LAKE COOK
ORTHOPEDICS

REVIEW OF SYSTEMS-LAKE COOK ORTHOPEDICS

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? CIRCLE YES OR NO *ON EACH ONE*

PATIENT NAME: _____

PLEASE DO NOT CIRCLE YES OR NO IN GROUPS

ALLERGIC:
1. FREQUENT INFECTIONS ..... Yes ..... No
2. METAL ALLERGIES ..... Yes ..... No
3. SHELLFISH ALLERGIES ..... Yes ..... No
4. IODINE ALLERGY ..... Yes ..... No
5. LATEX ALLERGY ..... Yes ..... No
6. ANAPHYLACTIC REACTION ..... Yes ..... No

CARDIOVASCULAR
7. CHEST PAIN ..... Yes ..... No
8. RAPID HEART BEAT AT REST ..... Yes ..... No
9. ANKLE SWELLING ..... Yes ..... No
10. HIGH CHOLESTEROL ..... Yes ..... No
11. HEART MURMUR ..... Yes ..... No
12. IRREGULAR HEARTBEATS ..... Yes ..... No
13. PAIN IN CALVES WITH WALKING ..... Yes ..... No
14. VARICOSE VEINS ..... Yes ..... No
15. CALF CRAMPING AT NIGHT ..... Yes ..... No

CONSTITUTIONAL
16. FATIGUE ..... Yes ..... No
17. LOSS OF APPETITE ..... Yes ..... No
18. WEIGHT LOSS ..... Yes ..... No
19. FEVER ..... Yes ..... No
20. ACHE ALL OVER ..... Yes ..... No
21. SLEEP PROBLEMS ..... Yes ..... No

EAR, NOSE, THROAT
22. DIFFICULTY WITH HEARING ..... Yes ..... No
23. RINGING IN THE EARS ..... Yes ..... No
24. FREQUENT BLOODY NOSES ..... Yes ..... No
25. SINUS PROBLEMS ..... Yes ..... No
26. LOSS OF SENSE OF SMELL ..... Yes ..... No
27. SORES IN MOUTH ..... Yes ..... No
28. INFECTED TEETH ..... Yes ..... No
29. BLEEDING GUMS ..... Yes ..... No
30. HOARSENESS ..... Yes ..... No
31. DIFFICULTY SWALLOWING ..... Yes ..... No
32. SORE THROAT ..... Yes ..... No
33. SWOLLEN GLANDS ..... Yes ..... No
34. SNORING ..... Yes ..... No

ENDOCRINE
35. POOR HEALING ..... Yes ..... No
36. EXCESSIVE APPETITE ..... Yes ..... No
37. HOT FLASHES ..... Yes ..... No
38. EXTREME THIRST ..... Yes ..... No
39. EXCESSIVE HAIR GROWTH ..... Yes ..... No

EYES
40. BLURRED VISION ..... Yes ..... No
41. DOUBLE VISION ..... Yes ..... No
42. ABRUPT LOSS OF VISION ..... Yes ..... No
43. GLASSES ..... Yes ..... No

GASTROINTESTINAL
44. PAIN IN STOMACH ..... Yes ..... No
45. DIARRHEA ..... Yes ..... No
46. NAUSEA ..... Yes ..... No
47. VOMITING ..... Yes ..... No
48. BLOOD IN STOOLS ..... Yes ..... No
49. LOSS OF CONTROL OF BOWELS ..... Yes ..... No
50. DARK BLACK STOOLS ..... Yes ..... No

GENITOURINARY
51. IMPOTENCE ..... Yes ..... No
52. NEED TO URINATE OFTEN ..... Yes ..... No
53. VAGINAL/PENILE DISCHARGE ..... Yes ..... No
54. BLOOD IN URINE ..... Yes ..... No
55. BURNING WITH URINATION ..... Yes ..... No
56. LOSS OF CONTROL OF URINE ..... Yes ..... No

