

Health History – Comprehensive Orthopaedics

Patient Last Name _____ First Name _____ Sex M F

Appointment date _____ Date of birth _____ Age _____

Family doctor _____

How did you hear about us? Doctor Therapist Family/Friend Radio Newspaper Internet Other

Dominant hand R L

Is this work-related? YES NO

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Body part/problem _____

When did you notice problem/date of injury? _____

How did it start? _____

What makes the problem worse? _____

What makes the problem better? _____

Have you had this before? _____

How painful is the problem currently? [1 (mild) – 10 (severe)] _____

What is the most painful the problem has been? [1 (mild) – 10 (severe)] _____

Type of pain (dull, sharp, radiating) _____

Other symptoms _____

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Please do not write in this space. Office use only.

Circle any previous treatment/tests:

X-ray MRI/CT Physical Therapy Injection Other:

Past Medical History (please circle all that apply): NONE

Diabetes Heart Disease High Blood Pressure Asthma Arthritis Cancer
High Cholesterol Thyroid Disease Ulcers/Reflux Kidney Failure Osteoporosis
Multiple sclerosis Osteoarthritis Bleeding Disorders Fibromyalgia

Other (please list) _____

Past Surgical History (please circle all that apply): NONE

Back Surgery Carpal Tunnel Surgery Joint Replacement Arthroscopy
Joint Surgery (list site) _____
Other (be specific) _____

Current Medications (please be specific):

Do you currently take aspirin or other blood thinning drugs? NO YES _____

Have you ever had a reaction to anesthesia? NO YES _____

Drug Allergies (circle yes or no): NO YES (please list allergies below)

Family History (circle the condition any immediate family member has had):

Osteoporosis Rheumatoid arthritis Osteoarthritis Multiple Sclerosis Fibromyalgia
Joint Replacements Problems with anesthesia Back problems Bleeding Disorders
Kidney Failure High Blood Pressure Heart Problems Diabetes

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Please do not write in this space. Office use only.

Social History (circle the following):

Occupation _____ Employer _____

Currently working? YES NO Any restrictions at work? _____

Marital Status: Married Single Widowed Divorced

Smoker? NO YES _____ Alcohol? NO YES _____

Recreational Drugs? NO YES _____

(Please note if you currently have had any of the following in the past 12 months that HAVE NOT BEEN addressed by another provider)

Constitutional Fever / Chills Yes No Weight Loss Yes No Weakness Yes No Other _____	Integumentary Skin rash/sores Yes No Bruising Yes No Redness Yes No Other _____
Cardiovascular Chest pain Yes No Palpitations Yes No Fullness in chest Yes No Other _____	Respiratory Shortness of breath Yes No Wheezing Yes No Frequent cough Yes No Other _____
Gastrointestinal Abdominal pain Yes No Nausea/vomiting Yes No Indigestion/heartburn Yes No Diarrhea/Constipation Yes No Bloody stools Yes No Other _____	Allergies/immunologic Hay fever Yes No Pollen/grass allergies Yes No Runny nose Yes No Other _____
Musculoskeletal Joint pain/stiffness Yes No Back pain Yes No Difficulty walking Yes No Lack of strength Yes No Other _____	Neurological Confusion Yes No Weakness Yes No Numbness/tingling Yes No Loss of memory Yes No Other _____
Psychiatric Depression Yes No Disorientation Yes No Anxious/agitated Yes No Other _____	Hematologic/lymphatic Swollen glands Yes No Abnormal bruising Yes No Abnormal bleeding Yes No Other _____

Patient Signature _____ Date _____

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Please do not write in this space. Office use only.

Height _____ Weight _____ Blood pressure _____ Pulse _____ Resp. _____

MD Signature/initials _____ Date _____



Comprehensive Orthopaedics, S.C.

Jonathan D. Main, MD¹
Sports Medicine & Orthopaedic Surgery

Michael Didinsky, DO³
Spine & Orthopaedic Surgery

Joshua M. Gershtenson, MD¹
Hand, Upper Extremity & Orthopaedic Surgery

Hardik A. Vashi, DO²
Physical Medicine & Rehabilitation

Michael J. Slimack, DO³
Joint Replacement & Orthopaedic Surgery

Michael A. Engel, DPM⁵
Podiatric Surgeon

Thomas S. Werbie, MD¹
Orthopaedic Surgery

Michael J. Nute, DPM⁵
Podiatric Surgeon

John C. Pick-Jacobs, DO
Sports Medicine

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Orthopaedic Surgeon

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Today's Date: _____

Patient Name: _____

Date of Birth: _____

Body Part: _____

Doctor Seen: _____

Is this a work related injury?

_____ :Yes

_____ :No

If Yes, please complete the following:

What is the date of injury? _____

How did the injury occur? _____

Have you filed a claim with your company? _____

What is your claim number? _____

Which company is the claim paid through? _____

What is the name and phone number of your adjuster?

To be completed by the front desk:

FD Representative name: _____

WC details entered on fee ticket/appointment notes? _____

WC info entered into insurance field? _____

WC info verified open and active? _____

WC alert entered onto chart? _____

¹Diplomate, American Board of Orthopaedic Surgeons

²Diplomate, American Board of Physical Medicine & Rehabilitation

³Diplomate, American Osteopathic Board of Orthopedic Surgeons

⁴Diplomate, American Board of Family Medicine

⁵Diplomate, American Board of Podiatric Medicine

COMPREHENSIVE ORTHOPAEDICS, S.C.
Patient Acknowledgement & Record of Disclosures

I, _____, _____ acknowledge that I have received, and/or
Patient Name Date of Birth
been advised of the written Notice of Privacy Practices from Comprehensive Orthopaedics, SC.

- The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

Telephone Number: _____

- Leave message with detailed information
 Leave message with call back number only

Alternate Telephone: _____

- Leave message with detailed information
 Leave message with call back number only

Written Communication

- Can mail to Home address: _____
 Can Email to this address: _____
 Can mail/fax to Work address: _____

I consent to have my personal health information disclosed to: (3rd party friend/family or other)

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Patient (or Guardian) Signature

Date

Printed Name

This form MUST be filled out NEATLY & COMPLETELY or it will be considered VOID.



Patient Financial Policy

At Comprehensive Orthopaedics, S.C. we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The patient or guarantor is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay prior to each visit.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay a portion at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Comprehensive Orthopaedics, S.C. contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We will bill major medical insurance.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, a **deposit of \$200** is required on the day of your appointment before being seen by the provider and \$75 copays at any follow up appointments. Any fees remaining will be billed to you following your appointment. By initialing here, I acknowledge I have received the Self-Pay agreement. _____

Urgent Care: During our after-hours Urgent Care, our financial policy will revert back to a self-pay/Uninsured status until your Insurance can be verified.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent with whom the child resides with will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections are not included in the post-operative period.

Responsible Party: I have read the financial policy and understand that I will be responsible for all Comprehensive Orthopaedics, S.C. charges incurred regardless of my insurance status including expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a \$25 fee per check returned.

IN THE EVENT THAT I "NO SHOW" MY APPOINTMENT WITHOUT CALLING THE OFFICE AT LEAST 24 HOURS IN ADVANCE, I UNDERSTAND I MAY INCUR A \$50.00 "NO SHOW" FEE. IN ADDITION, COMPREHENSIVE ORTHOPAEDICS, S.C. RESERVES THE RIGHT TO TERMINATE MY CARE FOR NON-COMPLIANCE AT ANY TIME.

*Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, or American Express.
Please sign that you have read and agree to this Financial Policy.*

Patient Name (Print): _____

Responsible Party Signature: _____

Date: _____