

Today's Date: ____ / ____ / ____

Last Name: _____ First Name: _____ MI: _____

Home Address: _____

City: _____ STATE: _____ Zip: _____

Home Phone :(____) _____ - _____ Work/Alt Phone :(____) _____ - _____

Social Security# _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Sex (M / F) Marital Status: S M D W Email: _____

Employer: _____ Address: _____

City: _____ ST: _____, Zip: _____ Phone: (____) _____ - _____

Location of Injury: R L Bilateral: _____, Date of Injury: _____

Please Describe Problem/Injury: _____

How did you hear about our office? _____

Who referred you to our office? _____

Who is your Primary Care Physician? _____ Phone # (____) _____ - _____

Did you file a Workman's Comp Claim for this injury? YES NO

If Workman's Comp, indicate Name and Phone # of person at your place of employment who authorized your treatment: _____, Phone #: (____) _____ - _____

Is your injury a direct result of an auto accident? YES NO

Have you filed or are you anticipating on filing a lawsuit in connection with this injury? YES NO

If YES, please indicate Name and Phone # of your attorney: _____

Phone #: (____) _____ - _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone # (____) _____ - _____

PRIMARY INSURANCE

Company: _____, Phone #: (____) _____ - _____

Group #: _____, Identification #: _____

Name of Person Insured: _____, Relationship to Patient: _____

Social Security #: _____ - _____ - _____, Insured Date of Birth _____ - _____ - _____

Employed By: _____

SECONDARY INSURANCE

Company: _____, Phone #: (____) _____ - _____

Group #: _____, Identification #: _____

Name of Person Insured: _____, Relationship to Patient: _____

Social Security #: _____ - _____ - _____, Insured Date of Birth: _____ - _____ - _____

Employed By: _____

ORTHOPEDIC ASSOCIATES OF NAPERVILLE

HISTORY SURVEY

This questionnaire is given to aid the doctor in having a more comprehensive insight into your medical past and to aid in your future care. Please answer as requested to the best of your knowledge and recollection.

PATIENT NAME _____ DATE _____

List any physicians presently taking care of you:

Practice Type

Physician Name

Primary Care Physician

ALLERGIES:

Do you have any allergies to medications? _____ Yes _____ No

Allergy To: Reaction Since When Treatment for reaction

MEDICATIONS:

Do you take medication prescribed by a physician? _____ Yes _____ No

Medication Dosage How Often Since when

Do you take over the counter or herbal medication on a regular basis? _____ Yes _____ No

Medication Dosage How Often Since when

PAST MEDICAL HISTORY:

Please check any below that you have been diagnosed with and write approximately how long:

Heart Disease _____	High Blood Pressure _____
Kidney Disease _____	Diabetes _____
Blood Clots _____	Cancer _____
Rheumatic Fever _____	Stoke _____
Ulcers _____	Arthritis _____
Other (please list) _____	

PAST SURGICAL HISTORY:

Have you had surgery? _____ Yes _____ No

Type of Surgery When Hospital Surgeon Any Complications

Did you have any problems with anesthesia? _____ Yes _____ No

What Problem? _____

HISTORY SURVEY Continued

PAST HOSPITALIZATIONS:

Have you been hospitalized for a non-surgical problem? ____ Yes ____ No

Diagnosis When Hospital Surgeon Any Complications

SOCIAL HISTORY:

Live alone or with: _____

Occupation _____

Have you ever smoked? Yes ____ No ____ Packs/day for ____ years Quit when _____

Alcoholic beverages: glasses/week ____ beers/week ____ never drink ____

Drug use: Marijuana ____ Cocaine ____ Opiates ____ LSD ____ None ____ Other _____

REVIEW OF SYSTEMS:

____ Recent change in weight	____ Recent change in appetite	____ Problems with Insomnia
____ New moles	____ New rashes	____ Skin ulcers
____ Headaches	____ Dizziness	____ Recent change in vision
____ Blurring vision	____ Double vision	____ Change in hearing
____ Ringing in ears	____ Sores in mouth	____ Change in voice
____ Chest pain	____ Heart skips beats	____ Cough
____ Shortness of breath	____ Wheezing	____ Coughing up blood
____ Abdominal pain	____ Change in bowel habits	____ Nausea/Vomiting
____ Blood diarrhea	____ Black, tarry stool	____ Incontinence
____ Waking up to urinate	____ Frequent urination	____ Pain on urination
____ Swelling in joints	____ Joint pain	____ weakness
____ Numbness	____ Episodes of confusion	____ Recent change in behavior
____ Problem breathing at night	____ Nervousness	____ Depression
____ Other (please list) _____		

FAMILY HISTORY:

Name	Age-If Living	Age at Death	Cause of Death
Mother _____			

Father _____

Siblings: _____

 M/F _____

 M/F _____

Children: _____

 M/F _____

 M/F _____

Do you have a family history of:

Heart Disease ____ Yes ____ No ____ Relationship

Diabetes ____ Yes ____ No ____ Relationship

Circulatory Problems ____ Yes ____ No ____ Relationship

Kidney Disease ____ Yes ____ No ____ Relationship

Cancer ____ Yes ____ No ____ Relationship

Arthritis ____ Yes ____ No ____ Relationship

Other hereditary illnesses in the family (please list) _____

ORTHOPEDIC ASSOCIATES OF NAPERVILLE

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Orthopedic Associates of Naperville for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of Orthopedic Associates of Naperville. I understand that diagnosis or treatment of me by Dr. Markarian may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Orthopedic Associates of Naperville is not required to agree to the restrictions that I may request. However, if Orthopedic Associates of Naperville agrees to restrictions that I request, the restrictions are binding on Orthopedic Associates of Naperville and Dr. Markarian.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Markarian or Orthopedic Associates of Naperville has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Orthopedic Associates of Naperville's Notice of Privacy Practices prior to signing this document. The Orthopedic Associates of Naperville's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the Orthopedic Associates of Naperville. The Notice of Privacy Practices for Orthopedic Associates of Naperville is also provided at the receptionist desk. This Notice of Privacy Practices also describes my rights and the Orthopedic Associates of Naperville's duties with respect to my protected health information.

Orthopedic Associates of Naperville reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices for Orthopedic Associates of Naperville by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

ORTHOPEDIC ASSOCIATES OF NAPERVILLE
FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

***** Please call our billing department if you have any questions at **815-838-8530** *****

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CHECK, VISA , MASTERCARD or DISCOVER
- ALL PATIENTS MUST COMPLETE OUR "PATIENT REGISTRATION FORM" AND OTHER RELATED FORMS.
- FOR CASES WHICH WE BILL INSURANCE DIRECTLY, WE MUST HAVE A COPY OF THE INSURANCE ID CARD.
- **IF PAYMENT IS NOT RECEIVED FROM THE INSURANCE CARRIER OR OTHER RESPONSIBLE THIRD PARTY IN 90 DAYS, WE HAVE THE RIGHT TO BILL YOU DIRECTLY.**
- PLEASE NOTIFY US IMMEDIATELY OF ANY CHANGES IN YOUR INSURANCE OR COVERAGE.
- 24-HOUR NOTICE IS REQUIRED FOR COPIES OF MEDICAL RECORDS OR X-RAYS AND THERE MAY BE A NOMINAL FEE.
- **NO SHOW POLICY IS AS FOLLOWS: IF PATIENT FAILS TO CALL THE OFFICE TO CANCEL OR RESCHEDULE FOR AN APPOINTMENT WITH THE DOCTOR THERE IS A \$35 FEE; PHYSICAL THERAPY APPOINTMENTS ARE \$50 FOR EACH MISSED NO CALL/NO SHOW APPOINTMENT.**

UCR (USUAL AND CUSTOMARY RATES)

We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of UCR.

SELF PAY PATIENTS

Self-pay patients are required to pay the entire balance at the time of service unless prior arrangements have been made.

MEDICARE

We accept Medicare assignment. As a Medicare patient you are responsible only for the difference between the approved charge and the amount Medicare pays and your yearly deductible. If you have supplemental insurance we will bill it directly for you. You will receive a bill after your insurance has paid.

PPO INSURANCE

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. We are In Network with Blue Cross Blue Shield. PPO patients will only be responsible for their co-payments and co-insurance.

WORKERS COMPENSATION

If you are here as a result of a work related injury, we will require information regarding both health insurance and your employer's Workers' Compensation Insurance. We will also need to verify that your employer assumes responsibility for charges incurred. If we cannot verify responsibility or we are unable to obtain information on your employer's Workers Compensation Insurance, as a courtesy we will bill your health insurance carrier. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

ACCIDENT CLAIMS

If you are here as a result of an accident claim, we will require information regarding both health insurance and accident insurance. In addition, we will need the name, address and phone number of your attorney. In the case of a lawsuit we may need to file liens for payment. If payment is not received from these third parties within 90 days, we have the right to bill you directly.

When contacting you do we have your permission to identify ourselves? ____ Yes ____ No

I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed to ensure payment for services rendered to me. I understand that I am ultimately responsible for payment for all services.

Print Name of Patient _____

Signature of Patient or Responsible Party _____

Date: _____



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Gregory G. Markarian, M.D.
Medical Director

Diplomat of American
Board of Orthopedic Surgeons

Advanced Arthroscopic Surgery
in Disorders of the Knee,
Shoulder, Elbow & Ankle

Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____ authorize Orthopedic Associates of Naperville to release and obtain my private health information to/from (check all that applies):

My spouse/partner Name of spouse: _____

My primary care physician/staff Name of Doctor: _____

My Pharmacy Name of Pharmacy: _____

My parent/child(ren) Name(d): _____

My personal representative Name of representative: _____

Other Name: _____

Other Name: _____

None of the above. **May our office identify ourselves and leave a message on your machine?** Yes No

Are there any restrictions on PHI to be disclosed Yes No

If yes:

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am a patient with Orthopedic Associates of Naperville. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Attn: Medical Records 10 W Martin Ave Suite 50 Naperville, IL 60540. I understand that my revocation will not affect any actions taken by Orthopedic Associates of Naperville prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This authorization shall be effective one year from the date signed. At which time this authorization to obtain and release this protected health information expires.

Print Patient Name

Date

Patient Signature or Authorized Representative