

Name:  
DOB:  
Chart:  
Age:  
Date:



### Health History

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

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

Date of Birth: \_\_\_\_\_

Handedness:  Right  Left

Age: \_\_\_\_\_

Provider: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referred by: \_\_\_\_\_

What problem/issue brings you here today? \_\_\_\_\_

Since your last visit, are your symptoms:  Better  Worse  The Same

If better, by how much on a scale of 0-100% (if 0 was the way you were and 100 was completely normal: \_\_\_\_\_ %

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What do you want to accomplish from today's visit? \_\_\_\_\_

No Pain ----- Worst Pain Ever  
0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like:  Dull  Achy  Burning  Stabbing  Numb  Tingling  Pulling  
 Cramping  Tight

Please describe the course of your pain:  Constant  Comes and goes  Fluctuating  Worsening  Improving

Employment Status:  FT  PT  Light Duty  Off Duty due to injury  Full-time Parent  Not Working  Retired

Number of alcoholic beverages per week? \_\_\_\_\_ Current Tobacco use (cigarettes, pipe, chew):  Yes  No

Current Medications: (ALL medications including prescription, over-the-counter (i.e. Advil, Supplements, Vitamins)

New medical issues/surgeries since last doctor visit?  Yes  No

New family medical problem since last doctor visit?  Yes  No

Drug Allergies:  Yes  No If yes? \_\_\_\_\_

What are you doing for exercise now? \_\_\_\_\_

Night pain, fevers, unintentional weight change?  Yes  No

Vision Change, double vision?  Yes  No

Chest pain, palpitations?  Yes  No

Shortness of breath, wheezing, coughing after exercise?  Yes  No

Nausea, vomiting, black stools, loss of control of stools?  Yes  No

Loss of control of urine, urinary frequency, or urgency?  Yes  No

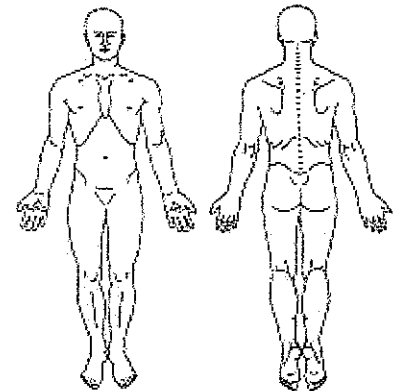
New rashes or psoriasis?  Yes  No

Dizziness, weakness, numbness, tingling?  Yes  No

Depressed mood, sleep problems, anxiety?  Yes  No

Current low back pain, other joint swelling, or muscle pain?  Yes  No

Please draw where you have Pain:



Patient Initials: \_\_\_\_\_

Health Care Provider Initials: \_\_\_\_\_

Name:  
DOB:  
Chart:

Date:



### PATIENT REGISTRATION FORM

All Forms must be completed and signed prior to treatment.

#### GENERAL INFORMATION

Patient Name: \_\_\_\_\_  
First Middle Last

Address: \_\_\_\_\_  
Street City State Zip

Home Phone No: \_\_\_\_\_ Work Phone No: \_\_\_\_\_

Cell Phone No: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender:  Male  Female  
(Circle One)

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_ City: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_ City: \_\_\_\_\_

Is this visit for the purpose of:  Workman's Compensation  Motor Vehicle Accident  Personal Injury  Self-Pay  
(Circle One)

Marital Status:  Single  Married  Widowed  Divorced  Student  Full time  Part time  
(Circle One) (Circle One)

Spouse Name: \_\_\_\_\_

Spouse Date of Birth: \_\_\_\_\_ Spouse Social Security Number: \_\_\_\_\_

#### PLACE OF EMPLOYEMENT

Name of Patient / Primary Guarantor's Employer: \_\_\_\_\_ Phone No: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Name of Spouse / Secondary Guarantor's Employer: \_\_\_\_\_ Phone No: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Is this a work related injury?  Yes  No  If you answered yes, please fill out the Workman's Compensation Information Form included in the Patient Registration Packet.  
(Circle One)

