Dale E. Bauwens, MD | James E. Cain, Jr., MD | Anthony A. Ferguson, MD | Thomas B. Huizenga, MD | Charles A. Klein, MD | David B. Kornreich, DO
Lawrence J. Maciolek, MD | Donald K. Middleton, MD | Jacqueline S. Mlsna, MD | Stephen E. Robbins, MD | Jeffrey J. Stephany, MD | Sean C. Tracy, MD

Doctor you are seeing today: ______________________________

Primary Doctor: ______________________________

Primary Doctor's Phone number: ______________________________

Who referred you to our office: ______________________________

How would you like to be addressed: ______________________________

FIRST NAME: ______________ MI: ________ LAST NAME: ______________

DATE OF BIRTH: ____________ AGE: ______ E-MAIL ADDRESS: ______________

ADDRESS: ______________________________

CITY: ______________ STATE: ____________ ZIP: ____________

HOME PHONE: ____________ WORK PHONE: ____________ CELL PHONE: ____________

SOCIAL SECURITY #: ______________________________

EMPLOYER: ______________________________

OCCUPATION: ______________________________

☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

RACE : ☐ Indian ☐ Alaskan ☐ Asian ☐ Black ☐ Caucasian
☐ Pacific Islander ☐ Other ☐ Declined

ETHNICITY: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

LANGUAGE: ______________ (English, Spanish, French, German, Arabic, etc)

EMERGENCY CONTACT NAME: ______________ PHONE NUMBER: ____________

PHARMACY NAME: ______________ PHONE NUMBER: ____________

LOCATION: ______________________________

Are your injuries work related? ☐ Yes ☐ No

If yes, have you filed a claim? ______________________________

Payment of this bill: I authorize payment of medical benefits to Wisconsin Bone and Joint, S.C. physicians for services rendered. I acknowledge that you may release information to process all claims as a service to me.

SIGNED: ______________________

DATE: ______________________
MM:DD:YYYY

Mayfair Location
2500 N. Mayfair Road, Suite 500
Wauwatosa, WI 53226

P: (414) 257.2525
F: (414) 257.1772

Glendale Location
525 W. River Woods Parkway, Suite 130
Glendale, WI 53212

P: (414) 961.0304
F: (414) 961.2061

www.wiscboneandjoint.com

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PATIENT NAME: ____________________

PRIMARY INSURANCE: ____________________

POLICY HOLDER'S NAME: ____________________

POLICY HOLDER'S DATE OF BIRTH: ____________________

PRIMARY INSURANCE CO.: ____________________

ADDRESS: ____________________

ID NUMBER OR POLICY NUMBER: ____________________

GROUP NUMBER: ____________________

RESPONSIBLE PARTY NAME: ____________________

RELATIONSHIP: ____________________

ADDRESS: ____________________

PHONE: ____________________

SECONDARY INSURANCE: ____________________

SECONDARY POLICY HOLDER'S NAME: ____________________

SECONDARY POLICY HOLDER'S DATE OF BIRTH: ____________________

SECONDARY INSURANCE CO.: ____________________

ADDRESS: ____________________

ID NUMBER OR POLICY NUMBER: ____________________

GROUP NUMBER: ____________________

RESPONSIBLE PARTY NAME: ____________________

RELATIONSHIP: ____________________

ADDRESS: ____________________

PHONE: ____________________

WORKMENS COMPENSATION INFORMATION:

BILLING NAME AND ADDRESS (Workmen's Compensation Carrier): ____________________

____

EMPLOYER'S NAME: ____________________

CONTACT PERSON: ____________________ CONTACT PERSON'S PHONE #: ____________________

CLAIM NUMBER: ____________________

DATE OF INJURY AND BODY PART(S): ____________________

Patient Name: ______________________________

DOB: ______________________________

REVIEW OF SYSTEMS

Have you been experiencing any of the listed problems?

Please explain any checked boxes in the space provided

Constitutional Symptoms
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Loss or Gain
- ☐ Weakness
- ☐ Fatigue
- ☐ Loss of Appetite

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain

Allergic/Immunologic
- ☐ Hay Fever
- ☐ Hives

Neurological
- ☐ Tremors/Seizures
- ☐ Dizzy spells/Fainting
- ☐ Numbness/Tingling
- ☐ Headache
- ☐ Paralysis
- ☐ Memory Loss/Dementia

Endocrine
- ☐ Excessive thirst/Hunger
- ☐ Too hot/cold
- ☐ Tired/Sluggish

Gastrointestinal
- ☐ Abdominal/Stomach Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion/Heartburn
- ☐ Rectal Bleeding
- ☐ Black Stools

Cardiovascular
- ☐ Chest Pain
- ☐ Varicose Vein Discomfort
- ☐ Excessive coldness/discoloration in legs or arms
- ☐ Irregular Heart Beat
- ☐ Swollen Legs

Integumentary
- ☐ Skin Rash
- ☐ Boils
- ☐ Persistent itch

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain

Ear/Nose/Throat/Mouth
- ☐ Ear Infection/Pain
- ☐ Sore Throat
- ☐ Sinus Problem
- ☐ Swallowing Problems
- ☐ Hoarseness
- ☐ Nose Bleeds

Genitourinary
- ☐ Urine Retention
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Urinary Frequency
- ☐ Incontinence
- ☐ Vaginal or Penile Sores/Discharge
- ☐ Testicular Pain

