



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. Mlsna, 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: _____ **PHONE #:** _____

EMERGENCY CONTACT RELATIONSHIP: _____

PHARMACY NAME: _____ **PHONE#:** _____

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
F: (414) 257.1772

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: _____ CP PHONE #: _____

CLAIM NUMBER: _____

DATE OF INJURY AND BODY PART(S): _____



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Orthopedic Surgery, Sports Medicine & Spine

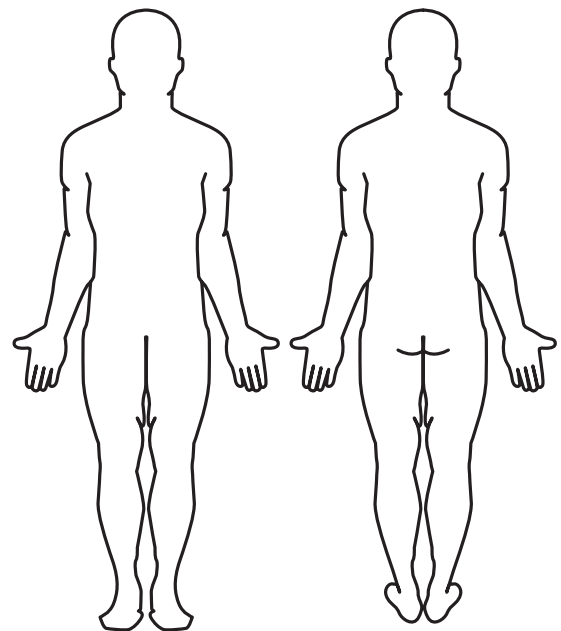
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Spine Questionnaire	
Name:	DOB:
Age:	
Chief complaint:	
Occupation:	
Are you currently working? <input type="checkbox"/> yes / <input type="checkbox"/> no	If no, last day worked?
Does your current problem involve a lawsuit or motor vehicle accident? <input type="checkbox"/> yes / <input type="checkbox"/> no	
Does your current problem involve a workers' compensation claim? <input type="checkbox"/> yes / <input type="checkbox"/> no	
How long have your symptoms been present?	
How did the problem start? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually <input type="checkbox"/> Due to accident/injury <input type="checkbox"/> Due to work related incident	
Have you had spine injuries/surgeries in the past? <input type="checkbox"/> yes / <input type="checkbox"/> no if yes, when?	
Check all that make your pain worse	<input type="checkbox"/> lifting <input type="checkbox"/> coughing <input type="checkbox"/> running <input type="checkbox"/> standing <input type="checkbox"/> sleeping <input type="checkbox"/> bending <input type="checkbox"/> sneezing <input type="checkbox"/> lying down <input type="checkbox"/> walking <input type="checkbox"/> sitting <input type="checkbox"/> twisting <input type="checkbox"/> straining
What makes pain better?	<input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> lying down
Hobbies effected by condition:	
Do you exercise regularly? <input type="checkbox"/> yes / <input type="checkbox"/> no	

Notes:

Please mark pain and radiating pain in the below diagram with the following notions:
 Numbness (===) Pins and needles (000)
 Burning (xxx) Stabbing (///)

Have you had any diagnostic studies for this problem?		
<input type="checkbox"/> X-Ray	<input type="checkbox"/> CT	<input type="checkbox"/> MRI
<input type="checkbox"/> Myelogram	<input type="checkbox"/> EMG	
Have you had any of the following treatments?		
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Facet Injections	<input type="checkbox"/> Epidural Injections
<input type="checkbox"/> SI Joint Injection	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Chiropractic Care



Patient Signature: _____

Date: _____

Physician Signature: _____

Date: _____



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Patient History

Name:		DOB:		Height:		Weight:	
Have you been diagnosed with any of the following?							
High blood pressure	<input type="checkbox"/> yes / <input type="checkbox"/> no	Blood clots	<input type="checkbox"/> yes / <input type="checkbox"/> no	Hepatitis/Liver disease	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Diabetes	<input type="checkbox"/> yes / <input type="checkbox"/> no	Pulmonary Embolism	<input type="checkbox"/> yes / <input type="checkbox"/> no	Seizures	<input type="checkbox"/> yes / <input type="checkbox"/> no		
High cholesterol	<input type="checkbox"/> yes / <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes / <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes / <input type="checkbox"/> no		
COPD/emphysema	<input type="checkbox"/> yes / <input type="checkbox"/> no	Ulcer/GERD	<input type="checkbox"/> yes / <input type="checkbox"/> no	Rheumatoid arthritis	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Cardiac disease/attack	<input type="checkbox"/> yes / <input type="checkbox"/> no	Hyper/Hypothyroidism	<input type="checkbox"/> yes / <input type="checkbox"/> no	Cancer (yes, list below)	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Other medical conditions:							
Past Surgical Procedures							
Medications							
Allergies							
Family History							
Blood clot	<input type="checkbox"/> yes / <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes / <input type="checkbox"/> no	Heart disease	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Pulmonary embolism	<input type="checkbox"/> yes / <input type="checkbox"/> no	Cancer	<input type="checkbox"/> yes / <input type="checkbox"/> no	Malignant hyperthermia	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Social History							
Smoker?	<input type="checkbox"/> yes / <input type="checkbox"/> no	If yes, Amount per day:					
Alcohol use?	<input type="checkbox"/> yes / <input type="checkbox"/> no	If yes, amount per day:					
Review of systems: Have you experienced the following recently							
Fever, night sweats	<input type="checkbox"/> yes / <input type="checkbox"/> no	Difficulty urinating	<input type="checkbox"/> yes / <input type="checkbox"/> no	Intolerance to heat/cold	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Unexplained weight loss	<input type="checkbox"/> yes / <input type="checkbox"/> no	Muscle pain	<input type="checkbox"/> yes / <input type="checkbox"/> no	Easy bruising	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Sore throat	<input type="checkbox"/> yes / <input type="checkbox"/> no	Joint pain	<input type="checkbox"/> yes / <input type="checkbox"/> no	Environmental allergies	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Chest pain	<input type="checkbox"/> yes / <input type="checkbox"/> no	Skin rash/sores	<input type="checkbox"/> yes / <input type="checkbox"/> no	Visual problems	<input type="checkbox"/> yes / <input type="checkbox"/> no		
Shortness of breath	<input type="checkbox"/> yes / <input type="checkbox"/> no	Arm/leg numbness	<input type="checkbox"/> yes / <input type="checkbox"/> no				
Abdominal pain	<input type="checkbox"/> yes / <input type="checkbox"/> no	Gait difficulty	<input type="checkbox"/> yes / <input type="checkbox"/> no				

Patient Signature:	Physician Signature:
Date:	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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