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, 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
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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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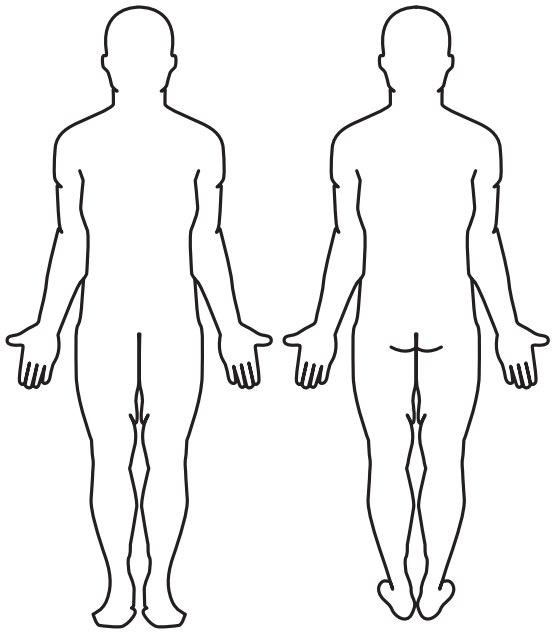
Spine Questionnaire

Name:			DOB:	Age:
Chief complaint:				
Occupation:				
Are you currently working? ☐ yes / ☐ no			If no, last day worked?	
Does your current problem involve a lawsuit or motor vehicle accident? ☐ yes / ☐ no				
Does your current problem involve a workers' compensation claim? ☐ yes / ☐ no				
How long have your symptoms been present?				
How did the problem start? ☐ Suddenly ☐ Gradually ☐ Due to accident/injury ☐ Due to work related incident				
Have you had spine injuries/surgeries in the past? ☐ yes / ☐ no if yes, when?				
Check all that make your pain worse	☐ lifting ☐ sleeping ☐ walking	☐ coughing ☐ bending ☐ sitting	☐ running ☐ sneezing ☐ twisting	☐ standing ☐ lying down ☐ straining
What makes pain better?	☐ sitting	☐ standing	☐ lying down	
Hobbies effected by condition:				
Do you exercise regularly? ☐ yes / ☐ 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?		
☐ X-Ray	☐ CT	☐ MRI
☐ Myelogram	☐ EMG	
Have you had any of the following treatments?		
☐ Physical Therapy	☐ Facet Injections	☐ Epidural Injections
☐ Sl Joint Injection	☐ Acupuncture	☐ 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	☐ yes / ☐ no	Blood clots	☐ yes / ☐ no	Hepatitis/Liver disease	☐ yes / ☐ no
Diabetes	☐ yes / ☐ no	Pulmonary Embolism	☐ yes / ☐ no	Seizures	☐ yes / ☐ no
High cholesterol	☐ yes / ☐ no	Stroke	☐ yes / ☐ no	Kidney disease	☐ yes / ☐ no
COPD/emphysema	☐ yes / ☐ no	Ulcer/GERD	☐ yes / ☐ no	Rheumatoid arthritis	☐ yes / ☐ no
Cardiac disease/attack	☐ yes / ☐ no	Hyper/Hypothyroidism	☐ yes / ☐ no	Cancer (yes, list below)	☐ yes / ☐ no

Other medical conditions:

Past Surgical Procedures

Medications

Allergies

Family History

Blood clot	☐ yes / ☐ no	Diabetes	☐ yes / ☐ no	Heart disease	☐ yes / ☐ no
Pulmonary embolism	☐ yes / ☐ no	Cancer	☐ yes / ☐ no	Malignant hyperthermia	☐ yes / ☐ no

Social History

Smoker?	☐ yes / ☐ no	If yes, Amount per day:
Alcohol use?	☐ yes / ☐ no	If yes, amount per day:

Review of systems: Have you experienced the following recently

Fever, night sweats	☐ yes / ☐ no	Difficulty urinating	☐ yes / ☐ no	Intolerance to heat/cold	☐ yes / ☐ no
Unexplained weight loss	☐ yes / ☐ no	Muscle pain	☐ yes / ☐ no	Easy bruising	☐ yes / ☐ no
Sore throat	☐ yes / ☐ no	Joint pain	☐ yes / ☐ no	Enviromental allergies	☐ yes / ☐ no
Chest pain	☐ yes / ☐ no	Skin rash/sores	☐ yes / ☐ no	Visual problems	☐ yes / ☐ no
Shortness of breath	☐ yes / ☐ no	Arm/leg numbness	☐ yes / ☐ no		
Abdominal pain	☐ yes / ☐ no	Gait difficulty	☐ yes / ☐ no		

Patient Signature:

Date:

Physician Signature:

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 by 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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