Bone&Joint SPECIALISTS

9001 Broadway, Merrillville, IN 46410
Phone: (219) 795-3360 Fax: (219) 756-6500

PLEASE PRINT

TODAY'S DATE	PATIENT REGISTRATION	MRN #:

PATIENT INFORMATION

LAST NAME				FIRST NAME AND INTIAL			
PATIENT SSN#		SEX		DOB		MARITAL STATUS	
PREFERRED LANGUAGE		PCP		Referring Physician			
ADDRESS							
CITY		STATE		ZIP			
PRIMARY CONTACT #	HOME PHONE		WORK PHONE		CELL PHONE		
E-MAIL ADDRESS							
EMPLOYER		EMPLOYER'S ADDRESS					
OCCUPATION				EMPLOYMENT STATUS			
SPOUSE'S NAME							
SPOUSE'S HOME PHONE		SPOUSE'S WORK PHONE		SPOUSE'S CELL PHONE			

ETHNICITY: NO, NOT HISPANIC YES, HISPANIC OR LATINO

RACE: AMERICAN INDIAN ALASKAN NATIVE ASIAN BLACK OR AFRICAN AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE OR CAUCASIAN OTHER PATIENT REFUSED

NAME OF PRIMARY INSURANCE:						
POLICYHOLDER NAME				RELATIONSHIP		
ADDRESS		CONTACT PHONE				
POLICYHOLDER SSN#		SEX		POLICYHOLDER DOB		
EMPLOYER		EMPLOYER PHONE		EXT		
EMPLOYER ADDRESS						

NAME OF SECONDARY INSURANCE:						
POLICYHOLDER NAME				RELATIONSHIP		
ADDRESS		CONTACT PHONE				
POLICYHOLDER SSN#		SEX		POLICYHOLDER DOB		
EMPLOYER		EMPLOYER PHONE		EXT		
EMPLOYER ADDRESS						

EMERGENCY CONTACT INFO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH		RELATIONSHIP				
ADDRESS						
PRIMARY CONTACT #	HOME PHONE		WORK PHONE		CELL PHONE	

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

PT. NAME: MRN #:

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis – I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.
I give my permission to Bone and Joint Specialists **and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.**

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments – I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

No Show Policy – Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **$35 no show fee. You must give 24 hour advanced notice to cancel appointments. Failure to do so will result in a $35 fee charged to your account. By signing below, I acknowledge that I have read and understand this policy.**

Precertification – If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

Advance Directive – Information regarding advance directives is provided in the Patient Information Guide.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

Patient Signature ______ Date ______ Responsible Party Signature ______ Date ______

Witness Signature ______ Date ______ Relationship to Patient ______

(Section 1) I give consent & authorization for the medical, or billing staff of my physicians office to release information regarding my medical care to:

______ (Name/ Relationship) ______ (Name/ Relationship)

______ (Name/ Relationship) ______ (Name/ Relationship)

(Section 2) AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and priviledge to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent that action has already been taken in reliance on the consent.

Name______ Relationship______

Name______ Relationship______

I understand I may revoke this privilege listed in (Section 1) and (Section 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature ______ DATE ______

ADVANCED DIRECTIVE

Have you appointed a Health Care Representative? yes ____ no____ Do you have a living will? yes ____ no____

Have you given anyone your Power of Attorney? yes ____ no____

Michael Knesek M.D.

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PATIENT HISTORY

Referred By: ______________________________

Date: __________________ Patient Name ____

Age: ________ Sex: M / F Hand Dominance: R / L

Occupation: ____

PRESENT ILLNESS

Chief Complaint: ____

Date of onset/injury: ____

Mechanism of injury: ____

Pain

- Where does it hurt: ____
- Describe the pain: ____
- Severity (1-10, 10 being very severe): ____
- How often: ____
- How has it changed over time: ____

What makes it better? ____

What makes it worse? ____

Associated symptoms: ____

Prior Treatment

- Physician: ____
- Medications: ____
- Injections: ____
- Therapy: ____
- Tests: ____

Occupational Y / N Work missed? Y / N Last date worked: ______________

Return to work (date): ______________________ with (full / light) duty

Pharmacy name and location: ____

List all Current Medications: ____

____

____

Are you claustrophobic? [ ] mild [ ] moderate [ ] severe [ ] NO

Drug Allergies and Reaction: ____

Anesthesia Complications: ____

PAST MEDICAL HISTORY: circle all that apply

CV: Heart attack, chest pain, congestive heart failure, arrhythmia, high blood pressure, murmur, varicosities, blood clots
Respiratory: Asthma, emphysema, chronic bronchitis, pneumonia, asbestosis
GI: Ulcers, esophagitis, gastritis, hiatal hernia, hepatitis, GERD
Renal: Kidney infections / failure, kidney stones, UTI
Cancer: ______________________________
Hematologic: Anemia, hemophilia, or other bleeding disorder
Endocrine: Hypo/Hyper thyroidism, diabetes, pituitary gland disorder
Rheumatologic: Gout, rheumatoid arthritis, Lupus, scleroderma, rheumatic fever, psoriasis, fibromyalgia
DVT Risk Factors: Varicosities, heart disease, HBP, obesity, stroke, previous blood clot, diabetes
History of MRSA or Staph infection
OTHER: ______________________________

PAST SURGICAL HISTORY: please list

__________________ __________________
__________________ __________________
__________________ __________________

FAMILY HISTORY: please include mother, father, siblings, grandparents

Anesthesia Complications: ______________________________
Cardiovascular: ______________________________
Cancer: ______________________________
Hematologic: ______________________________
Musculoskeletal: ______________________________
Renal: ______________________________
Diabetes/thyroid problems: ______________________________

SOCIAL HISTORY

Tobacco: Current /Nonsmoker / Former________years quit
Alcohol: Frequent / Social / Occasional / Rare / None
Illicit Drug Use: Type ____________ Amount ________________ Frequency _________
Do you have any personal preferences/beliefs that would prevent you from receiving a blood transfusion?______________________________

REVIEW OF SYSTEMS: please circle all that apply

Constitutional: Chills, fevers, night sweats, weight loss, weight gain
Eyes: Near-sightedness, far-sightedness, astigmatism, double vision, glaucoma
Ears: Hearing loss, tinnitus, vertigo
Nose, Mouth, Throat: Rhinorrhea, congestion, sore throat
CV: Chest pain, heart palpitations, edema
Respiratory: Cough, wheezing, difficulty breathing, coughing blood, shortness of breath
GI: Nausea, heartburn, bowel irregularities, hemorrhoids
GU: Frequency/hesitancy, blood in urine, incontinence, irregular menstrual cycle
Musculoskeletal: Muscle aches, joint swelling, neck pain, back pain
Integumentary: Skin lesions (stable / changing), acne, rashes
Neurological: Headaches, loss of consciousness, seizures, tingling/numbness, gait disturbance
Psychiatric: Depression, mood-swings, hallucinations, anxiety
Endocrine: Excessive thirst/frequent urination, hyperactivity, difficulty sleeping
Hematologic: Easy bruisability, anemia, bloody noses, excessive blood loss, HIV risk
Height: ____________ Weight: ___________