Respiratory
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Blood in Sputum

Hematologic/Lymphatic
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Easy Bruising/Tendency to Bleed

Psychologic
- ☐ Depression
- ☐ Paranoid Thoughts
- ☐ Anxiety
- ☐ Suicidial Thoughts

Physician use only: *(Comments/Notes)*

____

____

____

____

Physician: ______________________ Date: _____ /_____ /_____

Patient Name: ______________________

Birthdate: ______________________ Age: ________

Area to be examined: ______________________

Date symptoms began: ______________________

Please explain any checked boxes in the space provided

- ☐ **Currently pregnant**

Have you ever had any hospitalizations or surgeries? – LIST:

____

____

____

____

____

Please list current medications:

____

____

____

____

____

____

____

____

____

Have you had an allergy or unfavorable reaction to medication such as:

- ☐ Anti-inflammatory (NSAIDS)
- ☐ Aspirin
- ☐ Penicillin
- ☐ Anesthetic General or Local
- ☐ Allergy to latex (rubber)
- ☐ Other:

____

____

____

____

Past or present history of:

- ☐ Tobacco - if yes, packs per day:________
- ☐ Alcohol - if yes, daily/frequency:_______
- ☐ Use of street drugs
- ☐ Drug or alcohol addiction

Gastrointestinal:

- ☐ Stomach / intestinal ulcers
- ☐ Colitis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver disease
- ☐ Cirrhosis
- ☐ Reflux esophagitis

Respiratory:

- ☐ Allergies or Hives
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Tuberculosis (TB)

Cancer/Malignancy Type:

____

____

- ☐ Chemotherapy
- ☐ Radiation Therapy

Hematologic:

- ☐ Blood transfusion
- ☐ Anemia
- ☐ Leukemia/Lymphoma
- ☐ Sickle cell (anemia) disease
- ☐ Hemophelia
- ☐ Blood clots, pulmonary embolism

Dermal/Musculoskeletal:

- ☐ Eczema
- ☐ Rheumatoid Arthritis
- ☐ Artificial Joint
- ☐ Lyme disease
- ☐ Lupus
- ☐ Psoriasis
- ☐ Herniated Disc/Sciatica

Urinary-sexually transmitted:

- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Sexually transmitted disease; Syphilis, Gonorrhea, Chlamydia, Genital Herpes
- ☐ HIV positive (AIDS)

Neural and Sensory:

- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Stroke
- ☐ Paralysis
- ☐ Dementia
- ☐ Epilepsy / Seizures / Convulsion

Psychiatric

- ☐ Depression
- ☐ Anxiety/Nervouseness
- ☐ Schizophrenia

Cardiovascular:

- ☐ Heart failure
- ☐ Heart disease or attack
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Rheumatic fever
- ☐ Congenital heart defect or lesion
- ☐ Arrhythmia heart pacemaker or defibrillator
- ☐ Heart surgery/transplant
- ☐ Aneurysm
- ☐ Other heart problem – LIST:

____

____

____

Endocrine:

- ☐ Diabetes
- ☐ Thyroid disease

Disease, problem, or condition NOT listed:

____

____

____

____

____

Family history of:

- ☐ Spine problems
- ☐ Joint replacements
- ☐ Arthritis
- ☐ Diabetes
- ☐ Hypertension
- ☐ Blood Clots

Patient: ______________________ Date: ______ /______ /______

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SUMMARY OF HIPAA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Wisconsin Bone & Joint, S.C. may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Additionally, Wisconsin Bone & Joint, S.C. may use and disclose appointment reminders, treatment alternatives and health related benefits and services either by mail or phone.

When appropriate, Wisconsin Bone & Joint, S.C. may share health information with a person who is involved in my medical care or payment for my care. Under certain circumstances, Wisconsin Bone & Joint, S.C. may use and disclose health information for research. We will disclose health information when required to do so by international, federal, state, or local law, or to avert a serious threat to health or safety. Other entities include but are not limited to: business associates, organ and tissue donation organizations, the military and worker's compensation.

I understand I have a right to inspect, copy and amend records. I have a right to an accounting of disclosures, as well as being able to request restrictions and disclosures and request confidential communication with the office.

I further attest that I am aware that this is a summary of Wisconsin Bone & Joint, S.C.'s privacy notice and that I have been given the opportunity to obtain and review the notice in its entirety.

OWNERSHIP DISCLOSURE
Please be advised that Dr. James Cain, Dr. David Kornreich, Dr. Anthony Ferguson, Dr. Thomas Huizenga, Dr. Lawrence Maciolek, Dr. Donald Middleton, Dr. Stephen Robbins, and Dr. Jeffrey Stephany of this office have an ownership interest in Orthopaedic Hospital of Wisconsin; Drs. Dale Bauwens & Sean Tracy have an ownership in Midwest Orthopedic Specialty Hospital. In the course of your diagnosis and/or treatment at our office, you may be referred for services at Orthopedic Hospital of Wisconsin or Midwest Orthopedic Specialty Hospital. If you prefer that the services for which you are referred be provided at a different facility, please notify one of our staff members at, or as soon as possible after, the time of such referral so that alternative arrangements can be made.

______________________	______________	______________
Printed Name of Patient	Date of Birth	Today's Date

______________________	______________________
Signature of Patient or Legal Guardian	Printed Name of Guardian

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