NORTHWESTERN ORTHOPAEDIC INSTITUTE

Patient Information Form

TODAY'S DATE: ________/________/________

Have you previously been seen by any of the physicians at this office? □ YES □ NO

Name of the doctor you are seeing today: ______________________________

PATIENT INFORMATION
(Information provided will be kept strict and confidential)

Last Name: ______________________________

First: ______________________ Middle Intl.________

Address: ______________________ Apt #________

City:______________ State:______ Zip:__________

Employer: ______________________________

E-mail Address:______________________________

Home Phone (_______) _________-_________

Work (_____) _______-________Ext______

Cell Phone (_______) _________-_________

Social Security _______-_______-_______

Sex: M F Marital Status: __________

Age: ________ Date of Birth ____/____/____

Contact In Case of Emergency: ______________________ Relationship ______________

Emergency contact phone: (_________) _________-__________

Who referred you to our office? ______________________ Is this your Primary Care Physician? ❑ yes ❑ no

Primary Care Physician ______________________ Phone: (_______) _______-________

If patient is a minor, Name of parent or guardian: ______________________ S.S. # ______________

*********** MEDICARE PATIENTS MUST PROVIDE PIMARY CARE PHYSICIAN INFORMATION ****************

HEALTH INSURANCE INFORMATION

PRIMARY

Plan Type: ❑ Medicare ❑ PPO ❑ HMO/POS ❑ Other

Insurance Name: ______________________

Address: ______________________

Phone: (_________) __________-__________

I.D. No. ______________________

Group No. ______________________

Are you the insured? ❑ yes ❑ no

If not the insured, relationship: ❑spouse ❑ child ❑ other

Insured Name:______________________

Insured date of birth: ______/______/______

Insured Employer: ______________________

SECONDARY

Plan Type: ❑ Medicare ❑ PPO ❑ HMO/POS ❑ Other

Insurance Name: ______________________

Address: ______________________

Phone: (_________) __________-__________

I.D. No. ______________________

Group No. ______________________

Are you the insured? ❑ yes ❑ no

If not the insured, relationship: ❑ spouse ❑ child ❑ other

Insured Name:______________________

Insured date of birth: ______/______/______

Insured Employer: ______________________

ACCIDENT INFORMATION

1. Is this visit due to a work-related injury? ☐ Yes ☐ No **If yes, please complete the following:**

Indicate your date of injury (please be specific): ____________________ Name of Employer ____________________

Name of Work Comp Carrier: ____________________

Carrier's Address: ____________________ City, State, Zip ____________________

Adjuster's Name: ____________________ Phone: (______) ______-______

2. Is this visit due to an auto accident? ☐ Yes ☐ No **If yes, please read and complete the following:**

NOTE: WE WILL NOT BILL THIRD PARTY PAYERS, WE WILL SUBMIT YOUR MEDICAL CLAIM TO YOUR AUTO MED- PAY POLICY ONLY.

YOU MUST PROVIDE PROOF OF YOUR CURRENT PAYING CLAIM. WHAT IS YOUR MED PAY MAXIMUM? ____________________

Insurance company ____________________ Phone (______) ____________ Policy ____________

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. We are committed to making your treatment successful. Please understand that payment of your bill is part of facilitating your treatment. Your clear understanding of our financial policy is important to our professional relationship.

Our Financial Policy is as stated:

- All co-pays are due at the time of service.
- Payment in full at the time of service if uninsured or non-contracted. If you cannot make full payment at the time of service, a financial arrangement must be arranged, you may ask to speak to a billing representative.
- We accept Cash, Checks, Visa, MasterCard, American Express and Discover.

INSURANCE:

We are contracted with Medicare, Blue Cross/Blue Shield, numerous PPO networks and managed care plans. Please be aware that some or all of the services provided may be considered by your insurance to be **"non-covered"** services and may not be considered medically necessary under your plan's provisions. You will be responsible for these charges. Please check with your carrier or your handbook for information regarding your "non-covered" services.

If your policy requires you to have a referral or authorization by your primary care physician—please make sure that this is obtained prior to your appointment. Failure to obtain and present this at the time of service may result in a loss of benefits. If this occurs, you will be responsible to pay all unauthorized fees.

Your insurance coverage is a contract between you and your insurance company. We are not a party to this contract. We will submit all charges to your insurance carrier as a service to you.

Please notify us immediately of any changes to your insurance information or coverage.