HEMATOLOGIC
57. EASY BRUISING ..... Yes ..... No
58. BLEEDING PROBLEMS ..... Yes ..... No
59. SICKLE CELL DISEASE ..... Yes ..... No
60. ANEMIA ..... Yes ..... No
61. PREVIOUS BLOOD TRANSFUSIONS ..... Yes ..... No

INTEGUMENTARY
62. ACNE ..... Yes ..... No
63. BLISTERS ..... Yes ..... No
64. RASHES ..... Yes ..... No
65. PSORIASIS ..... Yes ..... No
66. EXCESSIVE SCARRING ..... Yes ..... No
67. SHINGLES ..... Yes ..... No

NEUROLOGICAL
68. HEADACHES ..... Yes ..... No
69. DIZZINESS ..... Yes ..... No
70. NUMBNESS ..... Yes ..... No
71. WEAKNESS ..... Yes ..... No
72. FORGETFULNESS ..... Yes ..... No
73. FAINTING ..... Yes ..... No
74. TREMORS ..... Yes ..... No

PSYCHIATRIC
75. INSOMNIA ..... Yes ..... No
76. DEPRESSION ..... Yes ..... No
77. SUICIDAL ..... Yes ..... No
78. ADDICTION DISEASE ..... Yes ..... No
79. PANIC ATTACKS ..... Yes ..... No
80. VICTIM OF ABUSE ..... Yes ..... No
81. EATING DISORDER ..... Yes ..... No

RESPIRATORY
82. SHORTNESS OF BREATH ..... Yes ..... No
83. CHRONIC COUGH ..... Yes ..... No
84. COUGHING UP BLOOD ..... Yes ..... No
85. SLEEP APNEA ..... Yes ..... No
86. SHORT OF BREATH WHEN LYING FLAT ..... Yes ..... No

DATE: _____

X _____
Patient signature

PHYSICIAN INITIALS AND DATE:

Initials signify review of the data with the patient and agreement with the data.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

LAKE COOK ORTHOPEDICS

LAKE COOK ORTHOPEDICS PATIENT HISTORY FORM

Today's Date: _____ Patient name: _____

Referring physician _____City _____ Phone # _____

Primary care physician _____ City_____ Phone # _____

*If your visit is related to an injury, circle the appropriate response below. If it is not related to an injury, please fill out the reason for your visit here: _____.

The injury is due to: car accident work injury sports injury fall other _____

The injury occurred at: home work school other _____

Are you off work due to the injury: Yes No If yes, last day worked _____

If no, any restrictions _____

Is legal action/litigation pending due to this injury? Yes No

Date of injury/onset _____/_____/_____ Symptoms_____

Location of symptoms_____ Right☐ Left☐ Both☐ N/A☐

Circle each & every characteristic that BEST describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe / Rate on a scale 1-10 with 10 being the worst _____

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During activity/ After activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throwing / Lifting / Other _____

CONTEXT: Improving / Worsening / Recurrent / More frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical therapy / Brace / Injection / Medication / Other _____

SYMPTOM AGGRAVATION: Activity / Position change / Repetitive motion / Fatigue / Other_____

ASSOCIATED SYMPTOMS:_____

MEDICATIONS (PRESCRIPTION / NONPRESCRIPTION / HERBAL SUPPLEMENTS / VITAMINS / OTHER):

MEDICATION	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

IF THERE ARE ADDITIONAL MEDICATIONS, PLEASE PROVIDE ON BACK OF FORM

Do you have allergies? Y N If yes, please list allergies & describe reaction _____

Pharmacy of choice:

Name Street Address, City, State Phone # Mail order?

