Midwest Orthopaedics at RUSH

Patient Registration Form

Patient information

Last Name	First Name	Middle Name
Address	City	State / Zip Code
	Date of Birth_____/_____/_____ mm dd yyyy	Age / Sex ☐F ☐M / Marital Status ☐S ☐M ☐W ☐D

Non-English Language Preference:
☐ Polish ☐ Hearing Impaired
☐ Spanish ☐ Other_____

Race:
☐ African American
☐ White ☐ American Indian ☐ Asian
☐ Hispanic ☐ Pacific Islander ☐ Other

Ethnicity:
☐ Hispanic or Latino
☐ Non-Hispanic/Latino

Please rank from 1 to 5 your preferred method of contact. Reminders to your 1st choice? ☐Yes ☐No
Exclude those you would not like us to use. Text to Cell? ☐Yes ☐No

__Home:_____
__Work/Day:_____ __E-Mail:_____
__Cell/Alt:_____ __Other:_____

Occupation	Employer	Employer Telephone ( )
Employer Address	City	State / Zip Code
Contact person	Reason for Appointment	What Side of Body? ☐Left ☐Right / Date Symptom Began
Referring Physician		Referring Physician Telephone ( )
Address	City	State / Zip Code
Primary Care Physician (PCP)		Primary Physician Telephone ( )
Address	City	State / Zip Code

Health Insurance

Primary Insurance		Policy Number: Group/ID Number:
Last Name	First Name	Middle Name
	Date of Birth_____/_____/_____ mm dd yyyy	Insurance Phone Number ( )
Employer Name		Business Telephone ( )
Employer Address	City / State / Zip Code	Contact Person

Secondary Insurance		Policy Number: Group/ID Number:
Last Name	First Name	Middle Name
	Date of Birth_____/_____/_____ mm dd yyyy	Insurance Phone Number ( )

PLEASE READ AND COMPLETE SECTIONS ON REVERSE SIDE

Guarantor/ Legal Guardian. Complete if Different from Patient			
☐Parent	☐Legal Guardian	☐Other	
Last Name	First Name	Relationship	
Home Phone ( )		Guarantor Birth Date_____/_____/_____ mm dd yyyy	
Address	City	State	Zip Code

Workers Compensation Information	
Work related injury ☐YES ☐NO	If yes, date of accident:
Name of Worker's Compensation Carrier	Claim Number
What Part of the body was Injured?	

Address	City	State	Zip Code
Phone Number ( )	Date Last Worked:		
Adjuster's Name	Phone Number ( )		

Accident Information			
Motor vehicle / Personal related injury ☐YES ☐NO	If yes, date of accident:		
Motor Vehicle Compensation Carrier	Claim Number		
Address	City	State	Zip Code
Phone Number ( )	Date last worked:	State Where accident occurred:	

Attorney Information			
Attorney's Name (if lawsuit is involved)	Phone Number ( )		
Address	City	State	Zip Code

Emergency Contact (Note: Different from your home information)	
Name	Relationship
Home Telephone ( )	Work Telephone ( )

How did you find out about Midwest Orthopaedics at Rush?	
☐Family / Friend / Relative	☐Sports Team (Specify):
☐MOR/ RUSH Employee	☐Workman Comp./ Case Manager
☐Physician/ MD / DO	☐Yellow Pages
☐Other Healthcare Provider	☐Website
☐Others (Specify):	☐Search Engine (Google, etc./Specify):

_____ _____

PATIENT SIGNATURE **DATE**

All the information provided above are complete and accurate to the best of my knowledge.

Photo ID, insurance card and co-pay are required on day of visit. If you did not bring insurance cards with you, all charges will be your responsibility and payable at the time of service. Obtaining required referral forms and treatment pre-certification is the patient's responsibility. All unpaid balances and or denied claims are your responsibility.