I have read the above policies and agree to them. I consent to medical treatment and diagnostic procedures necessary for my condition based on the judgment of my physician(s). I authorize Northwestern Orthopaedic Institute to furnish information to my insurance company, worker's compensation carrier, rehabilitation/clinical case manager or attorney concerning my injury and treatment. I understand that I am financially responsible for payment of all services not covered by my insurance carrier.

I authorize payment of benefits directly to Northwestern Orthopaedic Institute LLC, for services provided.

X ______________________________
Signature of Patient or Responsible Party required

________/________/________
Date

NOTICE OF PRIVACY PRACTICE

Receipt of Notice of Privacy Practices Form & Release and Use of Confidential Information

Effective April 14th, 2003 I, ___________________________, hereby acknowledge receipt of Northwestern Orthopaedic Institute, LLC's Notice of Privacy Practices. Northwestern Orthopaedic Institute LLC will use or disclose my PHI for the purpose of carrying out treatment, payment and healthcare operations. The Notice of Privacy Practices provides detailed information about how Northwestern Orthopaedic Institute LLC may use and disclose my confidential information.

I understand Northwestern Orthopaedic Institute LLC has reserved a right to change its Privacy Practices that are described in this Notice. I also understand that a copy of any Revised Notice will be provided to me or made available at my next office visit.

I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Northwestern Orthopaedic Institute LLC.

Signed: ____ Date: _________________

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

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NOI
NORTHWESTERN
ORTHOPAEDIC
INSTITUTE, LLC

:NT HEALTH HISTORY

FOI \VING SURGERY:
Plea 312.694.9712 and keep a copy for your files.
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Pro
Has this patient been scheduled for pre-operative testing? ☐ Yes ☐ No
Surgeon ______

The patient health history questionnaire helps the physicians and nurses to evaluate your health and plan your care. Please fill out this form to the best of your ability. We may call you to ask additional questions. Thank you.

Name ______ Date of Birth ______ Today's Date ______

Preferred Phone Number(s) (day) ______ (night) ______

Primary Care Physician / Internist ______ PCP Phone # / Location ______

*** Have you previously received medical care at Northwestern Memorial Hospital?** ☐ **Yes** ☐ **No**

Height ______ Weight ______ Primary Language ______

ALLERGIES: List any allergies to drugs or other materials (e.g. latex). What was the reaction?

______

CURRENT MEDICATIONS (If you have a brought a list of your current medications, we will make a copy and attach it to this form.)

List your current medications (include prescriptions, over-the-counter medications, birth control pills, etc.):

Medication Name	Dosage / Frequency / Route	Medication Name	Dosage / Frequency / Route

MEDICAL HISTORY List all past surgeries or hospital stays:

Reason (type of surgery or illness)	Date	Where treated?

Have you ever had problems with anesthesia? ☐ No ☐ Yes

If 'Yes' please describe the problem you experienced: ______

Have your family members ever had problems with anesthesia? ☐ No ☐ Yes ☐ Unsure

If 'Yes' please describe the problem experienced: ______

Please provide your name once more: ______________________________

Do you have heart problems (cardiovascular disease)? ☐ No ☐ Hypertension
☐ Heart Valve Abnormality ☐ Abnormal Heart Rhythm / Palpitations ☐ Pacemaker/Defibrillator (Provide model)
☐ Chest Pain / Angina ☐ Heart Attack ☐ Angioplasty / Stent ☐ Heart Surgery ☐ Congestive Heart Failure
☐ Other

What is your level of activity?
☐ Able to walk / run a mile in 15 minutes ☐ Able to walk 2 blocks without stopping ☐ Able to walk up a flight of stairs
☐ Able to complete normal activities of daily living ☐ Unable to do any of the above activities

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Do you have lung (pulmonary) problems?
☐ No ☐ Asthma ☐ Chronic Bronchitis ☐ Emphysema / COPD ☐ Pneumonia ☐ Pulmonary Hypertension
☐ Respiratory Infection ☐ Recent Cold / Flu ☐ Tuberculosis ☐ Other

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Do you use oxygen at home? ☐ No ☐ Yes

Do you have sleep disorders? ☐ No ☐ Stop Breathing During Sleep ☐ Daytime Drowsiness ☐ Loud Snoring
☐ Diagnosed Sleep Apnea (Do you use CPAP? Settings?) ______________ ☐ Other

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Do you have liver / stomach / gastrointestinal problems? ☐ No ☐ Hiatal Hernia ☐ Acid Reflux/GERD
☐ Liver Disease ☐ Hepatitis ☐ Cirrhosis ☐ Ulcer ☐ Crohn's Disease ☐ Ulcerative Colitis
☐ Irritable Bowel Syndrome ☐ Other

