Accident _____

Please note if any Liability Insurance involved (Auto, Homeowners, Liability) _____

Name, Address & Phone Number of Attorney (if one is representing you in this accident) _____

Do we have authorization to release information to the above listed attorney? Yes No

Signature _____ Date _____

2 INSURANCE

Insured Name (as appears on insurance card) _____

Relationship to Patient _____

Policyholder's Name _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____

Policyholder's Employer _____

Address _____

Phone# _____

Is patient covered by additional insurance? Yes No

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Midwest Orthopedic Specialists for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. In Medicare assigned cases, they physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are determined by the Medicare carrier.

Signature _____

Date _____

ASSIGNMENT AND RELEASE

I, the undersigned, hereby AUTHORIZE Midwest Orthopedic Specialists to furnish information to insurance carriers and/or healthcare facilities concerning my illness or treatments. I also assign any benefits to Midwest Orthopedic Specialists for services rendered by the physician (s). I understand that I am responsible for any amount not covered by insurance.

I understand that payment in full is due upon the rendering of services. If the account becomes delinquent and is referred to a collection agency and/or attorney, the undersigned agrees to pay all collection agency fees, attorney's fees, and expenses. If a suit is filed to enforce collection, it may be filed in the county where this Agreement is being signed and entered into.

Signature _____

Date _____

HISTORY FORM

-All information is strictly confidential-

Name _____

Age _____ Ht. _____ Wt. _____

Reason for your office visit today _____

Who recommended our office to you? _____

What was the date of onset? _____ Is this recurrent, chronic, new (circle)?

What makes your problem better/worse? _____

Describe your discomfort (i.e.: sharp, dull, numb, aching, other)? _____

Is this mild, moderate, severe? _____

What have you tried to relieve your symptoms? _____

What are your other medical problems: _____

List all surgeries: _____

List all medications (including herbal) and doses: _____

List any medical allergies _____

Pharmacy name _____

How much tobacco do you use? _____

How much alcohol do you drink? _____

What was/is your job? _____

Who lives in your home with you? _____

Describe any problem with anesthesia: _____

Check symptoms/disease you currently have or had in IN THE PAST YEAR:

GENERAL

- Depression/nervousness
- Dizziness/fainting
- Headaches
- Loss of weight
- Sweats/fever HIV
- Bleeding disorder

GASTROINTESTINAL

- Poor appetite
- Indigestion
- Hepatitis
- Rectal bleeding
- Vomiting blood
- Ulcers

HEENT

- Blurred vision
- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Sinus problems
- Glaucoma

ENDOCRINE

- Diabetes
- Thyroid problems

PULMONARY

- Tuberculosis
- Emphysema
- Asthma

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Fibromyalgia
 - Back Rheumatoid disease
 - Feet Osteogenesis
 - Hands imperfection
 - Hips Gout
 - Legs Osteoporosis
 - Neck
 - Shoulders

CARDIOVASCULAR

- Chest pain
- High/low blood pressure
- Irregular/rapid heart beat
- Swelling of ankles
- Varicose veins/blood clots
- Heart disease
- Pacemaker
- Cholesterol

SKIN

- Bruise easily
- Change in moles
- Thick scarring
- Sores that won't heal

NEUROLOGICAL

- Seizure disorder
- Stroke
- Migraine headaches
- Multiple sclerosis
- Polio

CANCER

- Thyroid Prostate
- Myeloma Breast
- Leukemia Kidney
- Lung Skin

GENITO-URINARY

- Frequent urination
- Lack of bladder control
- Painful urination
- Prostate problems

Circle illnesses which have occurred in your immediate family

- Arthritis - Type _____ Bleeding frequency
- Diabetes Heart Disease
- Stroke
- Nervous illness
- Other _____

LIST IMMEDIATE FAMILY IF DECEASED AND CAUSE OF DEATH _____

I certify that the above information is correct to the best of knowledge. I will not hold Midwest Orthopedic Specialists, Inc. or any member(s) of the staff responsible for any errors or omissions that I may have made in the completion of the form.

SIGNATURE _____ **DATE** _____