



Dale E. Bauwens, MD | Jesse 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. Misna, MD | Stephen E. Robbins, MD | Jeffrey J. Stephany, MD | Sean C. Tracy, MD

Primary Care Doctor: \_\_\_\_\_

Primary Care Doctor's Phone number#: \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

How would you like to be addressed: \_\_\_\_\_

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ EMAIL 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 & RELATIONSHIP:** \_\_\_\_\_ **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

**Cedarburg Location** - Creekside Center Building

N54W6135 Mill Street, Suite 200  
Cedarburg, WI 53012

P: (414) 257.2525  
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[www.wiscboneandjoint.com](http://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): \_\_\_\_\_



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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**

- |  |   |
|--|---|
| <input type="checkbox"/> Fever               | <input type="checkbox"/> Weakness         |
| <input type="checkbox"/> Chills              | <input type="checkbox"/> Fatigue          |
| <input type="checkbox"/> Sweats              | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Weight Loss or Gain |   |

**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/dicoloration 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**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> Ear Infection/Pain  | <input type="checkbox"/> Hoarseness  |
| <input type="checkbox"/> Sore Throat         | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problem       |                                      |
| <input type="checkbox"/> Swallowing Problems |                                      |

**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**

- |  |  |
|--|--|
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Anxiety           |
| <input type="checkbox"/> Paranoid Thoughts | <input type="checkbox"/> Suicidal 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
- Hemophilia
- 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 / Convulsions

**Psychiatric**

- Depression
- Anxiety/Nervousness
- 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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