

Today's Date: _____

PATIENT INFORMATION

Last Name: _____ First: _____ Mi. Init: _____

DOB: _____ Age: _____ SSN: _____ Gen: M F Marital Status: S M D WRace: African American American Indian Asian Caucasian Hispanic Pacific Islander Other

Address: _____ City: _____ State: _____ Zip: _____

Preferred phone #: _____ Secondary phone #: _____
select: CELL HOME WORK *select:* CELL HOME WORK

Email address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Contact Person: _____ Employer Phone #: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Preferred phone #: _____ Secondary phone #: _____
select: CELL HOME WORK *select:* CELL HOME WORK**REASON FOR VISIT / PHYSICIAN INFO**

Reason for appointment: _____ Date symptoms began: _____

Referring Physician (*if applicable*): _____ Phone #: _____

Referring Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone #: _____

PCP Address: _____ City: _____ State: _____ Zip: _____

PHARMACY

Preferred Pharmacy: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

HEALTH INSURANCE

Primary Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group ID #: _____

Policy Holder's Last Name: _____ First Name: _____ DOB: _____

Policy Holder's SSN: _____ Relationship to patient: Self Spouse Parent Other

Policy Holder's Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Insurance Phone #: _____

Policy #: _____ Group ID #: _____

Policy Holder's Last Name: _____ First Name: _____ DOB: _____

Policy Holder's SSN: _____ Relationship to patient: Self Spouse Parent Other

Policy Holder's Employer: _____ Employer Phone #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

GUARANTOR/LEGAL GUARDIAN (if applicable)

Parent Legal Guardian Other Last Name: _____ First Name: _____

DOB: _____ SSN: _____ Relationship to patient: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

WORKERS' COMP INFORMATION (if applicable)

Is this a work-related injury? YES NO Did you report it? YES NO Did your employer approve this visit? YES NO

Date/Time of injury: _____ Part of body injured: _____

Contact person at place of employment: _____ Date last worked: _____

Workers' Compensation Carrier: _____ Claim #: _____

Address: _____ City: _____ State: _____ Zip: _____

Adjuster's Name: _____ Phone #: _____

ACCIDENT/PERSONAL INJURY INFORMATION (if applicable)

Motor vehicle/personal injury? YES NO Date/Time of accident: _____ State accident occurred: _____

Insurance Carrier: _____ Claim #: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY INFORMATION (if applicable)

Attorney's name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

HOW DID YOU LEARN ABOUT PARKVIEW? (Please be specific.)

Family/Friend Physician (specify): _____

Have been our patient in the past Hospital/Urgent Care (specify): _____

Workers' Comp Case Manager or Attorney Coach/Trainer (specify): _____

Internet (circle: Google/Facebook/Parkview Website/Yelp/Healthgrades) Other (specify): _____

All of the information provided is complete and accurate to the best of my knowledge.

PATIENT SIGNATURE

DATE

YOUR PHOTO ID, INSURANCE CARD, AND COPAY ARE REQUIRED AT THE TIME OF THE VISIT. IF YOU DO NOT HAVE YOUR INSURANCE CARD AVAILABLE, ALL CHARGES WILL BE YOUR RESPONSIBILITY AND PAYABLE AT THE TIME OF SERVICE. OBTAINING ANY REQUIRED REFERRAL FORMS IS YOUR RESPONSIBILITY, AS ARE ALL UNPAID BALANCES AND/OR DENIED CLAIMS.