Office and Financial Policies

We would like to thank you for choosing Midwest Orthopaedics at Rush, LLC (MOR) as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Credit Card Policy:
MOR requires a valid credit card or direct bank debit account information prior to services being rendered. Your credit card / bank account will not be charged until 60 days after the services provided have been processed by your health insurance carrier and the balance deemed your responsibility. You will be notified by letter and/or phone of any outstanding balances prior to MOR charging your card or account at which time we will inform you of all your payment options.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within 24 hours to reschedule your appointment. This will enable us time to use your slot for another patient.

No Insurance: Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make prior arrangements with our Customer Service Representative or Financial Coordinator.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing MOR to waive this obligation.

You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Auto Accident Injury: If your injury is due to an automobile accident, we request that you provide us with any information that will assist us in getting your medical claims paid. This information may include:

- a copy of the police report
- a copy of your auto insurance
- medical insurance
- names and information on other parties involved.

Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.

Liability Injury: If your injury is a result from another party's negligence, we request that you provide us with any information that will assist us in obtaining reimbursement for the services rendered to you. This information may include:

- a copy of the accident report listing claim number and responsible party
- medical coverage and/or attorney information.

Payment for any services that we provide will ultimately be your responsibility if not paid by promptly another party.

Worker's Compensation: If your injury is due to an accident in your work place, please be sure to contact your employer and inform them of your injury. We will need to receive authorization from your employer before we can process any of your medical claims. Please have your employer contact our Worker's Compensation Department at 877-632-6637. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims will be your responsibility.

Return Checks: A $30.00 charge will be added to your account for any check returned by your bank for any reason.

Disability or Insurance Forms: There will be a charge of $15.00 - $35.00 for the completion of medical forms (charge is based upon number of pages and complexity of information requested). Payment is due at the time that you pick-up the forms. Please allow 7 – 10 days for the completion of these forms. If you would like the forms mailed to you or your insurance company, payment will be due prior to mailing.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7-10 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record. Rates charged are within Illinois state statutes.

X-Rays: We will provide you with a copy of your x-rays upon request. You will need to sign a letter of release at the time of pick-up. Please allow 48 hours from the time of your request. There is a $3.50 charge per x-ray, that is payable at the time of pick-up. If you have any questions or concerns, please contact our Customer Service Department at 877-632-6637.

Midwest Orthopaedics at RUSH

PATIENT NAME_____

Patient Financial Responsibility

I acknowledge full financial responsibility for services rendered by Midwest Orthopaedics at Rush, LLC (MOR). I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and copays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to MOR for any medical or surgical services furnished. I agree to all reasonable attorney fees and collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed _____ Date _____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I hereby give my consent to MOR to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of _____.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that MOR reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on MOR's website, available at each office or I may request a copy be sent to me by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office

Signed _____ Date _____

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of MOR's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that MOR has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed _____ Date _____

If you are not the patient, please specify your relationship to the patient _____

Richard A. Berger, MD

Joint Replacement and Orthopaedic Surgery

Name: _____ Date of Birth: _____ Date: _____

Who sent you to see us? Name: _____
Address: _____
City, State: Zip: _____
Phone #: _____

Why are you seeing the doctor today? _____
_____

Where is your pain?
□ Right Hip □ Right Knee □ Back □ Left Hip □ Left Knee

How long have you had this problem? _____

If you are having **HIP PAIN**, where is it located?
□ Groin □ Thigh □ Down below knee
□ Side of Hip □ Down to knee □ Down to foot

If you are having **KNEE PAIN**, where is it located?
□ Inside of the knee (close to the other knee) □ Front of knee (under kneecap)
□ Outside of knee (away from the other knee) □ Back of knee

Is your pain: □ Getting Worse □ Getting Better □ Staying the same

Is your pain: □ Intermittent □ Constant

How would you describe your pain?
□ Sharp □ Throbbing □ Burning □ Dull □ Tight □ Tingling

Do you have pain when you:
□ Walk □ Sit □ Stand □ At Night

Is your pain worse when you:
□ Walk □ Sit □ Stand □ At night

Rate your pain on a scale from 1-10 (1 = minimal pain, 10=severe pain): _____

Do you have any of the following:
□ Stiffness □ Numbness
□ Swelling □ Weakness

Do you have a limp?
□ None □ Moderate
□ Slight □ Severe

How far are you able to walk before you begin to experience pain?
□ Unlimited □ 2-3 blocks □ bed to chair only
□ 4-6 blocks □ Indoors only □ Unable to walk

