

ORTHOPEDIC



SURGICAL ASSOCIATES

JAMES S. SOBIEK, M.D.
DONALD S. HUENE, M.D.

Dear New Patient:

We are glad to have you as a patient in our practice. We hope that you will be pleased with our service and our commitment to help you.

Please complete the patient information page, and the patient history information pages. By having the information accurately entered on these forms, we can minimize the time you will spend in our waiting room.

We hope you understand that orthopedic surgery often involves emergency treatments which can disrupt a well-planned schedule. We will do our very best to see that you are informed of any delays that you may encounter. We understand that your time is as important for you as ours is for us.

We do not expect payment in full at the time of service if you have insurance that reimburses for our services in a timely manner. We offer you this service as a courtesy, yet do ask that you pay the uncovered services as they occur. In an era where a number of medical offices do not bill insurances and require payment at the time of service, we hope our billing courtesy helps make your orthopedic visit with us a pleasant experience.

If you have not met your yearly deductible, we would expect that amount at the time of service. If you are uninsured, a 50% payment is required when services are rendered.

Sincerely,

Orthopedic Surgical Associates

ORTHOPEDIC SURGICAL ASSOCIATES

JAMES S. SOBIEK, M.D

DONALD S. HUENE, M.D.

PATIENT HISTORY AND INFORMATION

(PLEASE PRINT)

Nature of Injury _____ Today's Date _____

Date of Injury _____ Worked Related? Yes ___ No ___

PATIENT INFORMATION

Is the patient Yourself ___ Your Spouse ___ Your Child ___

Patient's Height? _____ Patient's Weight? _____ SEX ___ M ___ F

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET ADDRESS

CITY STATE ZIP CODE

MAILING ADDRESS _____
STREET ADDRESS / P.O. BOX

CITY STATE ZIP CODE

PHONE: () _____ DATE OF BIRTH _____ AGE _____

SOCIAL SECURITY # _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ PHONE () _____

SPOUSE OR PARENT INFORMATION

NAME _____ DATE OF BIRTH _____
LAST FIRST MIDDLE

ADDRESS _____
STREET ADDRESS

CITY STATE ZIP CODE

SOCIAL SECURITY # _____ EMPLOYER _____

EMPLOYER'S ADDRESS _____ PHONE () _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER _____

INSURANCE ADDRESS _____ PHONE () _____

POLICY # _____ GROUP # _____ INSURED'S DATE OF BIRTH _____

SECONDARY INSURANCE

SECONDARY INSURANCE _____ POLICY HOLDER _____

INSURANCE ADDRESS _____ PHONE () _____

POLICY # _____ GROUP # _____ INSURED'S DATE OF BIRTH _____

PATIENT HISTORY INFORMATION

NAME _____ TODAY'S DATE _____

SS# _____ PRIMARY PHYSICIAN _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of a(n): **Check all that apply**

____ Car Accident ____ Work Accident ____ Accident Other _____

When did the accident happen? _____ Where? _____

This occurred during: **Check all that apply**

____ Lifting ____ Pulling ____ Pushing ____ Twisting ____ Falling ____ Bending

____ Reaching ____ Squatting ____ Hit by Object ____ Unknown

Please list any medications you are currently taking for any reason: _____

Do you now or have you ever been diagnosed with Sleep Apnea? ____ No ____ Yes

Are you currently taking ____ Coumadin ____ Insulin ____ Aspirin

Please list any allergies _____

Review of Systems

Are you currently or have you had problems with your: (Circle yes or no and describe all Yes response)

- Aids No Yes _____
- Arthritis No Yes _____
- Blackouts/Fainting No Yes _____
- Bladder Problems No Yes _____
- Bleeding Problems No Yes _____
- Cancer No Yes _____
- Diabetes No Yes _____
- Digestion – Stomach Ulcers No Yes _____
- Ears, Nose, Throat No Yes _____
- Eyes No Yes _____
- Heart No Yes _____
- Hepatitis No Yes _____
- High Blood Pressure No Yes _____
- Lungs/Breathing No Yes _____
- Numbness/Tingling No Yes _____
- Pregnancy No Yes _____
- Tuberculosis No Yes _____
- Thyroid No Yes _____

Reviewed By: _____ M.D. Date: _____

Comments: _____

Name: _____

Today's Date: _____

SS# _____

PAST MEDICAL HISTORY

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia? No Yes
 Have you had any problems with anesthesia? No Yes Describe _____

Family History: Arthritis Heart Disease Muscular Disease Diabetes
 Parents ages and Health (if deceased, age at death and cause) – Describe _____

Social History: Single Married Divorced Separated Widowed
 Children? No Yes (List number and ages) _____

Do you live alone? No Yes
 _____ Work in the home Employed (occupation) _____

Exercise? Daily Weekly Monthly Rarely Never
 What type of exercise? _____

Are you on a special diet? No Yes Describe _____

Do you have a history of substance abuse? No Yes What? _____

Do you currently smoke? No Yes Packs per day for _____ years.

Have you quit smoking? This year > 1 year >5 years > 10 years

Previously smoked ... Packs per day for _____ years.

Do you drink alcohol? Daily 1-2 times per week 1-2 times per month
 ____ 1-2 times per year

Reviewed By: _____ **M.D.** **Date** _____

SUBSEQUENT REVIEWS

_____ **M.D.** **Date** _____

_____ **M.D.** **Date** _____

COMMENTS

ORTHOPEDIC SURGICAL ASSOCIATES

JAMES S. SOBIEK, M.D

DONALD S. HUENE, M.D.

FINANCIAL AGREEMENT

PATIENT NAME: _____ **DATE** _____

We are medical doctors specializing in orthopedic surgery. This involves treatment of disorders of the bones, joints, muscles, and ligaments. In the interest of good medical practice, it is desirable to establish a credit policy. An effective credit policy enables you and the doctor to avoid misunderstandings. We feel it is very important that you understand you are responsible for payment of charges.

If you carry health care insurance you should remember that medical services rendered are charged to you and not your insurance company, unless otherwise stated. If you file an insurance claim, and a balance is due, you will receive a statement each month. Unfortunately, this office cannot accept responsibility for collecting an unpaid insurance claim, or for negotiating a settlement on a disputed claim.

If you are uninsured, 50% payment is expected when services are rendered. You are responsible for payment of your account. If you have not met your yearly deductible, we will expect that amount at the time of service. In cases of hardship, reasonable payment programs can be arranged.

PATIENT/GUARDIAN SIGNATURE

ASSIGNMENT OF BENEFITS

I hereby authorize payment of the amount due in my pending insurance claim be made directly to; James S. Sobiek, M.D. or Donald S. Huene, M.D.. Payment is authorized upon your receipt of an itemized statement of services.

SIGNATURE

DATE

RECORDS RELEASE AUTHORIZATION

I hereby authorize Dr. Sobiek or Dr. Huene to release to my referring physician, insurance company, or legal guardian, any information, including diagnosis and records or treatment, concerning my medical history and orthopedic care

SIGNATURE

DATE

MEDICARE PATIENT SIGNATURE AUTHORIZATION

I hereby authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries or carriers, or billing agent of this physician or supplier any information needed for this or related Medicare claims. I permit a copy of this authorization to be used in place of the original, and I request that payment under Medicare be made directly to James S. Sobiek, M.D. or Donald S. Huene, M.D. on any bills for service furnished to me by that physician.

SIGNATURE

DATE

MEDICARE I.D. NUMBER