PATIENT INFORMATION SHEET

NAME_____ DATE OF BIRTH___/___/___ GENDER_____

ADDRESS_____ DAYTIME NUMBER_____

CITY/STATE/ZIP_____ EVENING NUMBER_____

SOCIAL SECURITY #_____ E-MAIL ADDRESS_____

MARITAL STATUS_____ IS PATIENT EMPLOYED? YES or NO

WORK RELATED INJURY? YES or NO EMPLOYER NAME_____

DATE OF INJURY_____ CITY/STATE/ZIP_____

OCCUPATION_____ EMPLOYER PHONE #_____

IF PATIENT IS A STUDENT, IS IT? FULL-TIME or PART-TIME NAME OF SCHOOL_____

RACE (Circle one): Caucasian Black Asian Hispanic Native Hawaiian American Indian Middle Eastern Multiracial

ETHNICITY (Circle one): Hispanic Non-Hispanic LANGUAGE_____

PHARMACY_____ LOCATION/PHONE#_____

INSURED INFORMATION

INSURED RELATIONSHIP TO THE PATIENT (Circle one): SELF SPOUSE PARENT OTHER

NAME OF POLICY HOLDER_____ DATE OF BIRTH___/___/___ GENDER_____

ADDRESS_____ TELEPHONE #_____

CITY/STATE/ZIP_____ SOCIAL SECURITY # _____

EMPLOYER NAME_____ EMPLOYER PHONE NUMBER_____

EMPLOYER ADDRESS_____

INSURANCE CARRIER INFORMATION

PRIMARY CARRIER_____ ID/SUBSCRIBER #_____

ADDRESS_____ GROUP #_____

CITY/STATE/ZIP_____

SECONDARY CARRIER_____ ID/SUBSCRIBER #_____

ADDRESS_____ GROUP #_____

CITY/STATE/ZIP_____

NAME OF PRIMARY CARE PHYSICIAN_____

NAME OF REFERRING PHYSICIAN (IF ANY)_____

Assignment of Benefits: I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance and any other health plan payments to The Orthopedic Institute of Wisconsin. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid for by aforementioned insurance carrier(s). I hereby authorize said assignee to release all information necessary in order to secure payment. I understand that I am responsible for updating the above information, in a timely fashion, should there be any changes.

PATIENT SIGNATURE _____ DATE_____

Orthopedic Institute of Wisconsin

MEDICAL HISTORY FORM

LAST NAME: _____ FIRST NAME: _____MI: _____ TODAY'S DATE: ____/____/_____

DATE OF BIRTH: ____/____/_____ CURRENT AGE: _____ EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

CHIEF COMPLAINT (Reason for today's visit): _____

DID THE PROBLEM RESULT FROM A SPECIFIC INJURY? ☐ NO ☐ YES DATE OF INJURY: ____/____/_____

IS THIS A WORK RELATED INJURY? ☐ NO ☐ YES HAS THE INJURY BEEN REPORTED? ☐ YES ☐ NO

WHAT IS YOUR OCCUPATION? _____

IS THIS INJURY PART OF A LAWSUIT? ☐ NO ☐ YES

PLEASE DESCRIBE THE ONSET OF THE PROBLEM (How did the problem start?): _____

_____

DOMINANT HAND: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS HEIGHT: _____ WEIGHT: _____

SYMPTOMS: What symptoms **RELATED TO TODAY'S VISIT** are you experiencing? (Please check all that apply)

☐ Pain ☐ Weakness ☐ Swelling ☐ Stiffness or Motion Loss ☐ Instability

☐ Locking ☐ Grinding ☐ Clicking ☐ Numbness/Tingling ☐ Catching

☐ Other: _____

Describe the Symptoms: (Quality)

☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Burning ☐ Achy

☐ Shooting ☐ Radiating ☐ Other: _____

How long have you had symptoms? (Duration) _____

How often do you have symptoms? (Timing) ☐ Occasional ☐ Frequent ☐ Constant

When do symptoms occur? ☐ With activity ☐ Morning ☐ Night

Pain Level: (none=0, 10=severe, please circle)