Do you have kidney (renal) problems? ☐ No ☐ Kidney Failure ☐ Dialysis ☐ Other

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Do you have endocrine problems? ☐ No ☐ Diabetes ☐ Thyroid Disease ☐ Addison's ☐ Other

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Do you have brain or musculoskeletal (neurologic / nervous system) problems? ☐ No ☐ CVA / TIA (Stroke)
☐ Seizures ☐ Multiple Sclerosis ☐ Brain Aneurysm / AVM ☐ Brain Tumor ☐ Cerebral Palsy
☐ Spinal Cord Injury ☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ Other

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Are you currently being treated for psychiatric disorders? ☐ No ☐ Depression ☐ Bipolar Disorder
☐ Anxiety Disorder ☐ Panic Attacks ☐ Schizophrenia ☐ Other

Do you have any skin problems? ☐ No ☐ Active Shingles ☐ Eczema ☐ Open Wound ☐ New Rash ☐ Other

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Do you have blood (hematologic problems)? ☐ No ☐ Hemophilia ☐ Bleeding Disorder
☐ Bleed or bruise easily ☐ Family history of bleeding disorder ☐ Anemia ☐ Sickle Cell Anemia / Trait
☐ (Prior) Transfusions ☐ HIV ☐ Blood clots ☐ Other

Do you have any history of cancer? ☐ No ☐ Yes If yes, please list type, treatment(s) and date of last chemotherapy or radiation:

ADDITIONAL INFORMATION

Do you use tobacco? ☐ No, never ☐ Yes: Packs per day________ for________ years Quit (year)__________

Do you drink alcohol? ☐ No ☐ Past ☐ Current
On average, how many alcoholic drinks do you consume?__________ per day __________ per week

Do you use recreational drugs? ☐ No ☐ Past ☐ Current Type of drug used __________

Have you had unplanned weight loss within the past 6 months? ☐ No ☐ Yes ☐ Unsure

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Name ______________________________

Gender ☐ Male ☐ Female

Eye Problems ☐ No ☐ Yes ☐ Reading glasses/contacts only ☐ Cataracts ☐ Glaucoma ☐ Other

Ear, Nose, Throat, Mouth ☐ No ☐ Yes ☐ Sinus Problems ☐ Active Dental Problems ☐ Other

Muscle, Bone and Joints (Musculoskeletal Rheumatologic) ☐No ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Chronic Back Pain ☐ Other

Have you had a blood clot (DVT) or pulmonary embolus? ☐ No ☐ Yes ______________

Do you have any family history of blood clots (DVT) or pulmonary embolus? ☐ No ☐ Yes

If yes, please describe ______________________________

Do you exercise regularly ☐ No ☐ Yes If yes, how many times per week ________

Do you follow a special diet ☐ No ☐ Yes If yes, describe ______________________

What kind of work do you do: ☐ Sedentary ☐ Manual labor ☐ Retired ☐ Homemaker ☐ Unemployed ☐ On disability

Occupation: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐ Yes ☐ No If yes, how many? ________

Family History:

Member	Alive	Deceased	Age or Age at Death	Health Status/Cause of Death
Father	( )	( )		
Mother	( )	( )		
Sibling	( )	( )		
Sibling	( )	( )		
Sibling	( )	( )		
Sibling	( )	( )		
Sibling	( )	( )		
Sibling	( )	( )		

Date:______________

Northwestern Orthopaedic Institute, LLC

Name:____ Age:__________________________________

Height:__________________________ Weight:__________________________________

A. What problem are you seeing the doctor for today?

____

____

____

If the problem is related to a limb, is it right, left, or both?____________________________

What is your level of pain? (0-No pain/ 10-worst)____________________________________

B. When did this problem begin?

____

____

C. Current Medications:

____

____

D. Allergies? Y N

If yes, please list:

____

____

E. Is this a result of a specific event? Y N

If yes, please explain:

____

____

F. If this is an injury, is there any litigation pending? Y N

G. Is this a Workers Compensation claim? Y N

H. Has any doctor in our practice treated you in the past? Y N If yes which doctor?

____

I. Have you received treatment for your problem?

____

____

J. Did you have any tests (MRI or X-Rays)? Y N If yes, did you bring them?__________

K. Have you had a reaction to a medication? Y N If yes, please explain:

____

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