CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

PATIENT INFORMATION SHEET

Patient Name: ____ **DOB:** __________

Address: ____ SSN: __________
ADDRESS CITY, STATE, ZIP

Mailing Address: ____ ☐ Same as above
ADDRESS CITY, STATE, ZIP

Home phone: ________________ Cell phone: ________________ Work phone: ________________

Marital Status: Single / Married / Widowed / Divorced Gender: F / M **E-mail address**: ______________

Primary Care Physician: __________________ City: __________ Phone Number: ______________

Referring Provider: ________________ City: ______________ Phone Number: ______________

Is this visit for the purpose of: Workman's Compensation Motor Vehicle Accident Personal Injury Self-Pay

Preferred method of communication: ☐ Home number ☐ Cell number ☐ Email ☐ Other: ______________

Emergency contact: ______________________________________ Relationship: __________
NAME PHONE NUMBER

Do we have permission to contact this person regarding matters concerning your care? ☐ Yes ☐ No

Ethnicity: ______________ Race: ______________ Preferred Language: ____________________

Name of Employer: ______________ Address: ____________________ Phone Number: __________

Insurance Information

Name of Primary Insurance: __________________ ID #: ______________ Group #: ____________

Policy Holder's Name: ________________ Relationship to Patient: ________ DOB:______ SSN#: ________

Name of Secondary Insurance: ________________ ID #: ______________ Group #: ____________

Policy Holder's Name: ________________ Relationship to Patient: ________ DOB:______ SSN#: ________

Guarantor Information **(FILL OUT THIS SECTION ONLY IF PATIENT IS A MINOR)**

Primary Guarantor/Parent/Guardian Name:______________________________ **DOB:** __________

Address: ____ **SSN:** __________
ADDRESS CITY, STATE, ZIP

Do you have an advanced directive such as a living will or medical power of attorney? ☐ Yes ☐ No

Preferred Pharmacy

Name: ________________________ Address: ______________Phone Number: ______________

ELECTRONIC PRESCRIPTIONS: *Our electronic medical record program accesses your prescription/medication history in order for us to safely prescribe your medication. By signing this, you authorize us to do so.*

PLEASE PROVIDE VALID PICTURE ID & PRIVATE INSURANCE CARD

revised 7/17/18

PATIENT INFORMATION SHEET

CONSENT TO HEALTH CARE SERVICES

I, the undersigned Patient, or undersigned person responsible for consenting on patient's behalf hereby request and consent to Chicago Hand & Orthopedic Surgery Centers to be examined and treated by the medical, nursing and other healthcare personnel who may participate in the Patient's care. I hereby acknowledge that all information provided herein is true to the best of my knowledge.

I hereby assign, transfer and set over to Chicago Hand & Orthopedic Surgery Centers all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization and give written notice.

I understand that my copay, if applicable, is due prior to being seen and if my co-pay is not paid I may have to reschedule my appointment. I understand that all cancellations of appointments must be made at least 24 hours in advance and rescheduled within the same business week whenever possible. I also understand that three consecutive no show appointments may result in a discharge from Chicago Hand & Orthopedic Surgery Centers.

I hereby agree to pay the regular charges of the physician for any treatment performed on my behalf or authorized by me.
I understand that I am financially responsible for all charges whether or not they are covered by my insurance plan or fall into the insurance company's definition of usual and customary. Chicago Hand & Orthopedic Surgery Centers is committed to providing the best treatment possible for our patients and our charges are considered usual and customary for our area. I understand that all bills are to be paid in full within 45 days of submission to my insurance company. Chicago Hand & Orthopedic Surgery Centers does not wait for the settlement of lawsuits. An authorized, approved payment plan will eliminate collection fees. I understand that I am responsible for all costs of collection for any outstanding fees, including but not limited to any attorney fees, court costs, expenses and interest incurred from the date of my initial consultation with any physician at the Chicago Hand & Orthopedic Surgery Centers.