At worst: 1 2 3 4 5 6 7 8 9 10 At best: 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse? _____ Better? _____

Are you on Narcotic Medication for this issue? ☐ No ☐ Yes, Who is the prescribing Physician? _____

Have you had any prior injuries to the area? ☐ No ☐ Yes: _____

Have you had any previous treatment for this problem? ☐ No ☐ Yes: _____

If "yes", did any of these treatments provide relief? ☐ No ☐ Yes: _____

CHART#: _____

PAT NAME: _____

PERSONAL MEDICAL HISTORY:

Are you pregnant? ☐ Yes ☐ No ☐ Possibly

(Please check previous or current medical conditions)

☐ None ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots/DVT ☐ Cancer ☐ COPD

☐ Depression ☐ Diabetes ☐ Gout ☐ Heart Disease/CAD ☐ Hepatitis ☐ HIV

☐ High Blood Pressure ☐ High Cholesterol ☐ Irregular Heartbeat ☐ Liver Disease ☐ Lung Disease ☐ Osteoporosis

☐ Prostate ☐ Psoriasis ☐ Stomach Ulcer/Reflux ☐ Stroke ☐ Seizures ☐ Thyroid Disease

☐ Vascular Disease ☐ Dental infections or other Unresolved Dental Issues ☐ Other:_____

Have you ever had or been treated for MRSA (Methicillin-resistant Staphylococcus Aurous) or STAPH infection? ☐ No ☐ Yes :Date Cleared _____

Do you have a history of Post-Operative infections? ☐ No ☐ Yes, explain _____

SURGICAL HISTORY: (Please list previous surgeries and dates) ☐ NONE _____

_____

CURRENT MEDICATIONS: (Please list the names of any **prescription medications** which you are presently taking/or provide a list)

_____ _____ _____ _____

_____ _____ _____ _____

MEDICATION ALLERGIES: ☐ None ☐ Yes, name of drug and reaction: _____

ANY METAL ALLERGIES: ☐ None ☐ Yes, what metal? _____

ANY NICKEL ALLERGY: ☐ No ☐ Yes, reaction? _____

SOCIAL HISTORY: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Hobbies: _____

Smoking History: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker, _____packs/day for _____years

Alcohol History: ☐ Never ☐ Rare ☐ Social ☐ Daily

FAMILY HISTORY: (Please list any medical conditions which run in your family) ☐ None ☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots/DVT

☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Gout ☐ Heart Disease/CAD ☐ Hepatitis ☐ HIV

☐ High Blood Pressure ☐ High Cholesterol ☐ Irregular Heartbeat ☐ Liver Disease ☐ Lung Disease ☐ Metal Allergy

☐ Osteoporosis ☐ Prostate ☐ Psoriasis ☐ Stomach Ulcer/Reflux ☐ Stroke ☐ Seizures

☐ Thyroid Disease ☐ Vascular Disease ☐ Other: _____

REVIEW OF SYSTEMS: (Please check any of the following issues which you are **CURRENTLY** experiencing)

☐ Fatigue ☐ Weight gain/loss ☐ Fever/Chills ☐ Insomnia ☐ Depression ☐ Anxiety

☐ Vision Changes ☐ Hearing Loss ☐ Sinus Pain ☐ Sore Throat ☐ Mood Swings ☐ Stress

☐ Chest Pain ☐ Palpitations ☐ Edema ☐ Poor Circulation ☐ Hypoglycemia ☐ Diabetes

☐ Cough ☐ Short of Breath ☐ Wheezing ☐ Pneumonia ☐ Thyroid ☐ Hot Flashes

☐ Nausea/Vomiting ☐ Indigestion ☐ Acid Reflux ☐ Stomach Pain ☐ Easy Bruising ☐ Easy Bleeding

☐ Difficult Urination ☐ HIV ☐ Painful Urination ☐ Blood in Urine ☐ Anemia ☐ Blood Clots

