ELMHURST ORTHOPAEDICS

DIAGNOSTICS • TREATMENT • REHABILITATION

DATE: ____________________

PATIENT INFORMATION SHEET

PATIENT: LAST NAME ________________________________ FIRST NAME ________________________ MIDDLE _________

ADDRESS ____ CITY _____________________ STATE _____ ZIP __________

HOME PHONE # ___________________________________ DATE OF BIRTH ____/____/____ MALE _____ FEMALE _____

WORK # ____ SOCIAL SECURITY NUMBER ________ - ________ - _________

CELL # ____ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

SPOUSE'S NAME ____________________________________

LANGUAGE: _____________________ RACE: ______________________ ETHNICITY: ☐ Hispanic ☐ Non-Hispanic

EMERGENCY CONTACT: NAME _____________________________________ PHONE # ______________________________

RELATIONSHIP________________________ WORK PHONE # ___________________________

PHARMACY: NAME ____ PHONE # ______________________________

ADDRESS ____

I was referred to Elmhurst Orthopaedics by: ____

I had X-RAYs/MRIs at ____ on __________________________

EMPLOYER INFORMATION: (Patient's Employer)

NAME OF EMPLOYER ____

ADDRESS _____________________________________ CITY _________________________ STATE _____ ZIP ________

INSURANCE: PRIMARY

COMPANY NAME ____ PHONE # ______________________________

POLICYHOLDER NAME (IF OTHER THAN PATIENT) ____________________________ DATE OF BIRTH _____/_____/_____

EMPLOYER OF POLICYHOLDER ____ RELATIONSHIP _________________

INSURANCE: SECONDARY

COMPANY NAME ____ PHONE # ______________________________

POLICYHOLDER NAME (IF OTHER THAN PATIENT) ____________________________ DATE OF BIRTH _____/_____/_____

EMPLOYER OF POLICYHOLDER ____ RELATIONSHIP _________________

History & Physical Form

ELMHURST ORTHOPAEDICS
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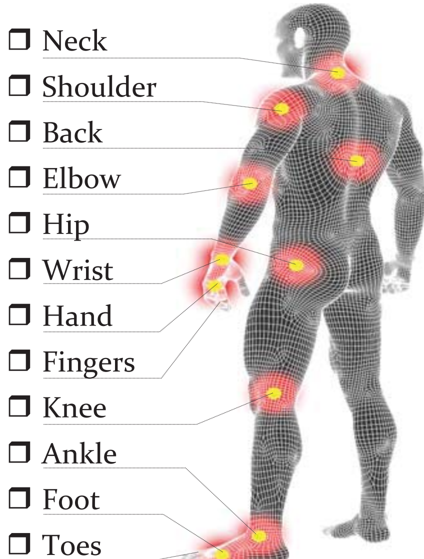
Name: ________________________ DOB: ____/____/____ Age:________ Date:____/____/____

Side: ❑ Left ❑ Right

- ❐ Neck
- ❐ Shoulder
- ❐ Back
- ❐ Elbow
- ❐ Hip
- ❐ Wrist
- ❐ Hand
- ❐ Fingers
- ❐ Knee
- ❐ Ankle
- ❐ Foot
- ❐ Toes



	Pain Frequency		Pain Level
❐	0	❐	0
❐	1	❐	1
❐	2	❐	2
❐	3	❐	3
❐	4	❐	4
❐	5	❐	5
❐	6	❐	6
❐	7	❐	7
❐	8	❐	8
❐	9	❐	9
❐	10	❐	10

Which doctor are you seeing today?

Eugene J Bartucci, MD
John W. Nikoleit, MD
Kevin M. Koutsky, MD J
Bijoy Abraham, DPM

My primary care provider is:

____

PH# ________________________

I am:
❐ Right-handed
❐ Left-handed

Height: __________ Weight: __________ Who referred you to us? ________________________

What is the reason for your visit? ____

____

How long have you had the pain? ______________ Is the pain resulting from an injury? ❑ Yes ❑ No

If an injury, please provide date of injury and describe how you were injured or what type of problems you are having now.

____/____/____ ____

Have you been treated previously by another orthopaedic doctor for this body part? ❑ Yes ❑ No

*If yes, please bring any X-Rays, MRI Films, or any other Medical Records that may be pertinent to this visit

Any previous problems or injuries? ❑ Yes ❑ No If yes, please describe: ________________________

What is your Occupation? ____

Is this a **WORK** injury? ❑ Yes ❑ No If so, is Worker's Comp involved? ❑ Yes ❑ No

Is this an **AUTO** injury? ❑Yes ❑ No

Is this a **SPORTS** injury? ❑ Yes ❑ No If so, what level do you play?

❑ Recreational ❑ Junior/High School ❑College ❑ Professional

Have you consulted or retained an attorney regarding this injury? ❑ Yes ❑ No

Check ANY previous treatments and/or testing for this injury/condition?

