Name:
DOB:
Chart:
Age:
Date:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated Divorced ☐ Widowed		
Referring Doctor:	**email address (optional):**	

What is the reason you seek care from a neurological surgeon?

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Do you have any lawsuits pending with regard to your chief complaint? ☐ Yes ☐ No

Please turn to next page

Name:
DOB:
Chart:
Age:
Date:

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	Are you on a special diet? If so, briefly explain:		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what kind?		
	How many drinks per week?		
	Have you ever felt you needed to cut down on your drinking?	☐ Yes	☐ No
	Have people annoyed you by criticizing your drinking?	☐ Yes	☐ No
	Have you ever felt guilty about drinking?	☐ Yes	☐ No
	Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
	☐ Cigarettes - pks/day: ☐ Chew - #/day: ☐ Pipe - #/day: ☐ Cigars - #/day:		
	☐ # of years: ☐ Or year quit:		
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
	Have you ever abused prescription narcotics?	☐ Yes	☐ No

Please turn to next page

Name:
DOB:
Chart:
Age:
Date:

Occupation Safety	Are you able to work in your current condition?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?	☐ Yes	☐ No
	Do you live with someone or know someone that can provide help for you at home?	☐ Yes	☐ No
	Do you have to go up or down more than five steps either to enter your home or enter your bedroom?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Patient Signature: _____ Physician Signature: _____

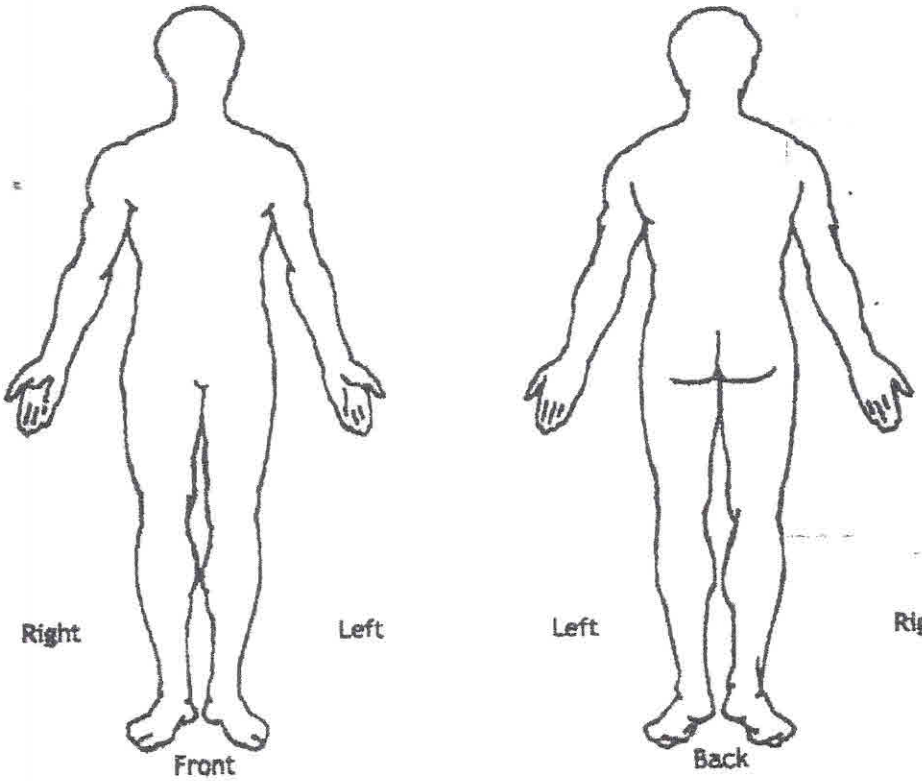
Patient Pain Drawing

Name _____ Date _____

Where is your pain now?

- Mark the areas on your body where you feel the sensations described below, using the appropriate symbol.
- Mark the areas of radiation.
- Include all affected areas.
- To complete the picture, please draw in your face.

Aching	Numbness	Pins and needles	Burning	Stabbing
▲ ▲ ▲	= = =	O O O	× × ×	/ / /



How bad is your pain now?

- Please mark with an X on the body form where the pain is worst now.
- Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain

Name:
DOB:
Chart:

Date:

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 Hand to Shoulder Clinic. Full payment or an approved payment plan is expected at the time of service.

FOR ALL PATIENTS

*Any insurance policy is a contact 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, all major credit cards and Care Credit are accepted for payment.
*You can contact the billing department with any questions.

Credit card payment authorization:

I hereby authorize MidAmerican 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:

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)

( ) 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: _____

Name: Date:
DOB:
Chart:

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 (Circle One) Student: Full time Part time (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 (Circle One) If you answered yes, please fill out the Workman's Compensation Information Form included in the Patient Registration Packet.

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