#### INSURANCE INFORMATION

Name of Primary Insurance Company: \_\_\_\_\_ Phone No: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Policy Holder's Name: \_\_\_\_\_ ID No: \_\_\_\_\_ Group No: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name of Secondary Insurance Company: \_\_\_\_\_ Phone No: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Policy Holder's Name: \_\_\_\_\_ ID No: \_\_\_\_\_ Group No: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name:  
DOB:  
Chart:  
Date:



**GUARANTOR INFORMATION**

Check and fill out this section **ONLY IF PATIENT IS A MINOR.**

THIS SECTION MUST BE COMPLETED BY THE PARENT(S)/GUARDIAN(S) THAT IS AUTHORIZING TREATMENT

**Primary Guarantor/Parent/Guardian Name:** \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
Street City State Zip

Home Phone No: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Secondary Guarantor/Parent/Guardian Name:** \_\_\_\_\_

Address (if different from above): \_\_\_\_\_  
Street City State Zip

Home Phone No: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**PLEASE PROVIDE VALID PICTURE I.D. & PRIVATE INSURANCE CARD.**

**CONSENT TO HEALTH CARE SERVICES**

I, the undersigned Patient, or undersigned person responsible for consenting on patient's behalf hereby request and consent to MidAmerica Orthopaedics to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the Patient's care. I hereby acknowledge that all information provided herein is true to the best of my knowledge.

I hereby assign, transfer and set over to MidAmerica Orthopaedics all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization and give written notice.

I understand that my co-pay, if applicable, is due prior to being seen and if my co-pay is not paid I may have to reschedule my appointment. I understand that all cancellations of appointments must be made at least 24 hours in advance and rescheduled within the same business week whenever possible. I understand that there will be a \$10.00 charge for all appointments cancelled with less than 24 hours notice, unless the appointment is rescheduled. I understand that there will be a \$25.00 charge for all appointments missed with no call made cancelling the appointment. I also understand that three consecutive no show appointments may result in a discharge from MidAmerica Orthopaedics

I hereby agree to pay the regular charges of the physician for any treatment performed on my behalf or authorized by me. I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan or fall into the insurance company's definition of usual and customary. MidAmerica Orthopaedics is committed to providing the best treatment possible for our patients and our charges are considered usual and customary for our area. I understand that all bills are to be paid in full within 45 days of submission to my insurance company. MidAmerica Orthopaedics Clinic does not wait for the settlement of lawsuits. Interest of 11/2% per month up to 9% annually will be charged after 60 days. An authorized, approved payment plan will eliminate interest charges and collections. I understand that I am responsible for all costs of collection for any outstanding fees, including but not limited to any attorney fees, court costs, expenses and interest incurred from the date of my initial consultation with any physician at the MidAmerica Orthopaedics.

\_\_\_\_\_  
Patient / Primary Guarantor / Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Spouse / Secondary Guarantor / Parent / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Private Insurance Policy Holder's Signature

\_\_\_\_\_  
Date

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Chart: \_\_\_\_\_



**IMPORTANT INSURANCE/PAYMENT INFORMATION**

Patients with private healthcare insurance:

The private healthcare insurance presented at the time of your visit will be billed for your treatment, HMO patients will need to start the process of securing a referral. Every effort will be made to ensure that claims are promptly and correctly submitted to your insurance company. Your insurance company has 30 days after receiving a correctly filed claim to process, pay, and/or given notice as to why the claim has not been paid. After that time the remaining balance will be your responsibility. If you are not satisfied with the payment made by your insurance company, contact them directly at the phone number listed on your insurance card. If you choose to appeal to your insurance company in writing for additional payment please provide MidAmerica Orthopaedics with a copy of the appeal for your file.

