Name:
DOB:
Chart:
Age:
Date:

ORTHOPAEDIC SPECIALISTS of Northwest Indiana

Patient Medical History

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Have you ever been treated for this problem before? ☐ Yes ☐ No

Date of Injury/ Onset of problem _____

Current problem is a result of: *Check all that apply:*

☐ Car Accident ☐ Work Accident ☐ Other *(specify)* _____

MEDICAL HISTORY

Are you currently receiving treatment or have you received treatment in the past for any of the following conditions?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Epilepsy	☐	☐	Kidney Problems	☐	☐	Pulmonary Embolism
☐	☐	Arthritis	☐	☐	Gallbladder Problems	☐	☐	Liver Disease	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Gout	☐	☐	Lung Problems	☐	☐	Sexually Transmitted Disease
☐	☐	Birth Defects	☐	☐	Heart Disease	☐	☐	Phlebitis			
☐	☐	Bladder Problems	☐	☐	Hepatitis	☐	☐	MRSA / Staph Infection	☐	☐	Stroke / TIA
☐	☐	Bleeding or Bruising	☐	☐	HIV / AIDS	☐	☐	Osteoporosis	☐	☐	Tuberculosis
☐	☐	Cancer Type _____	☐	☐	High Blood Pressure	☐	☐	Peripheral Vascular Disease	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	High Cholesterol				☐	☐	Ulcer Type _____
☐	☐	DVT / Blood Clots	☐	☐	Intestinal/ Bowel Problems	☐	☐	Polio			
						☐	☐	Psychological problems			

Are there any other medical problems we should know about? _____

Are you right or left-hand dominant? ☐ Right ☐ Left

Are you or could you be pregnant? ☐ Yes ☐ No

Do you exercise or participate in sports regularly? ☐ Yes ☐ No

Type and Frequency: _____

MEDICATIONS

Please list all medications you take with or without a prescription (use extra paper if needed)

Medication Name	Dosage / # per day	Reason for taking

ALLERGIES

Please describe any current or past allergic reactions

Allergy to (drug)	Reaction (itching, cough, hives, etc)	How was / is the reaction treated?

☐ I DO NOT have any allergies

SURGERIES AND HOSPITALIZATIONS

☐ Arthroscopy _____ Year _____ Physician _____ Complication? _____

☐ Joint replacement _____ Year _____ Physician _____ Complication? _____

☐ Bone or joint reconstruction _____ Year _____ Physician _____ Complication? _____

☐ Spine surgery _____ Year _____ Physician _____ Complication? _____

☐ Other general surgery _____ Year _____ Physician _____ Complication? _____

_____ Year _____ Physician _____ Complication? _____

☐ Other hospitalizations _____ Year _____ Physician _____ Complication? _____

☐ I HAVE NOT HAD any surgeries or hospitalizations

Name:
DOB:
Chart:
Age:
Date:

FAMILY HISTORY

Have your mother, father, grandparents, brothers or sisters been treated in the past or are they currently receiving treatment for any of the following conditions?

Yes	No		Yes	No		Yes	No		
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	Osteoporosis	Other _____
☐	☐	Arthritis	☐	☐	Gout	☐	☐	Stroke	_____
☐	☐	Cancer	☐	☐	Heart Disease	☐	☐	Sudden Death	_____

SOCIAL HISTORY

Do you smoke or chew tobacco? ☐ Yes ☐ No Number: ____ packs per day for _____ years
Do you drink alcoholic beverages? ☐ Yes ☐ No Amount and frequency: _____
Do you use recreational drugs? ☐ Yes ☐ No Type and frequency: _____

REVIEW OF SYSTEMS *Please check the following symptoms you have experienced on a regular basis:*

GENERAL
☐ Fever
☐ Weight change
☐ Hormonal problems
☐ Other _____
☐ NONE

CARDIOVASCULAR
☐ Chest pain
☐ Palpitations
☐ Fluid/ Swelling in extremities
☐ Other _____
☐ NONE

KIDNEY/ BLADDER
☐ Painful urination
☐ Frequent urination
☐ Incontinence
☐ Other _____
☐ NONE