PATIENT INFORMATION SHEET

Please complete all four pages of this form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Type of work done: _____

Who referred you to this office? _____

Significant sporting or recreational activities: _____

What is the main reason for your visit? (e.g. pain, weakness, numbness, scoliosis): _____

Where is the pain/numbness? (e.g. neck, right arm, low back, left thigh, shoulder, hip, etc.) _____

When did your back or neck symptoms begin? _____

When did your arm or leg symptoms begin? _____

Is this related to an injury? (yes/no/possibly) _____ Date of injury: _____

Classify the injury:

- Injury on the job
- Vehicular accident; State accident occurred: _____
- Sporting injury
- Slip & fall
- Lifting/bending
- Other: _____

Please describe the injury (e.g. stopped at a traffic light when rear-ended, or bent over to pick up a box, or no known injury)

If you were injured on the job, was an injury report filed? Yes No

Who was your employer at the time of the injury? _____

Work Status:

- Employed without restrictions or limitations
- Employed with restrictions or limitations
- Homemaker without restrictions or limitations
- Homemaker with restrictions or limitations
- Temporarily not working because of pain
- Released from work because pain prevents job completion
- Not employed
- On disability
- Student
- Retired
- On Workman's Compensation
- Other: _____

Legal Action:

- None
- Potential
- Progressing
- Settled

Do you have a living will? Yes No

Do you have either bowel or bladder incontinence? Yes No

If yes, please explain: _____

Are your symptoms worse in the:

- Morning
- Afternoon
- Evening
- Night
- Varies
- Does not apply

Does the pain waken you during the night? Yes No

What is the one activity or position which best relieves your symptoms? _____

What is the one activity or position that makes your symptoms their worst? _____

What can you not do because of your pain? _____

Which of the following diagnostic tests have you had done:

- None
- X-rays
- MRI
- CT Scan
- Myelogram
- EMG
- Bone Scan

Other: _____

Do you have a family history of spinal problems? Yes No

SOCIAL HISTORY:

Who do you live with? Family Friends Alone Other: _____

Do you smoke: Yes No If yes, how many packs per day? _____

Do you drink alcohol? None Rarely Socially Daily

MEDICAL HISTORY:

Physician's name: _____ Date of last physical: _____

Do you have any medical problems?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |

List all your past surgeries (for any surgeries performed in the past three years, list the month and year) _____

What medications do you regularly take, or are you currently taking? _____

List the medications to which you are allergic: _____

GENERAL REVIEW OF SYSTEMS: Please check yes or no, for current and unexplained symptoms.

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Recent unexplained weight loss | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blurred or double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing loss or ringing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nausea or vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood in stool | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burning or painful urination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Rash or itching | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Light headed or dizzy | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Memory loss or confusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding or bruising tendency | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

HAVE YOU HAD PRIOR BACK OR NECK SURGERY? Yes No

INFORMATION REGARDING PREVIOUS SPINE SURGERY

Name: _____ Date: _____

Anatomical location of previous spine surgery:

- Cervical
- Thoracic
- Lumbar

Procedure:

- Laminectomy
- Discectomy
- Fusion with metal
- Fusion without metal
- Anterior (front) procedure
- Posterior (back) procedure
- Date of surgery: _____

Date of onset of symptoms before surgery: _____

Symptoms before surgery (e.g. pain, numbness, weakness): _____

Location of symptoms before surgery (e.g. arm, leg, back, neck): _____

Describe specific location of symptoms on extremities (e.g. back of thigh, back of calf, bottom of foot):

Was surgery a success?

