REGISTRATION SHEET

Dr.________________________________ Date________________

PATIENT INFORMATION

Name________________________________ Date of Birth (mo) ______ (day) ______ (yr) ______

Home Phone # ________________________________

Address ________________________________ Cell Phone # ________________________________

City/State ____________________Zip_________ Work Phone # ________________________________

Sex: ☐ Male ☐ Female Email Address:________________________________

Are you a Student? ☐ Full-time ☐ Part-Time Marital Status ☐Married ☐ Single ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No Emergency Contact ________________________

Employer________________________________ Emergency Daytime Phone # ____________________

Address ________________________________ Pharmacy Name # ________________________

Pharmacy Phone # ________________________

BILLING INFORMATION (IF DIFFERENT THAN PATIENT)

Bill to Name________________________________ Relationship to Patient________________________

Address________________________________ Home Phone# ______________Work#____________

City, State, Zip________________________________ Date of Birth (mo)_______(day)_______(yr)________

HEALTH INSURANCE INFORMATION

PRIMARY (If you are not the policyholder, please complete the section below.)

Insurance Company Name____________________ Relationship to Patient________________________

Name of Policyholder________________________ Employer________________________________

Date of Birth (mo)_______(day)_______(yr)______ Employment Status: ☐ Active ☐ Retired

Sex: ☐☐ Male ☐ Female

SECONDARY (If you are not the policyholder, please complete the section below.)

Insurance Company Name ____________________ Relationship to Patient________________________

Name of Policyholder________________________ Employer________________________________

Date of Birth (mo)______(day)_______(yr)_______ Employment Status: ☐ Active ☐ Retired

Sex: ☐☐ Male ☐☐ Female

In compliance with Orthopedic Associates' participation in a government program on patient quality of care we ask that you provide the following information (please note that you have the option to decline to answer these questions)

Race: ☐African-American ☐ Asian ☐ American Indian ☐ Caucasian ☐ Hispanic ☐Native Hawaiian ☐ Other Race

Preferred Language: ____________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

FINANCE AGREEMENT

I understand that I am financially responsible for all charges whether or not paid by insurance.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Orthopedic Associates, S.C. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

CO-PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED

Signature____ **Date**____________________

(If Minor – Parent or Guardian Signature)

Orthopaedic History

Name: ______________________ **Today's Date:** ______________________

SS#: ______________________ **Date of Birth:** ______________________

Medications you take: (*please list all*) ☐ None

Medication	Dosage and Frequency	Reason For Taking

Herbal Supplements you take: ______________________

ALLERGIES to Medications: (*please list all*) ☐ No Known Allergies

____

____

Allergic to metal? ☐ Yes ☐ No

If yes, which type? ______________________

Are all immunizations up to date? ☐ Yes ☐ No

If no, Which immunizations are due? ______________________

Medical History: (*please check all that apply*) ☐ None apply

☐ Heart attack
☐ Heart failure
☐ Heart murmur
☐ High blood pressure
☐ Stroke
☐ Diabetes
☐ High cholesterol
☐ Rheumatoid arthritis
☐ Liver trouble
☐ Lupus
☐ GERD
☐ Cancer: __________
☐ Osteoporosis
☐ Asthma
☐ Tuberculosis
☐ Emphysema
☐ Lung disease
☐ Blood vessel disease
☐ Osteoarthritis
☐ Mental illness
☐ Sleep apnea
☐ ADHD / ADD
☐ Gout
☐ Other: ______________________
☐ Stomach ulcers
☐ Kidney stones
☐ Kidney failure
☐ Transplants
☐ Chemical abuse
☐ Alcohol dependence
☐ HIV positive / AIDS
☐ Hepatitis
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Hyperlipidemia
☐ Phlebitis
☐ Blood clots in legs
☐ Blood clots in lungs
☐ Bleeding disorders
☐ Scarring tendency
☐ Sickle cell disease
☐ Peripheral neuropathy
☐ Peripheral arterial disease
☐ Peripheral vascular disease
☐ Coronary artery disease
☐ Herniated disc
☐ Spinal stenosis