*Patient/Primary Guarantor/Parent/Guardian Signature:*____ *Date:* ________________

*Private Insurance Policy Holder's Signature:*____ *Date:* ________________

CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

HEALTH HISTORY

Name: ______________________ DOB: ____________ Height: __________ Weight: __________

Occupation: ____

Hand Dominance (right or left):______________ Area Affected (e.g. right hand): ______________________

Reason you were referred here: ____

Date of Injury: ____________ How long have you had this condition?: ______________________

Is this injury or condition work related? ____

Have you been treated for this condition before? Yes No If yes, list treatment: ______________________

____

Do you have any of the following diseases?

YES	NO	(Please check all that apply)	YES	NO	
____	____	Asthma / Bronchitis	____	____	Stomach Ulcer / GERD
____	____	Emphysema	____	____	Liver Problem _________
____	____	Respiratory Disease	____	____	Hepatitis A B C D E
____	____	Anemia	____	____	Diabetes
____	____	High Blood Pressure	____	____	Thyroid Hyper / Hypo
____	____	High Cholesterol	____	____	Arthritis
____	____	Heart Problem / Pacemaker	____	____	Gout
____	____	Bleeding Problem	____	____	Epilepsy/Seizure Disorder
____	____	Blood clot / DVT	____	____	Other________________

FAMILY HISTORY

____	____	Family History of Anesthesia Problems (Mother / Father)	____	____	Family History of Diabetes (Mother / Father)
____	____	Family History of Bleeding Problems (Mother / Father)	____	____	Family History of Heart Disease (Mother / Father)

Please list all medications you are taking:

Medications	Dosage	Frequency
____________________	__________	____________________
____________________	__________	____________________
____________________	__________	____________________
____________________	__________	____________________

Are you allergic to any medications / latex / metals? YES ____NO ____ If yes, what: ______________________

Do you smoke? YES ____NO ____ If yes, how much: ______________________

Do you drink alcohol? YES ____NO ____ If yes, how much: ______________________

Past Surgeries: YES NO What kind / Date Performed: ______________________

____

Have you had a tetanus shot? YES NO If yes, when? ______________________

Patient's Signature: ______________________________ Date: ____________________

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CHICAGO HAND & ORTHOPEDIC SURGERY CENTERS

HEALTH HISTORY

Name: ____ DOB: ______________________

Please circle symptoms that you currently have or have had in the **past 3 months**:

GENERAL

YES	NO	
____	____	Chills
____	____	Depression
____	____	Dizziness
____	____	Fainting
____	____	Fever
____	____	Fever
____	____	Headache
____	____	Loss of sleep
____	____	Weight loss
____	____	Weight gain
____	____	Nervousness
____	____	Sweats

GASTROINTESTINAL

YES	NO	
____	____	Poor appetite
____	____	Bloating
____	____	Constipation
____	____	Diarrhea
____	____	Nausea
____	____	Rectal bleeding
____	____	Stomach pain
____	____	Vomiting
____	____	Vomiting Blood

MUSCLE JOINT

(pain, numbness/weakness in)

YES	NO	
____	____	Arms
____	____	Back
____	____	Feet
____	____	Hands
____	____	Hips
____	____	Legs
____	____	Neck
____	____	Shoulder

GENITO-URINARY

YES	NO	
____	____	Blood in Urine
____	____	Frequent Urination
____	____	Lack of Bladder Control
____	____	Painful Urination

SKIN

YES	NO	
____	____	Bruise easily
____	____	Hives
____	____	Itching
____	____	Rash
____	____	Scars
____	____	Change in mole
____	____	Non-healing scar

CARDIOVASCULAR

YES	NO	
____	____	Chest pain
____	____	Irregular Heartbeat
____	____	Low Blood Pressure
____	____	Poor Circulation
____	____	Rapid Heartbeat
____	____	Ankle Swelling
____	____	Varicose Veins

EYE/EAR/NOSE/THROAT

YES	NO	
____	____	Bleeding gums
____	____	Hoarseness
____	____	Nosebleeds
____	____	Persistent cough
____	____	Ringing in ears

FOR WOMEN ONLY

YES	NO	
____	____	Abnormal pap smear - Date of last papsmear______________________
____	____	Bleeding between periods - Date of last period ____________________
____	____	Hot flashes
____	____	Had a mammogram Number of children ____________________
____	____	Pregnant

Patient's Signature: ____ Date: ____________________

Physician's Signature: ____ Date: ____________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name: ____Date of Birth:_________________SSN:_________________

This notice advises you about the ways in which we may use and disclose your Protected Health Information (PHI). Protected Health Information (PHI) means any of your health information that could be used to identify you and that relates to your past, present, future physical or mental health or condition and related health care services. It also describes your rights and our duties with respect to your PHI. The law requires us to provide a copy of this notice to you which explains our legal duties and privacy practices.