- Yes No Partial

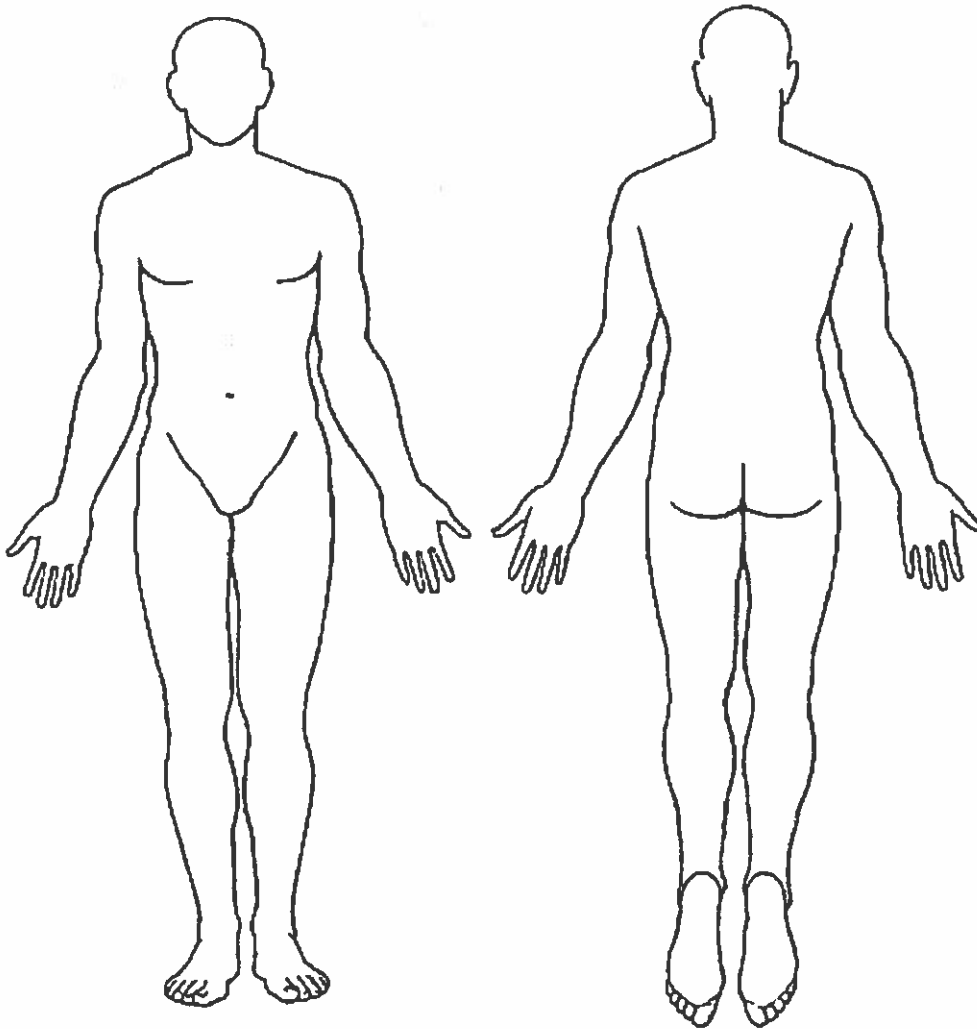
Post-op improvement:

- 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
- None Surgery worsened my symptoms

How long were your symptoms absent after surgery? _____

Mark the area of your body where you feel abnormal sensations and / or pain. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

- Numbness: -----
- Pins and needles:
- Burning: xxxxxxxxxxxxxxxxxxxxxx
- Stabbing: //////////////////
- Pain: ++++++



Please circle the number which represents your average pain over the past week:

0	2	4	6	8	10
No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I hereby consent to the treatment provided by **Hinsdale Orthopaedics** (the Practice) and its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs. (_____)

INITIAL

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION. I authorize use and disclosure of my Personal Health Information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize the Practice to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that the Practice may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. (_____)

INITIAL

I authorize the Practice to release information about my medical condition to the following people:

Name: _____ **DOB:** _____ **Relationship:** _____

Name: _____ **DOB:** _____ **Relationship:** _____

PATIENT COMMUNICATIONS. I consent to be contacted by the Practice or anyone calling on its behalf for any reason, including appointment reminders and regarding past due patient balances. I authorize the Practice to contact me at any telephone number or physical or electronic address I provide. I agree that the Practice may contact me in any way, including calls or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system. I agree to promptly notify the Practice at any time my contact information changes. (_____)

INITIAL

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees. (_____)

INITIAL

PRIVACY POLICY. I acknowledge having received the Practice's "Notice of Privacy Practices." My rights, including the rights to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent the practice has already made disclosures with my prior consent. (_____)

INITIAL

This consent was signed by (Patient or Authorized Person):

Relationship (if not patient):

PRINT NAME

Signature: _____ **Date:** _____

If patient is unable to sign, verbal consent may be given. Reason: _____

Witness Signature: _____ **Date:** _____