1. _____ _____ _____ Y / N

2. _____ _____ _____ Y / N

PATIENT HISTORY FORM CONTINUED

If you are permanently or temporarily residing in a skilled medical nursing facility/long term care facility/nursing home or rehabilitation center please complete below:

Facility name:_____City _____Dates _____

PAST MEDICAL AND FAMILY HISTORY: PLEASE CHECK THOSE THAT APPLY

	Self	Father	Mother	Sibling	Child	Grandparent		List any other medical conditions
1. Arthritis								
2. Asthma								
3. Cancer								
4. Diabetes								
5. Emphysema								
6. Glaucoma								
7. Heart disease								
8. Hepatitis								
9. High blood pressure								
10. Kidney disease								
11. Neurological disease								
12. Seizures								
13. Stroke								
14. Thyroid problem								
15. Stomach ulcers								

PAST SURGICAL HISTORY:

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

Procedure _____ Surgeon _____ Date _____

SOCIAL HISTORY: Circle one for each that apply below

Tobacco use: every day smoker / occasional smoker / heavy smoker / never smoked/ former smoker

Year started smoking _____ Year Quit _____ Are you pregnant? Y N

Alcohol use: How many drinks per week? _____ History of alcoholism: Y N History of drug use: Y N

Do you live alone? Y N If no, who do you live with? _____**Height _____Weight _____**

CONSENT TO TREAT/EVALUATE: I, for myself, or the patient named on this form, hereby consent to such medical evaluation (e.g. IME) and/or treatment and diagnostic procedures (e.g. x-rays, MRI, therapy) as necessary and appropriate for my condition or illness based on the judgment of my physician(s), to be performed by the physician(s), physician(s) assistant(s), nurse(s) or other health care provider(s). I have had, and will continue to have, an opportunity to discuss treatment options with my health care provider, ask questions regarding such treatment options and understand the options discussed.

Patient's signature: _____ Date: _____
(Parent/legal guardian if patient is a minor)

LAKE COOK ORTHOPEDICS

REGISTRATION FORM

_____ _M or F_____

Patient Last Name First Name Middle Sex (Circle)

_____ S M D W O

Social security # Date of birth Age Marital Status (Circle)

_____

Address Apt # (if applicable) City State Zip Code

(_____)_____(_____)_____

Home phone # Cell phone # Email address (used for patient portal) Referring physician

_____(_____)_____

Employer Employer address Occupation Business phone #

_____(_____)_____

Emergency Contact name Emergency contact phone # Relationship to patient

Primary Race (circle one): Caucasian African-American Asian American Indian Native Hawaiian unknown

Ethnicity (circle one): Hispanic Non-Hispanic unknown

Preferred language (circle one): English Spanish Other _____

MEDICAL INSURANCE INFORMATION (MUST COMPLETE EVEN IF INSURANCE CARD PRESENTED)

Primary insurance company name: _____ Phone#_____

Policy holder Name: _____Date of birth_____ Social Security # _____

Relationship to patient _____ ID #_____ Group # _____

Secondary insurance company name: _____Phone#_____

Policy holder Name: _____Date of birth_____ Social Security # _____

Relationship to patient _____ ID #_____ Group # _____

GUARANTOR INFORMATION (APPLICABLE IF PATIENT IS A MINOR)

_____

Guarantor Last Name First Name Middle Social security # Date of birth

_____

Address Apt # (if applicable) City State Zip Code

(_____)_____(_____)_____

Home phone # Cell phone # Relationship to patient

_____(_____)_____

Employer Employer address Business phone #

RELEASE & ASSIGNMENT: I authorize any holder of medical or other information about me to release any information needed to process my insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits to the undersigned provider(s).

Signature: _____ Date: _____

(patient, parent or legal guardian)

LAKE COOK
ORTHOPEDICS

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Welcome to Lake Cook Orthopedics and thank you for choosing us as your care provider. Your health is our primary concern. Please understand that payment of your bill is considered part of your treatment. Should you have health insurance, it is your responsibility to provide us with complete, accurate, and up to date information in order for us to successfully bill your insurance company. Here are some key components of our Financial Policy:

Identification/Self Pay:

- Proper photo identification must be presented prior to service being rendered.
- Current insurance cards must be presented at each visit prior to service being rendered.
- Unless other arrangements have been made prior to service being rendered, full payment is due at the time of service. We accept cash, check & all major credit cards.

