MIDWEST SPORTS MEDICINE INSTITUTE

Comprehensive History Questionnaire

Name: _____ Date : _____

Height_____ Weight_____ Handed: RT☐ LT☐ Ambidextrous☐

How did you hear about us?_____

Name of Family Physician:_____ Doctor's Phone number (if known)_____

Chief Complaint: (brief description of your current orthopaedic problem) _____

History of Present Illness: (answer these questions regarding your current problem(s) only)

(may indicate on the pictogram below)

Where on your body are you having this problem?

_____

_____

What symptoms are you experiencing?_____

_____

_____

How long have you had this problem?_____

_____

Have you had similar pains in the past?

☐ yes ☐ no If yes, when?_____

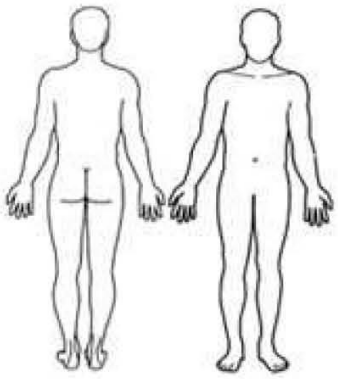
_____

How did it happen?_____

_____

Injury? ☐ yes ☐ no If yes, give date:_____

Where did it occur?_____



Work related? ☐ yes ☐no If yes, give date of injury?_____

How did accident happen?_____

Are you working now? ☐ yes ☐ no

How severe is this for you? (place an "X" on the line below)

No pain (0)----------(10) Worst pain of your life

What makes it worse? (eg. sitting, standing, walking, exercise, coughing/sneezing)

_____

_____

What makes it better? (eg. lying, sitting, standing, walking, exercise, pain pills)_____

_____

Any previous treatment for this problem? (eg. emergency room, physical therapy, chiropractic or other alternative treatments)

_____

_____

Have you had any of the following diagnostic studies for your current problem?

Diagnostic X-rays	☐ yes	☐no	Date:_____
MRI (magnetic resonance imaging)	☐ yes	☐no	Date:_____
EMG (electromyogram) / NCV (nerve conduction velocity)	☐ yes	☐no	Date:_____
Other_____			Date _____

Review of Systems: (please indicate yes or no)

Constitutional
- fever ☐ Y ☐ N
- weight change ☐ Y ☐ N

Eyes
- visual change ☐ Y ☐ N

Ears, Nose, Mouth
- hearing change ☐ Y ☐ N
- sinus problems ☐ Y ☐ N
- dental problems ☐ Y ☐ N

Cardiovascular
- chest pain ☐ Y ☐ N
- hypertension ☐ Y ☐ N
- shortness of breath ☐ Y ☐ N

Respiratory
- tuberculosis ☐ Y ☐ N
- pneumonia ☐ Y ☐ N
- asthma ☐ Y ☐ N

Endocrine
- diabetes ☐ Y ☐ N
- if Yes – Insulin dependent? ☐ Y ☐ N
- thyroid problem ☐ Y ☐ N

Gastrointestinal
- nausea/vomiting ☐ Y ☐ N
- blood in stool ☐ Y ☐ N

Genitourinary
- urinary infections ☐ Y ☐ N
- incontinence ☐ Y ☐ N

Skin
- infections ☐ Y ☐ N
- lesions/ulcers ☐ Y ☐ N

Neurologic
- seizures ☐ Y ☐ N
- paralysis ☐ Y ☐ N

Psychiatric
- depression ☐ Y ☐ N

Hematologic
- blood clots ☐ Y ☐ N
- bleeding ☐ Y ☐ N

Past Medical History: (please circle those medical conditions for which you are followed by your doctor)

AIDS/HIV	Circulatory Problems	High Cholesterol	Rheumatoid Arthritis
Anemia	Diabetes	High Blood Pressure	Shortness of Breath
Arthritis	DVT/Blood Clots	Irregular Heartbeat	Sinus Problems
Artificial Heart Valves	Ear/Eye Problems	Kidney Problems	Sleep Apnea
Asthma	Foot/Leg Cramping	Liver Diseases/Hepatitis	Stomach Ulcer
Bleeding Disorders	Gout	Nervous Problems	Stroke
Cancer	Headaches	Osteoporosis	Thyroid Disorder
Chemical Dependency	Heartburn/Acid Reflux	Psychiatric Care	Other_____
Chest Pain	Heart Disorders	Respiratory/Lung Disorders	Other_____

Past Surgical History: (please list prior surgeries, especially those related to your current problem)

1._____ 2._____
3._____ 4._____

Allergies: (circle or write in any medication allergies that apply) None ☐

Penicillin	Latex	Aspirin	Advil, Aleve, Motrin
Morphine	Aspirin	Sulfa Drugs	Other _____
Novocain	Adhesive tape	Shrimp,Iodine,Merthiolate	Other_____

Medications: (please list name, dose, and frequency)

1._____ 2._____
3._____ 4._____
5._____ 6._____

Women: (If yes, please list)

Are you taking birth control pills? Yes ☐ _____ No ☐
Are you on hormone replacement therapy (HRT)? Yes ☐ _____ No ☐

Family Medical History: (list medical illnesses affecting your immediate family)

1._____ 2._____
3._____ 4._____

Social History: (please check all that apply)

☐ single ☐ married ☐ widowed ☐ divorced/separated
☐ tobacco use (packs per day):_____ ☐ alcohol use (drinks per week):_____

