



Jake D. Bauwens, MD | Jesse E. Bauwens, MD | Kenneth C. Berg, MD | Michael G. Crimmins, MD | Steven J. Donatello, MD
Anthony A. Ferguson, MD | Thomas B. Huizenga, MD | David B. Kornreich, DO | Joseph M. Kroner, MD | Lawrence J. Maciolek, MD
Austin H. Middleton, MD | Donald K. Middleton, MD | Stephen E. Robbins, MD | Jeffrey J. Stephany, MD | Todd M. Swenson, MD

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: _____
HOW WOULD YOU LIKE TO BE ADDRESSED: _____

Primary Care Doctor: _____
Primary Care Doctor's Phone Number#: _____
How Did You Hear About Us: _____

☐ 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**
Mayfair Mall Office Building
2500 N. Mayfair Road
Suite 500
Wauwatosa, WI 53226
P: 414-257-2525
F: 414-257-1772

📍 **Glendale Location**
OHOW Medical Office Building
525 W. River Woods Pkwy
Suite 100
Glendale, WI 53212
P: 414-332-6262
F: 414-332-0422

📍 **Cedarburg Location**
OHOW Cedarburg Building
W62N208 Washington Ave.
Cedarburg, WI 53012
P: 262-376-7480
F: 262-375-4700

Rev. 10/02/26



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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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REVIEW OF SYSTEMS

Have you been experiencing any of the listed problems?

Please explain any checked boxes in the space provided

Constitutional Symptoms

☐ N/A

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

Eyes

☐ N/A

- ☐ Blurred Vision
☐ Double Vision
☐ Pain

Allergic/Immunologic

☐ N/A

- ☐ Hay Fever
☐ Hives

Neurological

☐ N/A

- | | |
|--|--|
| ☐ Tremors/Seizures | ☐ Multiple Sclerosis/MS |
| ☐ Dizzy spells/Fainting | ☐ Parkinsons |
| ☐ Numbness/Tingling | |
| ☐ Headache | |
| ☐ Paralysis | |
| ☐ Memory Loss/Dementia | |

Endocrine

☐ N/A

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

Gastrointestinal

☐ N/A

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

Cardiovascular

☐ N/A

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

Patient Name: _____

Birthdate: _____ Age: _____

Height: _____ Weight: _____

Area to be examined: _____

Date symptoms began: _____

Integumentary

☐ N/A

- ☐ Skin Rash
☐ Boils
☐ Persistent itch

Musculoskeletal

☐ N/A

- ☐ Joint Pain
☐ Neck Pain
☐ Back Pain

Ear/Nose/Throat/Mouth

☐ N/A

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

Genitourinary

☐ N/A

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

Respiratory

☐ N/A

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

Hematologic/Lymphatic

☐ N/A

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

Psychologic

☐ N/A

- | | |
|--|--|
| ☐ Depression | ☐ Anxiety |
| ☐ Paranoid Thoughts | ☐ Suicidal Thoughts |

Physician use only: (Comments/Notes)

Physician: _____

Date: ____ / ____ / ____

REVIEW OF SYSTEMS

Have you been experiencing any of the listed problems?
Please explain any checked boxes in the space provided

Patient Name: _____

Birthdate: _____ Age: _____

Height: _____ Weight: _____

Area to be examined: _____

Date symptoms began: _____

☐ Currently pregnant ☐ N/A

Have you ever had any hospitalizations
or surgeries? - LIST: ☐ N/A

Please list current medications: ☐ N/A

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: ☐ N/A

Past or present history of: ☐ N/A

- ☐ 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

☐ N/A

Respiratory:

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

☐ N/A

Cancer/Malignancy Type:

☐ N/A

- ☐ Chemotherapy
☐ Radiation Therapy

Hematologic:

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

☐ N/A

Dermal/Musculoskeletal:

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

☐ N/A

Urinary-sexually transmitted: ☐ N/A

- ☐ 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

☐ N/A

Psychiatric

- ☐ Depression
☐ Anxiety/Nervousness
☐ Schizophrenia

☐ N/A

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:

☐ N/A

Endocrine:

- ☐ Diabetes
☐ Thyroid disease

☐ N/A

Disease, problem, or condition NOT listed:

Family history of:

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

☐ N/A

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. Jake Bauwens, Dr. Jesse Bauwens, Dr. Kenneth Berg, Dr. Steven Donatello, Dr. Anthony Ferguson, Dr. Thomas Huizenga, Dr. David Kornreich, Dr. Joseph Kroner, Dr. Lawrence Maciolek, Dr. Donald Middleton, Dr. Stephen Robbins, Dr. Jeffrey Stephany, and Dr. Todd Swenson of these offices have an ownership interest in Orthopaedic Hospital of Wisconsin. In the course of your diagnosis and/or treatment at our offices, you may be referred for services at the Orthopaedic Hospital of Wisconsin. 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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