Surgical History: ☐ None

Operation (*exclude child birth*)	Date or Approx. Age	Surgeon	Hospital

History of anesthesia problems: ______________________ ☐ None

Surgical Complications: (*ie: Infection*) ______________________ ☐ None

Other Hospitalizations: (*not for surgery*) ☐ None

Reason	Date or Approx. Age

Other Major Illness or Injury: ☐ None

Description	Date or Approx. Age

Family History: (*please check all that apply*) ☐ None apply

Condition	Which Family Member	Condition	Which Family Member
☐ Heart disease		☐ Scoliosis	
☐ Stroke		☐ Spinal problems	
☐ High blood pressure		☐ Kidney failure	
☐ Diabetes		☐ Mental illness	
☐ Osteoporosis		☐ Bleeding/Blood clots	
☐ Rheumatoid arthritis		☐ Anemia	
☐ Osteoarthritis		☐ Alcohol dependence	
☐ Lupus		☐ Cancer of:	
☐ Sickle cell disease		☐ Other: (*list*)	

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Do you have children? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Describe the type of work you do: ____________________

Are you or could you possibly be pregnant? (*women only*) ☐ Yes ☐ No

Risk Factors *Patients 13 years old and over*

Do you smoke or use tobacco? ☐ Everyday ☐ Occasionally ☐ Former ☐ Never

Do you drink alcohol? ☐ Yes ☐ No How many drinks per day? ____________________

Do you exercise regularly? ☐ Yes ☐ No How often? ____________________

What is your primary exercise activity? ____________________

____________________ Date: ____________

Signature of Patient (or Guardian if minor)

Reviewed by: ____________________ M.D./D.O. Date: ____________

PATIENT QUESTIONNAIRE

☐ Initial Visit ☐ New Problem ☐ Recurrent Problem

PATIENT NAME:______________________________ **AGE:**__________

PHYSICIAN: ☐ Dr. Kim ☐ Dr. Sladek ☐ Dr. Moss

Who is your primary care physician? Name:____________________**City:**__________

Whom may we thank for referring you to our practice?______________________________

1. Date of ☐ illness ☐ accident or ☐ injury: Mo_______Day______Year________

2. What part of your body are you being seen for ?________________ ☐ Left ☐ Right

3. Where did the accident or injury happen? ☐ work ☐ auto accident ☐ home

   ☐ other please specify: ____

4. How did the accident or injury happen? ______________________________________

   ____

5. Have you been treated for this problem somewhere else? ☐ Yes ☐ No

   If yes, where?____________________________When?________________________

6. Did you bring x-rays with you today? ☐ Yes ☐ No

   Where were the x-rays taken? ☐ NWCH ☐ Treatment Center (which one) ___________

   ☐ Other, please specify ____

Signature____**Date**______________

Request for Confidential Communication

I, ________________________, hereby request Orthopedic Associates, SC
(Name of Patient or Authorized Agent)

to keep communications regarding my protected health information confidential. To accomplish this request please adhere to the following requests:

Phone: You can contact me by phone at ___________________________

Leave messages on answering machine: ____ Yes ____ No

Leave message with any other person: ____ Yes ____ No

FAX: ____ Please do not contact me by FAX

____ Please contact me by FAX at ______________________

May we discuss your protected health information with any family members?

____ Yes Name and relationship__________________________________

____ No

Other Requests for Confidential Communications: ______________________________

____

____

This request may be changed or revoked by filing a new request or revoking this one in writing.

Signed: ____ Date: ___________________

If you are not the patient, please specify your relationship to the patient: ___________________

– Patient's file

ORTHOPEDIC
ASSOCIATES, S.C.
415 W. GOLF RD., SUITE 68 ARLINGTON HEIGHTS, IL 60005 (PHONE) 847-593-5511 (FAX) 847-593-0872

CANCELLATION AND NO-SHOW POLICY

The staff at Orthopedic Associates would like to thank you for choosing us as your provider. We understand that sometimes events beyond your control will force you to miss your appointment.

In order that we can provide you and all of our patient's with the best service possible, we ask that you adhere to the following:

- If you arrive more than **15 minutes** late we may need to reschedule your appointment.
- If you need to cancel an appointment, please give us 24 hours notice by calling 847-593-5511, if no-one answers, please leave a message on our voice mail.
- You may be charged a fee of **$25.00-$50.00** (depending on the appointment type) for no-shows or cancellations without 24 hours' notice. This amount will be charged directly to you, not your insurance company.

Your understanding and cooperation is appreciated.

I have read and understand this policy.

____
Patient's Name (Please Print)

______________________________ ____/____/____
Signature of patient/policyholder Date Signed

____
Relationship, if not patient