WISCONSIN BONE AND JOINT S.C.

Orthopedic Surgery, Sports Medicine & Spine

Dale E. Bauwens, MD | Jake D. Bauwens, MD | Jesse E. Bauwens, MD | Steven Donatello, MD | Anthony A. Ferguson, MD | Thomas B. Huizenga, MD | Charles A. Klein, MD
David B. Kornreich | 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
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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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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
- ☐ Suicidal Thoughts

Physician use only: *(Comments/Notes)*

_____

_____

_____

_____

Physician: _____ Date: _____ /_____ /_____

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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 currently, packs per day: _____
☐ Alcohol - if currently, 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 / 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. 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, Jesse 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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