Commercial Health Insurance/HMOs:

- Co-payments will be collected prior to the service.
- Co-insurance/deductible amounts will be billed after the date of service.
- LCO does not participate with every commercial insurance plan. As the owner of your policy, you are responsible for verifying that we are an in-network provider.
- It is the patient's responsibility to understand their benefits. We encourage you to contact your health plan with questions about your coverage/benefits.
- HMO plans require a referral for every visit with our office. It is the patient's responsibility to obtain necessary referrals.
- Each HMO referral must list each complaint and each possible treatment.

Medicare:

- We accept Medicare assignment. As a Medicare patient, you are responsible for the difference between Medicare's approved charge and the amount Medicare pays. This includes your deductible and charges for any service not covered by Medicare. If you have supplemental insurance, we will bill it directly for you. You will receive a bill after your insurance(s) has/have paid.

Workers Compensation/Motor Vehicle Accidents:

- LCO will bill Worker's Comp/MVA but it is your responsibility to supply us with the correct contact and billing information prior to services being rendered. It is including but not limited to; auto insurance, third party & attorney info.
- Patients shall be financially responsible for any and all services related to third party liability. LCO does not bill third party.
- We require a copy of health insurance to bill in case worker's comp denies coverage or auto med pay is exhausted.

Failure to honor your financial obligation to Lake Cook Orthopedic Associates in accordance with this signed agreement will result in your account being referred to collections and termination of the treatment relationship in accordance with regulations that govern ethical medical care. All fees and/or costs related to collection of your account will be applied (i.e. agency fees, court costs, attorney fees, etc.) The costs of collections include a $25 collection agency fee and/or up to 50% of collections cost. I agree to pay Lake Cook Orthopedics a $25 NSF fee for any returned checks. I agree to pay Lake Cook Orthopedics a $50 no show fee for any MRI service, Hip injection or Epidural injection, $25 for any therapy service & $75 for an EMG procedure that I do not call and cancel/reschedule within 24 hours. I hereby authorize my attorney to pay Lake Cook Orthopedics any outstanding balances due immediately upon receipts of any Workers Compensation and/or Third Party Insurance settlements.

ACKNOWLEDGEMENT: I have read the above financial policy, which I understand and agree to.

Name of patient: _____

Signature: _____ Date: _____

(Signature of patient, parent or legal guardian)

LAKE COOK
ORTHOPEDICS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT/ PHONE MESSAGE AND CONTACT AUTHORIZATION

Patient Name: _____ **Date of birth: _____**

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your health records. It also describes your rights with respect to your health records. Please read the entire NPP carefully. We will use and share your health records to: treat you and to bill you for the services we provide; to run our business and as required/allowed by law.

Under HIPPA, the law requires you to sign this page acknowledging that you had the opportunity to read and receive a copy of the NPP.

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Relationship: _____

Phone message and contact authorization:

Do the physicians and staff of LAKE COOK ORTHOPEDIC ASSOCIATES have your permission to leave messages containing medical and/or financial information on your voicemail? Please circle/fill in below.

At home Y N** **At work** Y N **On cell** Y N**

Even if you check N for no, the date, time and location of appointments will be left on your voicemail.

The individual(s) mentioned below will be your additional contacts**. I give authorization to the doctors and staff of Lake Cook Orthopedics to discuss my medical and/or financial information with the following people:**

	Name	Relationship	Phone #
1.	_____	_____	_____
2 .	_____	_____	_____
3 .	_____	_____	_____

I understand that is my responsibility to inform Lake Cook Orthopedics of any desired changes in this authorization.

NOTE: THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE OF SIGNATURE.

Signature: _____ Date: _____