Name:
DOB:
Chart:
Age:
Date:

Health History

Patients Name:_____ Birthdate:_____ Sex: ☐ Female ☐ Male
Phone #:_____ ☐ R-Handed ☐ L-Handed
Primary Care Physician:_____ Physician's Address:_____
Referred by:_____
Occupation:_____ Work Related Injury: ☐ Yes ☐ No DOI:_____ Reported:_____

History of Present Illness:
Height:_____ Weight:_____lbs. Age:_____ Problem with: ☐ R-extremity ☐ L-extremity
CC/Why are you here today?_____

Location:_____ Quality:_____
Severity:_____ Duration:_____
Timing:_____ Context:_____

Associated signs/symptoms:_____
Modifying Factors:_____
Previous treatments to date (check all that apply):
☐ Rest ☐ Brace ☐ Ice ☐ Injections ☐ Anti-Inflammatories ☐ Physical Therapy
☐ Activity modification _____

Have you seen any other physicians regarding this condition prior to coming to our office? ☐ Yes ☐ No

Doctor	When	Tests	Results	Treatment

Past History of Present Illness:'
Have you ever experienced any injury or symptoms regarding this body part? ☐ Yes ☐ No
If so, please provide details:_____

Please list any hobbies/sports you enjoy:_____

Which of the above activities are you unable to perform due to your pain?_____

Name:
DOB:
Chart:
Age:
Date:

Past Medical History: Have you ever had any of the following? Please check all pertinent boxes:

☐ HIV/AIDS	☐ Bronchitis	☐ Hepatitis	☐ Mumps	☐ Thyroid Disease
☐ Anemia	☐ Chicken Pox	☐ High Blood Pressure	☐ Pnemonia	☐ Tuberculosis
☐ Arthritis	☐ Diabetes	☐ Infectious Mono	☐ Polio	☐ Ulcer
☐ Asthma	☐ Epitheria	☐ Kidney Disease	☐ Rheumatic Fever	☐ Venereal Disease
☐ Back Trouble	☐ Epilepsy/Seizures	☐ Low Blood Pressure	☐ Scarlet Fever	☐ Whooping Cough
☐ Bladder Infections	☐ Glaucoma	☐ Measles	☐ Sleep Apnea	☐ Other (please list)
☐ Bleeding Tendency	☐ Heart Disease	☐ Migraine Headaches	☐ Smallpox	_____
☐ Blood Transfusions	☐ Hemorrhoids	☐ Mitral Valve Prolapsed	☐ Stroke	_____

Medications: Include non prescription and herbal supplements

Drug Name	Dosage	Frequency

Allergies:

Medication	Reaction

Taking blood thinners? Yes No Tape Allergy? Yes No Latex Allergy? Yes No Contrast Dye Allergy? Yes No

Past Surgical/Hospitalization History:

Date	Surgery/Illness	Doctor	Hospital, City, State

Patient Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Use of Tobacco: ☐ Never ☐ Previously, but quit ☐ Currently ☐ Packs per day_____
Living Situation: ☐ With Family ☐ With Friends ☐ Alone ☐ Other_____

Family Medical History

	Age	Conditions or Diseases	If deceased, cause of death
Father			
Mother			
Siblings			

Review of Systems: Please indicate any personal history below: (Please circle all that apply)

Musculoskeletal		**Genitourinary**		**Psychatric**	
Joint Pain	Yes No	Frequent urination	Yes No	Memory loss	Yes No
Joint Stiffness or swelling	Yes No	Burning or painful urination	Yes No	Confusion	Yes No
Weakness of muscles or joints	Yes No	Blood in urine	Yes No	Nervousness	Yes No
Muscle pain or cramps	Yes No	Incontinence or dribbing	Yes No	Depression	Yes No
Back pain	Yes No	Female-# of pregnancies	Yes No	Insomnia	Yes No
Cold extremities	Yes No	Female-# of deliveries	Yes No		
Difficulty in walking	Yes No				

Name:
DOB:
Chart:
Age:
Date:

Constitutional Symptoms

Bad general health lately	Yes No
Recent weight change	Yes No
Fever	Yes No
Fatigue	Yes No
Headaches	Yes No

Ears/Nose/Mouth/Throat Yes No

Hearing loss or ringing	Yes No
Earaches or drainage	Yes No
Chronic Sinus Problems	Yes No
Nose Bleeds	Yes No
Bleeding gums	Yes No
Sore throat or voice change	Yes No
Swollen glands in neck	Yes No

Cardiovascular Yes No

Heart trouble	Yes No
Chest pain or angina pectoris	Yes No
Palpitation	Yes No
Shorthness of breath	Yes No
Swelling of feet/ankles/hands	Yes No

Integumentary (skin, breast)

Rash or itching	Yes No
Changes in skin color	Yes No
Varicose veins	Yes No
Breast pain	Yes No
Breast lump	Yes No

Neurological

Light headed or dizzy	Yes No
Numbness or tingling sensations	Yes No
Tremors	Yes No
Paralysis	Yes No

Endocrine

Excessive thirst or urination	Yes No
Heat or cold intolerance	Yes No
Skin becoming dryer	Yes No

Hematologic/Lymphatic

Slow to heal after cut	Yes No
Bleeding or bruising tendency	Yes No
Anemia	Yes No
Enlarged glands	Yes No

Gastrointestinal

Loss of appetite	Yes No
Nausea	Yes No
Diarrhea	Yes No
Constipation	Yes No
Rectal Bleeding	Yes No
Blood in Stool	Yes No
Abdominal pain	Yes No
Vomiting	Yes No

Respiratory

Chronic cough	
Wheezing	Yes No
Spitting up blood	Yes No
Shortness of breath	Yes No
	Yes No

Eyes

Eye disease	Yes No
Eye injury	Yes No
Use of glasses	Yes No
Use of contacts	Yes No
Blurred or Double Vision	Yes No

To the best of my knowledge, the questions on this form have been answered accurately, I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medial status. I also authorize the health care staff to perform the necessary services if I may need.

_____
Signature of Patient or Parent of Minor

_____
Date

_____
Signature of Physician

_____
Date

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:

MidAmerica Hand to Shoulder Clinic | MidAmerica Orthopaedics | OrthoNow Orthopaedic Immediate Care

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