EYES
☐ Glasses/ Contacts
☐ Cataracts
☐ Glaucoma
☐ Other _____
☐ NONE

RESPIRATORY
☐ Shortness of breath
☐ Sleep apnea
☐ Wheezing
☐ Other _____
☐ NONE

EARS, NOSE, THROAT
☐ Difficulty swallowing
☐ Ear pain
☐ Seasonal allergies
☐ Hard of hearing
☐ Other _____
☐ NONE

GASTROINTESTINAL
☐ Heartburn
☐ Diarrhea/ Constipation
☐ Abdominal pain
☐ Nausea/ vomiting
☐ Other _____
☐ NONE

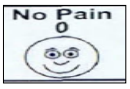
SKIN
☐ Rashes
☐ Lumps
☐ Other _____
☐ NONE

HEMATOLOGIC/ LYMPHATIC
☐ Anemia
☐ Blood problems
☐ Clotting disorder
☐ Lymph Problems
☐ Other _____
☐ NONE

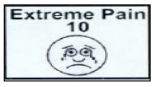
NEUROLOGICAL
☐ Headaches
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Other _____
☐ NONE

PSYCHOLOGICAL
☐ Anxiety
☐ Depression
☐ Mood swings
☐ Other _____
☐ NONE

Pain Scale - If you are having pain, please rate the intensity of your pain on a scale of 1 -10.



1 2 3 4 5 6 7 8 9



Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Name:
DOB:
Chart: Date:
Age:

PLEASE PRINT

TODAY'S DATE	**PATIENT REGISTRATION**	PT. ID:

PATIENT INFORMATION

LAST NAME				FIRST NAME & INITIAL			
PATIENT SS#		SEX	(Sex unknown)	DATE OF BIRTH			
LANGUAGE		MARITAL STATUS		RACE			
ADDRESS							
CITY				STATE		ZIP	
HOME PHONE		WORK PHONE		CELL PHONE		EMAIL ADDRESS	
EMPLOYER		EMLPOYER'S ADDRESS					
OCCUPATION				EMPLOYMENT STATUS	FULL TIME / PART TIME / RETIRED / STUDENT		
SPOUSE'S NAME							
WORK PHONE				SPOUSE'S CELL PHONE			
EMPLOYED	Y / N	EMPLOYER NAME					

RESPONSIBLE PARTY/GUARANTOR

RESP PARTY LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
CITY				STATE		ZIP	
SOCIAL SECURITY #				SEX	MALE / FEMALE	DATE OF BIRTH	
RESP PARTY EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							
HOME PHONE		WORK PHONE		CELL PHONE			

PRIMARY INSURANCE

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
POLICYHOLDER SS#				SEX	MALE / FEMALE	DATE OF BIRTH	
EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							

SECONDARY INSURANCE

POLICYHOLDER LAST NAME		FIRST NAME & INITIAL		RELATIONSHIP			
ADDRESS							
POLICYHOLDER SS#				SEX	MALE / FEMALE	DATE OF BIRTH	
EMPLOYER				EMPLOYER PHONE		EXT.	
EMPLOYER ADDRESS							

EMERGENCY CONTACT INFO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU				RELATIONSHIP	
ADDRESS					
HOME PHONE		WORK PHONE		CELL PHONE	

Name:
DOB:
Chart: Date:
Age:

Authorization for Treatment - I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis - I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employers workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information. I will be held personally responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits / Financial Obligation - In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments - I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	Date

I give consent and authorization to release my medical information to the following:

_____ (Name/ Relationship)
_____ (Name/ Relationship)
_____ (Name/ Relationship)

I give consent and authorization to release my billing information to the following:

_____ (Name/ Relationship)
_____ (Name/ Relationship)
_____ (Name/ Relationship)

(Section 2) AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be clone in writing, except to the extent that action has already been taken in reliance on the consent.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

I understand I may revoke the privilege listed in (Section 1) and (Section 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature _____ DATE _____

ADVANCED DIRECTIVE

Have you appointed a Health Care Representative? yes___ no___ Do you have a living will? yes___ no___
Have you given anyone your Power of Attorney? yes___ no___