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**PATIENT INFORMATION SHEET**

*(please fill out entire sheet)*

Patient Name: \_\_\_\_\_ Appointment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Last) (First) (MI)

Address: \_\_\_\_\_  
 (Apt #) (City) (State) (Zip)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Health Insurance: \_\_\_\_\_ Subscriber #: \_\_\_\_\_

Nearest Relative in Case of Emergency: \_\_\_\_\_  
 (Name) (Phone) (Relationship)

We have an automatic computer system that calls and reminds patients of their appointments, do you give us permission to call you at your home phone number and remind you of your appointment?  YES  NO and leave a message?  YES  NO

**By whom were you referred to this office:** \_\_\_\_\_

**Who is Primary Care Physician:** \_\_\_\_\_

**If Parent Or Spouse Is Responsible For Patient – Please Complete Guarantor Information**

Guarantor Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_ Health Insurance: \_\_\_\_\_

Subscriber #: \_\_\_\_\_ Insured Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Group #: \_\_\_\_\_

**L&I AND/OR MVA INFORMATION**

Did this result from an accident at work?  YES  NO Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ State Industrial #: \_\_\_\_\_

If yes, give the employer's name where the injury occurred: \_\_\_\_\_

At what medical office did you file your claim? \_\_\_\_\_

**RELEASE OF BENEFITS AND INFORMATION:** I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim.

**Signed (X):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*(Read and sign back side)*



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**PATIENT HISTORY FORM**

Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First M.I.  
 Physician providing your primary medical care \_\_\_\_\_ Referred by \_\_\_\_\_

**CURRENT OR CHIEF PROBLEM**

For what problem are we seeing you? \_\_\_\_\_ Injury date if applicable \_\_\_\_\_

Have you been treated elsewhere for this problem?  Yes  No By whom? \_\_\_\_\_

Diagnosis given: \_\_\_\_\_

Briefly describe your present symptoms: \_\_\_\_\_

Previous treatment for this problem(include medications, injections, physical therapy, and/or surgery) \_\_\_\_\_

Have any tests been performed?  X-rays  MRI  CT Scan  EMG  Other \_\_\_\_\_

**PAST MEDICAL HISTORY Do you now or have you ever had: (mark with an x if yes)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Parkinson's Disease          |
| <input type="checkbox"/> AIDS/HIV                       | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pneumonia                    |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Psoriasis                    |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Seizure disorder             |
| <input type="checkbox"/> Bladder/kidney infections      | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Bleeding Problems              | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin disease                 |
| <input type="checkbox"/> Blood Clots                    | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Stomach/intestinal Ulcers    |
| <input type="checkbox"/> Cancer (what type) _____       | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Stroke                       |
| <input type="checkbox"/> Chemical dependency/alcoholism | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Thyroid disease              |
| <input type="checkbox"/> Depression                     | <input type="checkbox"/> Kidney stones       | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> None of the above            |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Osteoporosis        |   |

Other significant illnesses (please list): \_\_\_\_\_

Are you pregnant?  Yes  No Any previous fractures?  Yes  No

Describe: \_\_\_\_\_

Have you had a bone density study (DXA Scan)?  Yes  No If so, date of last test \_\_\_\_/\_\_\_\_/\_\_\_\_ Location of test: \_\_\_\_\_

**(Doctor Answer)** Recommends a DEXA Scan?  Yes  No



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**PREVIOUS OPERATIONS**

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

**PRESENT MEDICATIONS** (List all medications including aspirin, laxatives, vitamins, herbs, and other supplements)

Drug Name	Dose(mg)	Frequency(times per day)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

**DRUG ALLERGIES**

Drug Name	Reaction (rash, difficulty breathing, etc.)
1.	
2.	
3.	
4.	