Midwest Sports Medicine Institute

Patient Registration Form

Today's Date _____ **E-mail address** _____

Patient's Name _____ **Sex** _____ **Marital Status** _____

Date of Birth _____ **Age** _____ **Social Security Number** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone (**)** _____ **Work (** **)** _____ **Cell (** **)** _____

Local Pharmacy (**)** _____ **Phone (** **)** _____

Pharmacy City/State/Intersection _____

Patient Employed By _____ **Occupation** _____

Employer's Address _____

Spouse's Name _____ **Social Security Number** _____

Employed By _____ **Work Phone (** **)** _____

Name of Person to Contact in an Emergency _____

Phone Number (**)** _____ **Relationship to Patient** _____

Insurance

Primary Insurance _____ **Secondary Insurance** _____

Primary Cardholder _____ **Secondary Card Holder** _____

Relationship to Patient _____ **Relationship to Patient** _____

Date of Birth _____ **Date of Birth** _____

Social Security Number _____ **Social Security Number** _____

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If Patient is a Minor or Student Complete This Section

Father's Name _____ **Mothers Name** _____

Address _____ **Address** _____

Phone _____ **Phone** _____

Employer _____ **Employer** _____

Work Phone (**)** _____ **Work Phone (** **)** _____

Social Security Number _____ **Social Security Number** _____

Date of Birth _____ **Date of Birth** _____

Release of Medical Health Information

In the event that Midwest Sports Medicine Institute is unable to contact me, I give full permission to Midwest Sports Medicine Institute to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not limited to information regarding tests, reports, scheduling and business information. By my signature below, I agree to hold harmless and waive any liability against Midwest Sports Medicine Institute for the disclosure of information to the individual(s) designated below.

NAME	PHONE
_____	_____
_____	_____
_____	_____

I understand this release will be in effect unless changed or revoked by myself either in writing or by completing a new release.

Patient or Parent/Guardian if patient is a minor (print) _____ **Date** _____

Patient or Parent Guardian if patient is a minor (signature) _____

Release of Information and Authorization for Assignment of Benefits

I authorize Midwest Sports Medicine Institute to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that they may require processing my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due me in my pending claim for medical treatment of services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that,(regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient(or myself). I have read all the information contained in the Financial policy. I certify that, to the best of my knowledge, this information completed is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

Signature _____ _____ ***Date*** _____

Patient or Parent / Guardian if patient is a minor

Midwest Sports Medicine Institute Financial Policy

Thank you for choosing Midwest Sports Medicine Institute as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

- **All Patients must complete our "Patient Registration and Medical form" prior to seeing the doctor.**
- **FULL PAYMENT is due at the time of service unless prior arrangements have been made.**
- **Copays are due at the time of service.**
- **There will be a $35.00 service charge on all returned checks.**
- **The charges made for your visit depend on the nature and the complexity of your problem. If you have any questions regarding the charges made for any visit, please feel free to contact our billing office.**
- **Any charge that becomes sixty (60) days old without satisfactory payment provision having been made will be considered delinquent.**

  MSMI reserves the right to turn over delinquent accounts to a debt collection agency or an attorney for collection. Costs associated with collection efforts will be added to the balance due to MSMI.
- **Effective July 1, 2013, MSMI will charge a fee of $20.00 per form, each time you present a Short-term Disability Form, Long-term Disability Form, or an FMLA Form for completion by our office. Prior to submitting the form, you must complete your portion, including all personal information, all dates and the nature of any problems you are having. All fees must be paid at the time the form(s) is submitted to us, prior to its completion. The fee will not be billed to an insurance carrier or an employer. Please allow us 5 business days to complete the form.**
- **We accept cash, checks and Visa /Mastercard.**

Covered Services **-- Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services at the time they are rendered.**

Medicaid/Public Aid **-- If Medicaid/Public Aid covers you, you must present medical eligibility proof at the time you register for each service.**

Medicare**------- I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also apply.**

Insurance Plans **-- If you have a Managed care plan (HMO, EPO, POS or PPO), co-payments are due at the time of service in addition to any deductibles or fees for which you are responsible. If you have an Indemnity plan (80/20 plan), 20% payment is due at the time of service in addition to deductibles for which you are responsible. Insurance is a contract between you and your insurance company. We are not party to this contract. By law, insurance companies are required to pay health care providers within 30-45 days. If they do not fulfill their financial obligations, the responsibility will be transferred to the patient. You are responsible for the timely payment of your account. Ninety (90) days after the date of service any unpaid amounts will be assessed late payment charges of 0.5% monthly.**

Credit/ Debit Card Policy:

Midwest Sports Medicine Institute would like you to provide us with a Credit/Debit card if you proceed with surgery. This information will facilitate the settlement of any balances that may be your responsibility after we have settled with your health insurance carrier. You will be notified prior to us charging your credit card. If a valid credit card is not provided you are scheduled to have surgery then you are required to leave a $1,000.00 deposit. The deposit will be applied to whatever patient balances are not paid by your health insurance carrier (such as deductibles, co-insurances, co-pays and/or non-covered services). If the insurance carrier's benefits plus the amount on deposit exceed the amount owed for services, the difference will be refunded back to you.

I understand the above listed financial policy and agree to abide by this agreement. My signature serves as authorization to charge my credit card.

Signature _____ **Date** _____

Patient or Parent / Guardian if patient is a minor