# Northland Orthopedics & Sports Medicine – Patient Information

## PATIENT

Last Name_____First Name_____M_____

Preffered Name_____Date of Birth_____Age_____Sex_____SSN_____

Race: O Asian O Ameriacn Indian/Alaskan Native Ethnicity: O Hispanic or Latino

O Black/African American O Native Hawaiian/Other Pacific Islander O Not Hispanic or Latino

O White (Caucasian) O Declined or Unspecified O Declined or Unspecified

Preferred Language_____Marital Status_____

Address_____

City_____State_____Zip Code_____

Home_____Work_____Cell_____

Preferred Number_____ Appointment Reminder o Call o Text (Preferred number will receive)

Email_____

## EMERGENCY CONTACT INFORMATION

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

**May we share your personal health and financial information with your emergency contacts? o Yes o No**

*These questions are included to comply with new Federal Heatlth guidelines – we are required to ask for this information*

Referring Physician_____Primary Care Physician_____

Employer Name_____Occupation_____

Student Status O Full Time O Part Time

## RESPONSIBLE PARTY (if other than the patient)

Last Name_____First Name_____M_____

DOB_____Age_____Sex_____Marital Status_____Relationship to Patient_____

Address_____

City_____State_____Zip Code_____

Home_____Work_____Cell_____

Social Security Number_____

## INSURANCE - PRIMARY

Name of Carrier_____

Plan ID #_____Group #_____

Insured Name_____Relationship to Patient_____

Date of Birth_____Insured's Social Secuity Number_____

## INSURANCE - SECONDARY

Name of Carrier_____

Plan ID #_____Group #_____

Insured Name_____Relationship to Patient_____

Date of Birth_____Insured's Social Secuity Number_____

## PREFERRED PHARMACY

Name_____Phone Number_____

Address_____

Patient or Guardian Signature_____Date_____

Last name: First name: DOB: Date:

## ORTHOPEDIC HISTORY FORM

**HEIGHT** **WEIGHT** **BLOOD PRESSURE**

**CHIEF COMPLAINT** (Why are you seeing the doctor today?)

☐ Right
☐ Left Area of the body Description

How long have you had this problem?
When did the problem start?
Has the problem become worse? Describe
Have you had any diagnostic testing? (X-ray, MRI, CT, etc.) ☐ Yes ☐ No
If yes, what test? Where?
Current problem is a result of:
☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other: ☐ Not Applicable
Describe

Date of Accident Location of Accident (Include State)
Have you missed work/school because of this problem? How many days?

**SIGNS ASSOCIATED WITH THIS PROBLEM**

| Sign | Location | Sign | Location |
|---|---|---|---|
| ☐ Swelling | | ☐ Drainage | |
| ☐ Redness | | ☐ Muscle atrophy | |
| ☐ Warmth | | ☐ Muscle spasm | |
| ☐ Edema | | ☐ Muscle twitching | |
| ☐ Skin Changes | | ☐ Loss of movement | |
| ☐ Bruising | | ☐ Other | |

**SOCIAL HISTORY**

Do you currently smoke? ☐ Yes ☐ No If yes, # of packs per day for years.
Have you ever smoked? ☐ Yes ☐ No If yes, when did you stop smoking?
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? How often
Do you exercise daily ☐ Yes ☐ No If yes, what type of exercise
Are you currently experiencing an unusually stressful situation? Describe

**PAST AND PRESENT medical problems, surgeries and hospitalizations**

| Date | Surgery, Medical Problem, Hospitalization |
|---|---|
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| | |
| | |

Have you ever had general anesthesia? ☐ Yes ☐ No
Have you ever had any problems with general anesthesia? ☐ Yes ☐ No
If, yes describe:
Have you ever had any infectious diseases? (i.e., MRSA, VRE, Hepatitis) ☐ Yes ☐ No
What? When?
If yes, date cleared of infectious disease.

