North Point Orthopaedics

2015 New Patient Intake

Date: _____

Patient Name _____ Birth Date _____ Age _____

Address _____ City _____ State _____ Zip _____

Main Phone _____ Work Phone _____ Cell/Alternate Phone _____

SS#: _____ E-mail address: _____

Marital status: ❒ Married ❒ Single ❒ Divorced ❒ Widowed

Ethnicity: ❒ Caucasian ❒ African-American ❒ Hispanic ❒ Other ❒ Declined

Language: ❒ English ❒ Spanish ❒ Other _____

Current Occupation/Work Status: _____

Who can we thank for sending you to North Point Orthopaedics? _____

PURPOSE OF YOUR VISIT

What is the reason of your visit today? _____
(eg. Low back pain, right shoulder pain, left hip pain)

Did this condition arise as a result of: ❒ Motor vehicle accident ❒ Work Injury ❒ Sports Injury ❒ No injury

Date when pain/injury began? _____ Nature of the injury _____

Since you first felt the pain, it has: ❒ Improved ❒ Gotten worse ❒ Hasn't changed much

Your condition is interfering with: ❒ Work ❒ Sleep ❒ Daily routine

Since you began suffering from **this condition**, what treatments have you tried (check all that apply):

❒ Ice/Heat	❒ Rest	❒ Physical Therapy	❒ Over the counter and/or prescription med
❒ Traction	❒ Stretching	❒ Exercises	❒ Acupuncture
❒ Chiropractic care	❒ Massage	❒ Spinal Injections	❒ Surgical consultation
❒ Joint Injections	❒ Pain Clinic	❒ Seen a neurologist	❒ Other _____

❒ Previous surgery for this condition _____ Surgeon: _____

Have you had any testing done:

❒ X-Rays	❒ MRI of _____
❒ None	❒ CT of _____
❒ EMG needle study	❒ Ultrasound
❒ Bone scan	❒ Blood work

Name of Facility/Location of testing _____

ALLERGY HISTORY

Do you have any allergies to medications?	❒ No	❒ Yes. Please list:	_____
Do you have a latex allergy?	❒ No	❒ Yes	_____
Food – Medications--Environmental	❒ No	❒ Yes	_____

SOCIAL HISTORY

Do you smoke? ❒No ❒ Yes. I smoke _____ packs per day
❒ I have smoked in the past, but I quit _____ months / years ago

Do you drink alcoholic beverages? ❒ No ❒ Yes. I drink ____ beverages per day / week. What type? _____
❒ I have a history of drinking, but do not drink any longer

MEDICAL HISTORY

Place a check in the box if you have ever had any of the following:

☐ Cancer	☐ Neurologic Disease	☐ Kidney Disease	☐ Stomach Ulcer
☐ Aids / Hiv	☐ Autoimmune Disorder	☐ Blood Transfusion/S	☐ Major Infection
☐ Gout	☐ High Blood Pressure	☐ Thyroid Disease	☐ _____
☐ Strokes	☐ Lung Disease	☐ Rheumatoid Arthritis	☐ _____
☐ Diabetes	☐ Liver Disease/Hepatitis	☐ Anxiety / Depression	☐ _____
☐ Blood Clots	☐ Heart Disease	☐ Bleeding Disorder	☐ _____

Have you ever had a reaction to anesthesia? ☐ Yes. Please describe_____
☐ No

Surgical History

Type of Surgery	Date	Have You Had?	Date of Last exam or n/a
		Mamogram	or ☐ n/a
		Colorectal cancer screen	or ☐ n/a
		Glaucoma screen	or ☐ n/a
		Bone Mineral Density test	or ☐ n/a
		Spirometry	or ☐ n/a
		Influenza Vaccine	or ☐ n/a
		Cervical Cancer Screening	or ☐ n/a
		Annual Dental Visit	or ☐ n/a

FAMILY HISTORY

Check all that apply:

☐ Diabetes	☐ Hypertension	☐ Cancer	☐ Stroke
☐ Asthma	☐ Heart Attack/Disease	☐ Seizures	☐ Tuberculosis

Your Immediate Family History

	Major Medical Problems
Father	
Mother	
Siblings	
Children	

CURRENT MEDICATIONS/HEALTH STATUS

Primary Care Physician_____ **Other treating physicians:**_____

Medication/Dose	Prescribed by	Medication/Dose	Prescribed by

Preferred Pharmacy:_____ **Location/city:**_____

Current Height : _____ Current Weight: _____

HIPAA

I _____ (Print Your Name) DOB: _____

As required by the privacy regulations created as a result of HIPAA, North Point Orthopedics is dedicated and committed to your health information. In conducting business, North Point Orthopedics will comply with all legal duties and responsibilities that apply with HIPAA. I have been offered a copy of the HIPAA privacy practice and policy.

I have previously read the office policy. I understand that I am responsible for all charges not paid by my insurance company. Should it be necessary for North Point Orthopedics to submit my account to a collection agency or attorney, I understand I will be responsible for any costs of collection services, including reasonable attorney fees.

I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, for this date forward until revoked in writing.

I have given the information above freely, and I am not withholding any medical/billing information at this time.

_____ _____

Patient signature **Date**

I have reviewed the above information with the patient.

_____ _____

Provider **Date**

Medical Information Release

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] _Name _____ Relationship: _____

[ ] _Name _____ Relationship: _____

[ ] _Name _____ Relationship: _____

[ ] Information is not to be released to anyone

North Point Orthopaedics

Gregory P. McComis, M.D.
Phone: 219.836.1060
Fax: 219-836-1014

Patient Name:_____ Date:_____

Welcome to our office. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our authorization and financial policy which we require you to read and sign prior to treatment. All patients must complete our information before seeing the doctor.

Consent for Treatment

You authorize and consent to the performing of any medical procedure or examination or treatment and such additional procedures or treatments as are considered necessary. I understand that medical procedures may be necessary and I will discuss the possible complications and risks involved with my physician. I will ask questions until I am satisfied. I acknowledge that no guarantee will be given or has been made as to results or cure.

Regarding Insurance

We may accept assignment of insurance benefits. It is your responsibility to verify if we participate with your insurance plan. In accordance with your insurance, co-pays and deductibles are to be paid prior to service. Your insurance policy is a contract between you and your insurance company. You are responsible for the balance whether your insurance pays or not. We cannot bill your insurance company unless you provide the correct insurance information. A copy of your insurance card will be made at your first visit. Please update insurance information if this changes.

Usual and Customary Rates/Pre-certification

You are responsible for payment regardless of usual and customary rates. Our staff will be happy to assist you in understanding how to obtain the necessary authorizations. However, it is the responsibility of the patient to make sure prior authorization is obtained and patient is financially responsible if pre-cert is not obtained.

Minor Patients

The parent(s), or guardian of a minor are responsible for full payment. For unaccompanied minors, non-emergent treatment will be denied. A minor must be accompanied by an adult 18-years to receive healthcare services. The legal guardian of a minor unaccompanied by their legal guardian, must make prior arrangements in writing to the scheduled physician to allow for a non-custodial adult attendance.

Missed Appointment

Please give at least 24 hours notice in advance if you are unable to make your appointment.

Authorization and Release

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to North Point Orthopedics for any services rendered to me. I authorize North Point Orthopedics to release medical information about me to determine benefits payable to related services. I hereby give my consent to review and discuss pertinent aspects of my treatment relevant to my medical care to any physician, hospital and/or health professionals as necessary.

Patient Signature:_____ Date:_____

Responsible Party:_____ Witness:_____