☐ Rash ☐ Hives ☐ Sensitive Skin ☐ Easy Scarring ☐ Seasonal Allergies ☐ Food Allergies

☐ Headache ☐ Dizziness ☐ Seizures ☐ Tremor ☐ Frequent Infection ☐ Frequent Urination

THE INFORMATION PROVIDED IS TRUE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND ABILITY. I UNDERSTAND THAT I AM RESPONISIBLE FOR UPDATING THIS INFORMATION, IF ANY OF IT CHANGES, IN A TIMELY FASHION.

PATIENT SIGNATURE: _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Orthopedic Surgeons of Wisconsin, SC

Authorization to Release Information

Many of our patients allow specified individuals such as their spouse, parent or others to call and request the results of tests and procedures; or to contact us on their behalf to assist in explaining their statements. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have other specified individuals permitted to contact us on your behalf for the aforementioned purpose(s), you must specify to whom we may speak and you must sign this form.

I authorize Orthopedic Surgeons of Wisconsin, SC to release my results and reports; and/or to discuss matters relating to my statements with the following individuals.

1. _____Phone# ( )_____ Relationship to Patient: _____

2. _____Phone# ( )_____ Relationship to Patient: _____

3. _____Phone# ( )_____ Relationship to Patient: _____

Name of Patient: _____

Signature of Patient: _____ Date: _____

Authorization to Leave Message with Household Members/Answering Machine

From time to time it is necessary for representatives of Orthopedic Surgeons of Wisconsin, SC to leave a message for our patients. The purpose of these messages are to remind patients that they have an appointment, to notify the patients that medical staff would like to discuss lab or procedure results, or to ask a patient to call OIW regarding an issue or concern. At no time will a representative of OIW discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Name of Patient: _____

Signature of Patient: _____ Date: _____

The Orthopedic Institute of Wisconsin

Written Acknowledgement of Receipt of Privacy Practices

I, _____acknowledge that I have received the written Notice of Privacy Practices from The Orthopedic Institute of Wisconsin.

_____ _____

Signature of Patient or Personal Representative Date

FOR OFFICE USE ONLY

Note: If the patient is unable to sign this notice, please document the reason why and sign and date below:

_____

_____

_____

_____ _____

Employee Signature Date

Notice to Patients
of
ORTHOPEDIC INSTITUTE OF WISCONSIN

Our physicians are proud to be part of The Surgery Center located at 3111 West Rawson Avenue in Franklin, Midwest Orthopedic Specialty Hospital located at 10101 South 27th Street in Franklin, and the Wauwatosa Surgery Center located at 10900 West Potter Road in Wauwatosa. These facilities provide top quality health care that will be an extension of the high quality of care that we provide at our office. Accordingly, in the course of your treatment, you may be referred to those facilities for services.

The physicians of the Orthopedic Institute of Wisconsin have ownership interests in these facilities. Specifically, Doctors Butler, Edwards, Guehlstorf, Pennington, Stone, Trinkl and Pifel are part-owners of Associated Surgical and Medical Specialists, LLC, which in turn owns part of The Surgery Center. In addition, Doctors Butler, Edwards, Guehlstorf, Neubauer, Pennington, Perlewitz, Pifel, Stone, Trinkl, Evanich, McCarty, Bamrah and Afsari are part-owners of TS Ortho, LLC, which in turn owns part of the Midwest Specialty Hospital. Also, Doctors Evanich, McCarty and Bamrah are part owners of Potter Road Ventures, LLC, which in turn owns part of the Wauwatosa Surgery Center.

If you prefer that the services for which you are referred be provided at a facility other than The Surgery Center, Midwest Orthopedic Specialty Hospital, or Wauwatosa Surgery Center, please notify one of our staff schedulers as soon as possible so that alternative arrangements can be made.

We would appreciate your acknowledging receipt of this notice by signing below.

Patient's Signature_____Date:_____

Print Name_____