Have you had a reaction to local or general anesthesia?  Yes  No If yes, state reaction \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No

**SOCIAL HISTORY**

Do you smoke?  Yes  No  Past—If yes, number/day and years smoked \_\_\_\_\_ Quit when? \_\_\_\_\_

Do you drink alcohol?  Yes  No Type and number of drinks/week \_\_\_\_\_

Do you use drugs for reasons that are not medical?  Yes  No

If yes, please list: \_\_\_\_\_

Do you exercise regularly?  Yes  No Type and amount per week: \_\_\_\_\_

Married  Single  Retired  Living Independently Number of children: \_\_\_\_\_



**FAMILY HISTORY**

Do you know of any blood relative who has or had: (check and give relationship)

- Alcoholism \_\_\_\_\_  Diabetes \_\_\_\_\_  Psoriasis \_\_\_\_\_
- Asthma \_\_\_\_\_  Epilepsy \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_
- Bleeding tendency \_\_\_\_\_  Heart Disease \_\_\_\_\_  Stroke \_\_\_\_\_
- Bleeding tendency \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Tuberculosis \_\_\_\_\_

**SYSTEMS REVIEW** As you review the following list, please check any of those problems which have significantly affected you.

**Constitutional:**

- Fever
- Chills
- Night Sweats
- Unusual fatigue
- Recent weight gain: amount \_\_\_\_\_
- Recent weight loss: amount \_\_\_\_\_

**Skin**

- Rashes
- Easy bruising
- Skin lesions
- Hives

**Head**

- Frequent headaches

**Eyes:**

- Loss of vision
- Blurred vision
- Dryness

**Neurological:**

- Fainting
- Dizziness
- Fainting

**Ears-Nose-Mouth-Throat:**

- Loss of hearing
- Ringing in ears
- Nosebleeds
- Bleeding gums
- Sores in mouth
- Hoarseness
- Difficulty swallowing

**Respiratory:**

- Chronic Cough
- Coughing up blood
- Shortness of breath
- Wheezing

**Cardiovascular:**

- Heart murmur
- Chest pain
- Palpitations
- Difficulty breathing at night

**Gastrointestinal:**

- Nausea
- Vomiting
- Persistent Diarrhea
- Stomach pain

**Gastrointestinal(cont):**

- Increasing Constipation
- Blood in stools
- Black stools

**Genitourinary:**

- Difficult/painful urination
  - Increased frequency of urination
  - Cloudy or bloody urine
  - Discharge from penis or vagina
- For Women Only*  
 Age when periods began: \_\_\_\_\_  
 Date of last period \_\_\_/\_\_\_/\_\_\_

**Musculoskeletal:**

- Morning stiffness
  - Muscle weakness
  - Muscle tenderness
  - Joint pain
  - Joint swelling
- List joints affected in last 6 months  
 \_\_\_\_\_

**Psychiatric:**

- Anxiety

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_ Nurse Initials \_\_\_\_\_ Physician Initials \_\_\_\_\_



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## Patient Financial Policy for Northwest Orthopaedic Associates, PLLC

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Patient Financial Class Policies:**

You are required to present a valid insurance card at every visit and as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding patient balances and co-payments are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

Private Pay: We require \$100 deposit. Outstanding balances are due prior to your appointment or within 30 days.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System). If your secondary insurance does not crossover it is the patient's responsibility to either bill secondary themselves or provide at time of service information to bill their secondary insurance. We do not bill 3<sup>rd</sup> insurances. Any outstanding balances and deductibles are due prior to your appointments. Any non covered service will be due as service is rendered.

Medicaid: Our office is a Medicaid participating provider and we will bill Medicaid for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments.

Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company. If your workers compensation claim is not yet accepted and you have no "back-up" insurance we require a \$100 deposit that will be refunded after the claim has been opened.

Motor Vehicle Insurance (MVA): \$100 deposit is required on all MVA accounts. We will courtesy bill your MVA insurance if all information is provided at the time of service.

**Methods of Payment:**

Our office accepts the following payment methods:

Cash, Personal Check, Debit Cards, Visa, Master Card, Discover and Patient Financing options for those patients who are credit worthy.

For returned checks we assess a \$25.00 NSF charge.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

**24 hour cancellation notice is required, otherwise you will be charged a \$50 no show fee.**

**COLLECTION CHARGE** applied to all accounts unpaid after 60 days. **COLLECTION CHARGE** computed by a periodic rate of 1.5% per month, which is the annual percentage rate of 18.00%. Minimum charge of \$1.00.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health insurance. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
 (If patient is not signing)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**OFFICE USE ONLY**

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason
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