How many stairs do you walk up ***to get into*** your home?_____
How many stairs must you walk up ***inside*** your home?_____

Name: _____

Do you need assistance with walking?
□ None □ Cane all of the time □ Walker
□ Cane, long walks only □ Wheelchair

Do you have difficulty going up or down stairs?
□ No □ Take one step at a time
□ Use banister always □ Use crutches or cannot do stairs

Do you have difficulty putting on your shoes and socks?
□ No □ Unable □ With difficulty

Can you sit in a chair comfortably?
□ Any chair for more than 1 hour □ Unable to sit for 1/2 hour
□ High chair for ½ hour

Can you get up from a chair?
□ Normally □ Difficulty even when using my arms
□ Need help □ Unable to do alone

Have you tried any of the following medications?
□ Tylenol □ Aspirin □ Vioxx □ Celebrex
□ Motrin □ Alleve □ Other _____

Have you tried injections? □ Yes □ No

What kind of injections? □ Steroids □ Synvisc □ Don't know
How many injections? _____

Have you tried physical therapy/exercises? □ Yes □ No

PAST MEDICAL HISTORY
Please list all of your medical problems (such as high blood pressure or heart disease):
_____
_____
_____
_____

Please list all of your past surgeries/hospitalizations/severe injuries with dates (month/year):

_____

_____

_____

OTHER INFORMATION
Height :_____ Weight :_____

Name: _____

Do you have allergies to any medications? _____
If yes, what is your reaction? _____

What local pharmacy do you use? _____ Phone: _____

What medications do you presently take (include name and dose):
_____
_____
_____

Do you have a latex allergy? □ Yes □ No
If yes, what reaction?_____

SOCIAL HISTORY
What kind of work do you do?
□ Homemaker □ Manual labor □ Retired □ Desk Job
□ On disability □ Occupation: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed
Spouse's Occupation: _____

Do you have children? □ Yes □ No How many children? _____
Who lives at home with you? _____
Who will assist you after your surgical procedure? _____

Do you drink alcohol? □ Yes □ No If yes, # drinks per week:_____
Do you use illicit drugs? □ Yes □ No Describe:_____
Do you smoke? □ Yes □ No If yes, # packs per day: _____For how many years?_____

Do you exercise regularly? □ Yes □ No How many times per week? _____
Do you follow a special diet? □ Yes □ No What kind? _____

FAMILY HISTORY

Member	Alive/Deceased	Age/Health Status	Cause of death
Father			
Mother			
Sibling			
Sibling			
Sibling			

Name: _____

Do you currently or have you ever had problems with any of the following that you did NOT list elsewhere?

Constitutional Musculoskeletal

Recent weight loss	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Recent fevers	☐ Yes	☐ No
Ankylosing Spondylitis	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Paget's Disease	☐ Yes	☐ No

Eyes

Wear glasses	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No

Skin

Psoriasis	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Dermatitis	☐ Yes	☐ No

Ears, Nose, Throat, Mouth

Sinus problems	☐ Yes	☐ No
Active dental problem	☐ Yes	☐ No

Neurologic

Seizures/Epilepsy	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No
Polio	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No
Balance problems	☐ Yes	☐ No

Cardiovascular

Heart attack	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No
Irregular heart beat	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No
Valve problem	☐ Yes	☐ No

Psychiatric

Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
CPAP/ BiPAP	☐ Yes	☐ No

Endocrine

Diabetes	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No

Hematologic/Blood

Blood Clots	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Gastrointestinal

Colitis	☐ Yes	☐ No
Diverticulitis	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Hernia	☐ Yes	☐ No

Genitourinary

Prostate problem	☐ Yes	☐ No
Kidney problem	☐ Yes	☐ No
Bladder infections	☐ Yes	☐ No

Cancer ☐ Yes ☐ No

What kind? _____

Hepatitis/ liver problem ☐ Yes ☐ No