Patients with motor vehicle insurance/liability insurance:

If your injury was received as a result of a motor vehicle accident or a liability, and you do have private healthcare insurance, typically your private healthcare insurance will not make payments on your medical claims without a written denial from your motor vehicle insurance/liability insurance. It is very important that all pertinent information be given at the time of your visit regarding the motor vehicle insurance/liability insurance, including claim number, agent information, claim billing address, accident report etc.

Patients without private healthcare insurance - Self Pay:

If no private healthcare insurance is presented at the time of your visit, full payment or an approved payment plan is expected at the time of service.

Patients with Illinois Department of Public Aid - IDPA:

IDPA is not accepted at MidAmerica Orthopaedics. Full payment or an approved payment plan is expected at the time of service.

**FOR ALL PATIENTS**

- \*Any insurance policy is a contract between you and your insurance company.
- \*It is your responsibility to verify, with your insurance company, if a providers is in or out of network for your plan.
- \*Any unpaid balance left by your insurance company will be your responsibility.
- \*Insurance benefits paid directly to the patient will need to be forwarded to MidAmerica Orthopaedics to keep the account in good standing.
- \*If you have retained an attorney regarding your injury, it is very important to provide MidAmerica Orthopaedics with that information.
- \*Payment plans can be established with the approval of the billing department.
- \*Cash, checks, and all major credit cards are accepted for payment.
- \*You can contact the billing department with any questions.

Credit card payment authorization:

I hereby authorize MidAmerica Orthopaedics to use my credit card for co-pays, co-insurance, non-covered services, or other balances that are my financial responsibility if not paid within 45 days of service.

Credit card type: \_\_\_\_\_ Credit card account #: \_\_\_\_\_ ID#: \_\_\_\_\_ Expiration: \_\_\_\_\_

By signing below, the patient acknowledges that they have read the above information, understands this information and that upon request may obtain a copy of this form.

\_\_\_\_\_  
Printed Signature Date

**MidAmericaOrtho.com**  
**Palos Hills**  
10330 S. Roberts Road  
Palos Hills, IL 60465  
Phone 708-237-7200  
Fax 708-237-7201

**Mokena**  
19065 Hickory Creek Drive  
Mokena, IL 60448  
Phone 708-237-7200  
Fax 708-237-7201

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_  
Chart: \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

This notice advises you about the ways in which we may use and disclose your Protected Health Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to you PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of MidAmerica Orthopaedic's Notice of Privacy Practices at the time of registration.

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

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I hereby authorize the release of any and all records of my treatment to be forwarded to the following:

(Please check all that apply)

- I authorize MidAmerica Orthopaedics or any of its agents to obtain and/or release any information pertinent to my care to any insurance company, adjuster, case manager, medical provider or facility, referring parties, parties assisting in coordination of care, or attorney involved in my care or claim, as well as to attorneys or agencies necessary for collections.
- The referring occupational clinic, my employer, workers compensation representative who will be handling my claim, as well as any physicians and ancillary personnel involved in my medical care.
- The referring physician and any physicians and ancillary personnel involved in my medical care.
- My primary care physician.
- My private health insurance carrier and any associated entities.
- My employer: \_\_\_\_\_

Name of Employer

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

**AUTHORIZATION TO OBTAIN MEDICATION HISTORY**

I hereby authorize MidAmerica Orthopaedics to release to and obtain from any medical provider any and all records related to my medication history.

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

**PHONE MESSAGE AND CONTACT AUTHORIZATION**

At what phone number can we, or our representatives, call to speak with you and or leave a message regarding appointments or any other details related to your account? (Please circle Yes or No for each option)

Home Phone: YES NO Work Phone: YES NO Cell Phone: YES NO

Would you like to allow someone, other than yourself, to receive information regarding your treatment, appointments and billing/financial status at MidAmerica Orthopaedic? (Circle One) YES NO

If yes, please list their names, relationship and phone number:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

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