My signature acknowledges that I have been offered a copy of Chicago Hand & Orthopedic Surgery Centers Notice of Privacy Practices at the time of registration.

*Signature:*____ Date:_______________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release of any and all records of my treatment to be forwarded to the following: (Please check all that apply)

( ) The referring occupational clinic, my employer, workers compensation representative who will be handling my claim, as well as any physicians and ancillary personnel involved in my medical care.

( ) The referring physician and any physicians and ancillary personnel involved in my medical care.

( ) My primary care physician.

( ) My private health insurance carrier and any associated entities.

( ) My employer: ____
Name of employer

*Signature:*____Date:______________________

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IMPORTANT INSURANCE/PAYMENT INFORMATION

Patient with private healthcare insurance:
The private healthcare insurance presented at the time of your visit will be billed for your treatment, HMO patients will need to start the process of securing a referral. Every effort will be made to ensure that claims are promptly and correctly submitted to your insurance company. Your insurance company has 30 days after receiving a correctly filed claim to process, pay, and/or give notice as to why claim has not been paid. After that time the remaining balance will be your responsibility. If you are not satisfied with the payment made by your insurance company, contact them directly at the phone number listed on your insurance card. If you choose to appeal to your insurance company in writing for additional payment, please provide Chicago Hand & Orthopedic Surgery Centers with a copy of that appeal for your file.

Patients with motor vehicle insurance/liability insurance:
If your injury was received as a result of a motor vehicle accident or a liability, and you do have private healthcare insurance, typically your private healthcare insurance will not make payments on your medical claims without a written denial from your motor vehicle insurance/liability insurance. It is very important that all pertinent information be given at the time of your visit regarding the motor vehicle insurance/liability insurance, including claim number, agent information, claim billing address, accident report etc.

Patients without private healthcare insurance – Self Pay:
If no private healthcare insurance is presented at the time of your visit, full payment or an approved payment plan is expected at the time of service.

Patients with Illinois Department of Public Aid – IDPA:
IDPA is not accepted at Chicago Hand and Orthopedic Surgery Centers. Full payment or an approved payment plan is expected at the time of service.

FOR ALL PATIENTS
*Any insurance policy is a contract between you and your insurance company.
*It is *your responsibility* to verify, with your insurance company, if a provider is *in or out of network for your plan.*
*Any unpaid balance left by your insurance company will be your responsibility.
*Insurance benefits paid directly to the patient will need to be forwarded to Chicago Hand & Orthopedic Surgery Centers to keep the account in good standing.
*If you have retained an attorney regarding your injury, it is very important to provide Chicago Hand & Orthopedic Surgery Centers with that information.
*Payment plans can be established with the approval of the billing department.
*Cash, checks, and all major credit cards are accepted for payment.
*You can contact the billing department with any questions.

By signing below, the patient acknowledges that they have read the above information, understands this information and that upon request may obtain a copy of this form.

______________________________	______________________________	______________________
Printed Name	Signature	Date

revised 7/17/18

CHICAGO
HAND &
ORTHOPEDIC
SURGERY CENTERS

PROTECTED PRIVATE HEALTH INFORMATION

The following information will not be released and will only be used for the purpose of our office.
Please circle conditions you have or had:

AIDS/HIV Positive **Alcoholism** **Chemical Dependency** **Psychiatric Care**

*Patient/Primary Guarantor/Parent/Guardian Signature:*___________________________________ *Date:*___________

*Print Your Name:*____

*Patient's Name: (Please print):*____