Last name: First name: DOB: Date:

## ORTHOPEDIC HISTORY FORM

*Continued*

**MEDICATIONS** ☐ **I have attached a list.**

| **Prescription Medications** | **Dose** | **How often taken** |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |
| **Over the counters Medications** | **Dose** | **How often taken** |
| | | |
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| | | |
| **Herbal Preparations** | **Dose** | **How often taken** |
| | | |
| | | |
| | | |

**ALLERGIES** ☐ **I have attached a list.**

| Medication, Food or Latex | Reaction |
|---|---|
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**FAMILY HISTORY**

*Place an "X" in the appropriate boxes to identify all illnesses / conditions in your blood relatives.*

| Illness /Condition | Family Member | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Grandparents | Father | Mother | Brother | Sister | Son | Daughter | Other |
| Colon or rectal cancer | | | | | | | | |
| Heart Disease | | | | | | | | |
| High Blood Pressure | | | | | | | | |
| Diabetes | | | | | | | | |
| Liver Disease | | | | | | | | |
| High Cholesterol | | | | | | | | |
| Alcohol/Drug Abuse | | | | | | | | |
| Depression/Psychiatric Illness | | | | | | | | |
| Genetic(inherited)Disease | | | | | | | | |
| Other | | | | | | | | |

Last name: First name: DOB: Date:

## SYSTEM REVIEW

**Gastrointestinal**

- ☐ Poor appetite
- ☐ Abdominal pain
- ☐ Indigestion
- ☐ Trouble swallowing
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Nausea or vomiting
- ☐ Rectal bleeding or blood in stools
- ☐ History of liver disease

**Cardiovascular**

- ☐ Chest pain
- ☐ History of angina or heart attack
- ☐ History of high blood pressure
- ☐ History of irregular heart beat
- ☐ History of poor circulation

**Pulmonary/lungs**

- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing up blood
- ☐ Asthma or wheezing

**Muscle/joint/bone**

- ☐ Swelling of ankles or legs
- ☐ Pain, weakness or numbness in
- ☐ Arms or hands
- ☐ Back or hips
- ☐ Legs or feet
- ☐ Neck or shoulders

**Neurologic**

- ☐ History of stroke
- ☐ Blackouts or loss of consciousness

**General**

- ☐ Weight gain/loss of 10+ lbs during last 6 months
- ☐ Poor sleep
- ☐ Fever
- ☐ Headache
- ☐ Depression

**Endocrine**

- ☐ History of diabetes
- ☐ History of thyroid disease
- ☐ Change in tolerance to hot or cold weather
- ☐ Excessive thirst

**Eyes, ears, nose, throat**

- ☐ Blurred vision
- ☐ Other change in vision
- ☐ History of glaucoma or cataracts
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Hoarseness

**Genitourinary**

- ☐ Frequent or painful urination
- ☐ Blood in urine

**Skin**

- ☐ Itching
- ☐ Easy bruising
- ☐ Change in moles

**Women Only**

- ☐ Abnormal Pap smear
- ☐ Bleeding between periods

Date of last mammogram _____

**Men Only**

- ☐ PSA(prostate-specific antigen)

Do you have any other health concerns you would like to discuss with the physician?

_____

_____

_____

**Signatures:**

Patient or Guardian _____

Print Name of Patient or Guardian _____

Relationship to Patient _____

Physician _____

## Northland Orthopedic and Sports Medicine – Consents

_____ **Consent to Leave Information:** Northland Orthopedic and Sports Medicine requires their staff to obtain authorization from the patient to leave detailed messages for the patient if they are not available. This policy is to protect the privacy of the patient and to protect Northland Orthopedic and Sports Medicine from violating the patient's confidentiality. If there is not a signed consent on file, our staff will only leave their name and number on any answering machine, voice mail or with any person answering the phone. By completing this form, I am allowing the staff of Northland Orthopedic and Sports Medicine to leave a detailed message on an answering machine, voice mail, or with an individual. I can specify what information can be left and with whom. By initialing this section, I am also consenting to the mailing or faxing of any results requested by you, your primary care physician, and/or another physician involved in my care.

_____ **Consent to Treat:** Northland Orthopedic and Sports Medicine provides Orthopedic Specialty Health Care including the diagnosis and treatment of illness and injuries. Physicians, Physicians Assistants, and Nurse Practitioners provide services at our various locations. Physicians Assistants and Nurse Practitioners are not physicians but do function under their direct supervision. My care may be collaborative and involve the services of any combination of these medical providers. By initialing this section, I am consenting to the performance of those diagnostic procedures, examinations, and the rendering of medical treatment by the staff and their assistants as necessary and I understand that this consent will be valid and remain in effect as long as I am a patient.

