Comprehensive History Questionnaire

Name: _____ Date : _____

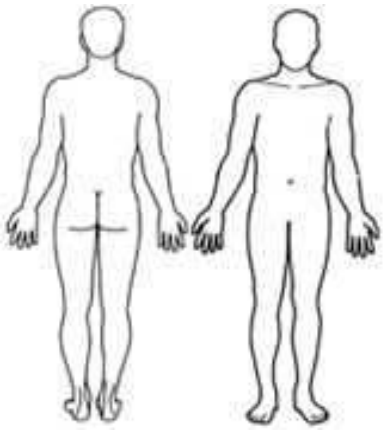
Height_____ Weight_____ Handed: RT☐ LT☐ Ambidextrous☐

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 for your Orthopaedic care. 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. You/guardian of a minor are responsible for PAYMENT FOR ALL balances for treatment associated with Midwest Sports Medicine Institute regardless of your contract with your insurance company.
---- Copays are due at the time of service.
---- There will be a $25.00 service charge on all returned checks.
---- The charges designated for your visit depend on the nature and the complexity of your problem and diagnosis. If you have any questions regarding your financial responsibility from your visit, please feel free to contact our billing office at 815-267-8830.

---- Any unpaid balances that become sixty (60) days old without satisfactory payment made will be considered delinquent. See Payment Authorization form for policy regarding safely storing your Credit Card on file for payment after 60 days payment delinquency.

---- MSMI reserves the right to turn over delinquent accounts to a debt collection agency or an attorney for collection. Costs associated with
the collection efforts will be added to the balance due to Midwest Sports Medicine Institute

--- We accept cash, check, Care Credit, and Visa/Mastercard. To set up financing with Care Credit, simply scan the QR code below.

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

I understand the above-listed financial policy and agree to abide by this agreement. INITIAL: _____

Medicare---- I authorize any holder of medical or other information about me to release any information needed for this or a related Medicare claim to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers. 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.

Release of Information and Authorization for Assignment of Benefits
I authorize MSMI 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 to process my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due 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 DUE 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

Midwest Sports Medicine Institute- Payment Authorization Form

Midwest Sports Medicine Institute is committed to making our billing process simple, transparent, and as easy as possible. Our goal is to streamline the process for patients and the practice so that we can focus our efforts on providing excellent orthopaedic care.

We require that all patients provide a credit card on file with our office, which we will store in a secure, compliant location. Your insurance company is billed within a week of the date of service. When your insurance claim is finalized, you will receive a document entitled Explanation of Benefits indicating what benefits were paid and the amount for which you are responsible. This may be in the form of a copay, co-insurance, deductible, or non-covered service.

Our billing office receives this same Explanation of Benefits form from your insurance and enters the information into your account. A statement is generated for any remaining amount/balance for which you are responsible. You have 30 days to remit payment from the time your explanation of benefits and personal responsibility is posted. Your payment is due upon receipt of your mailed paper statement from Midwest Sports Medicine Institute. We offer convenient payment options including online payment and financing through care credit. Prompt payment is necessary and appreciated. *If you have not responded to your statements after 30 days, we will charge your credit card on file, five days after sending you one final statement.* If your credit card is invalid and you are unreachable, your account will be sent to collections. If you would like to change your payment method before the card on file is charged, or have any questions about the statement, you may call our office.

Credit Card Information:

Family/Patient Name:
_____
Email:
_____
Phone #:
(_____)_____-_____

Billing Address:
_____
Address Line 2:
_____
City: State:
_____ _____
Zip Code: Country:
_____ _____

Is this a Health Savings Account, Flexible Spending Account, or a Health Reimbursement Arrangement Card? *
Yes No
Please sign:
I understand the above outlined policy on page 1, and I authorize Midwest Sports Medicine Institute to charge my credit card if the statement balance has not been paid in full by 30 days after insurance has finalized the claim. I am aware that I may cancel this authorization at any time by providing Midwest Sports Medicine Institute with a written request to cancel this authorization. I also understand that should my payment decline for any reason, that a representative from Midwest Sports Medicine Institute will reach out to process a different payment method. If our office is unable to get an updated form of payment, your account will be sent to collections for unpaid outstanding balances.
I also agree to authorize Midwest Sports Medicine Institute to use any card(s) provided at check-in or check-out as a payment method for said account and are aware that they will be securely stored in the system. I authorize Midwest Sports Medicine Institute to process stored card(s), even if not in person, with this same authorization and signature.
Signature
_____
Printed name:
_____
Relationship to Patient:
_____
Date:
_____