_____ **Consent to Release Information:** By initialing, I authorize Northland Orthopedic and Sports Medicine to release protected health information received or created in the course of the delivery of health care which will be used or released for treatment, payment, and health care operations. I also understand that Northland Orthopedic and Sports Medicine may disclose my health information in order to make decision about my care and treatment, refer to or consult with other health care providers or determine my eligibility for health plan, workmen's compensation, or insurance benefits. I understand that my health information may include information both created and received by this practice and may be in the form of written or electronic records or spoken words and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions and similar types of health related information.

_____ **Consent to Electronic Receipt of Medication History:** By initialing, I authorize Northland Orthopedic and Sports Medicine to receive my medication history electronically.

_____ **Consent to Assignment of Insurance Benefits:** By initialing, I hereby assign all benefits related to my care at Northland Orthopedic and Sports Medicine to Northland Orthopedic and Sports Medicine. I hereby authorize and direct my insurance carrier(s) to issue payment directly to Northland Orthopedic and Sports Medicine for medical services rendered to me and/or my dependents. I authorize that Northland Orthopedic and Sports Medicine may contact my insuance carrier or health plan administrator to obtain necessary information regarding coverages and payments under my policy.

_____ **Notice of Privacy Practices:** By initialing, I acknowledge that I have been offered a copy of Northland Orthopedic and Sports Medicine's Notice of Privacy Practices.

**I have read and understand the information above in front of office staff:** _____

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Guarantor | Printed Name | Date |

**Northland Orthopedic and Sports Medicine – Financial Policy**

Thank you for choosing Northland Orthopedic and Sports Medicine as your health care provider. We are committed to building a successful physician – patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. Let us know if you have any questions about our fees, our policies, or your responsibilities.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. **INSURANCE**: We are participating providers with most major insurance plans in the Kansas City Area and will file an insurance claim on your behalf if we are participating. If our physicians are not listed in your plan's network, you will be responsible for payment. Due to the many different insurance products, Northland Orthopedic and Sports Medicine cannot guaranty our network participation. Our staff will assist you to the best of their abilities but are not accountable for complete knowledge of participation or benefits in any particular network. You are responsible for obtaining a properly dated referral if required by your insurance carrier and you are responsible for payment if your claim rejects for the lack of one. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

3. **NON-PARTICIPATING PLANS**: We are non-participating with the following plans: Aetna Medicaid, Home State Health, Humana PPO X, Kancare, Medica Select and UHC Community Plan-Medicaid. If you participate with the following insurance plans we are not accepting new patients unless you were referred by the Emergency Room: Aetna Medicaid, Cigna Health Springs, Home State Health, Humana PPO X, Kancare, Medicaid, Missouri Care, MO Healthnet, and UHC Community Plan-Medicaid.

4. **RETURNED CHECKS** will incur a $35.00 service charge. You will be asked to bring cash, certified funds, or a money order to cover the amount of the check plus the $35.00 service charge.

5. **FORMS FEES**: We require prepayment for completing forms or copying medical records. Base form charges are $25.00 per occurrence. The copying fee for medical records is $26.06 and $0.60 per page.

6. **BILLING OFFICE**: If you have questions regarding any billing item, please call 816-841-3808.

7. **RESPONSIBILITY FOR PAYMENT**: I understand that I am personally financially responsible to Northland Orthopedic and Sports Medicine, Inc. for charges incurred.

8. **SELF PAY ACCOUNTS**: Self pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file. It is always the patient's responsibility to know if our office is participating with their plan. Self-pay patients are required to bring $200.00 deposit to cover the cost of the initial appointment and will be asked to make payment arrangements for the balance, if necessary.

9. **EXTENDED PAYMENT ARRANGEMENTS** are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible.

10. **WORKERS' COMPENSATION**: In the case of a workers' compensation injury or automobile accident, you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier prior to your visit. If this information is not provided, you will be asked to reschedule your appointment or pay for your visit at the time of service.

11. **STATEMENTS**: Our office does not send statements until after we have received the initial insurance payment. This can be delayed if the insurance claim is rejected or we have received incorrect information in submitting your claim. Payment is due upon receipt of your initial statement.

| Signature of Patient or Guarantor | Printed Name | Date |
|---|---|---|