❑ X-rays ❑ CT Scans ❑ MRI ❑ Physical Therapy ❑ Injections ❑ Surgery
❑ Medications ❑ Chiropractor ❑ Acupuncture ❑ EMG ❑ Discogram

Current Medical History

Patient Name: ______________________________

PAST MEDICAL HISTORY

- ❒ Anemia
- ❒ Asthma
- ❒ Bleeding/Hematology DZ
- ❒ Blood Clots
- ❒ Cancer
- ❒ Cardiac History
- ❒ Gout
- ❒ High Cholesterol
- ❒ HIV / AIDS
- ❒ Hypertension
- ❒ Kidney Disorders
- ❒ Liver, Stomach, Bowel Disease
- ❒ Osteoarthritis
- ❒ Osteoporosis
- ❒ Rheumatoid Arthritis
- ❒ Thyroid Disorders
- ❒ Other:

Past Medical History Continued:

Have you ever had a reaction to anesthesia? ❑ Yes ❑ No

Do you have a pacemaker? ❑ Yes ❑ No

Past hospitalizations (NOT for surgery) ❑ None ______________________________

____

____

____

____

What past operations have you had? When? ❑ None ______________________________

____

____

____

____

REVIEW OF SYSTEMS — Please check all that apply

CONSTITUTIONAL
- ❒ Fever
- ❒ Decrease in Appetite

EYE
- ❒ Blurry Vision
- ❒ Vision Problem

CARDIOVASCULAR
- ❒ Chest Pain
- ❒ Heart Disease
- ❒ Hypertension

RESPIRATORY
- ❒ Chronic Cough
- ❒ Shortness of Breath
- ❒ Wheezing

GASTROINTESTINAL
- ❒ Heartburn
- ❒ Nausea
- ❒ Vomiting
- ❒ Hepatitis

GENITOURINARY
- ❒ Dysuria
- ❒ Renal Disorders

HEME / LYMPH
- ❒ Easy Bruising
- ❒ Anemia
- ❒ HIV Infection

ENDOCRINE
- ❒ Thyroid Disorders
- ❒ Diabetes Mellitus

SKIN
- ❒ Skin Rash
- ❒ Skin Lesions

NEURO
- ❒ Headache
- ❒ Dizziness
- ❒ Seizures

MUSCULOSKELETAL
- ❒ Joint Stiffness
- ❒ Diabetes Mellitus
- ❒ Osteoporosis
- ❒ Joint Swelling
- ❒ Upper Back Pain
- ❒ Lower Back Pain
- ❒ Gout
- ❒ Rheumatoid Arthritis
- ❒ Ankle Joint Swelling

PSYCH
- ❒ Depression
- ❒ Alcohol Use
- ❒ Drug Use

Are you currently being treated for any of the conditions you checked above: ❑Yes ❑ No*

*If Yes, please follow up with your primary care physician.

SOCIAL HISTORY - Please check all that apply

WORK
- ❒ Working Full Time
- ❒ Working Part Time
- ❒ Currently on disability
- ❒ Not working

LIVING SITUATION
- ❒ Live with spouse
- ❒ Independently alone
- ❒ Living in a nursing home

ALCOHOL HISTORY
- ❒ Never drank alcohol
- ❒ Social Drinker
- ❒ Regular drinker

  ____/day OR ____/week
- ❒ Heavy Alcohol Consumption

TOBACCO
- ❒ Never Smoked
- ❒ Previous Smoker
- ❒ Currently smoking
- ❒ Chew Tobacco

DRUG USE - PRIVATE INFORMATION
- ❒ Marijuana
- ❒ Cocaine
- ❒ Intravenous Drugs

MARITAL STATUS
- ❒ Currently Married
- ❒ Divorced
- ❒ Never Married
- ❒ Single
- ❒ Separated
- ❒ Widowed

HABITS
- ❒ Exercise

Current Medical History

Patient Name: ____________________

FAMILY MEDICAL HISTORY - Please check all that apply

❒	Alcoholism	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Anemia	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Cancer	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Chronic Disabling Disease	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Diabetes Mellitus	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Gout	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Heart Disease	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	High Cholesterol	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	HIV / AIDS	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Hypertension	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Kidney Disease	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Liver Disease	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Osteoarthritis	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Osteoporosis	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Rheumatoid Arthritis	❒	Father	❒	Mother	❒	Brother	❒	Sister
❒	Other:	❒	Father	❒	Mother	❒	Brother	❒	Sister

MEDICATIONS:

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list: ____________________

____

Are you taking, or have you taken any blood thinners? ❑ Yes ❑ No If yes, please list: ____________________

Medication / Vitamins	Dosage	Frequency

PLEASE SIGN: The information on these forms is accurate to the best of my knowledge.

Signature ____________________ Date ____________________

FOR OFFICE USE ONLY

Reviewed by ____________________ MD /DPM/ Nurse Date: __________ Reviewed by ____________________ MD /DPM/ Nurse Date: __________

ELMHURST ORTHOPAEDIC, S.C.

CONSENT TO TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND AGREEMENT TO PAY

1. Consent to Diagnosis and Treatment. I hereby consent to diagnostic and medical treatment by the practitioners of Elmhurst Orthopaedics, S.C., including Eugene J. Bartucci, MD; John W. Nikoleit, MD; Kevin M. Koutsky, MD; William M. Noorlag, DPM; and/or Christine Koutsky, APN and their assistants and designees, including, if referred to, the physicians of Pain & Spine Institute.

2. Consent for Release of Information for Payment. I hereby authorize Elmhurst Orthopaedics to release to my employer, insurance companies, government agencies, or other third party payers and their agents, information concerning my medical care, treatment, supplies, or other information that may be necessary for the purpose of determining eligibility for available benefits and obtaining payment on my behalf for the health care services rendered to me.

3. Assignment of Benefits and Agreement to Pay. I authorize Elmhurst Orthopaedics to bill my medical insurer(s), worker's compensation carrier, auto carrier, and/or other insurer(s) and to receive payment directly from such insurer(s) for medical care provided to me. I further understand that I am financially responsible for any deductible, coinsurance, co-payment or any other amount not covered by such insurer(s). Further, I understand that I am responsible to Elmhurst Orthopaedics for payment of the entire bill at its established rates if my insurer(s) fail(s) to pay all or some amounts charged or if such amounts have not yet been awarded in a relevant legal case. Payment is due within 30 days of receipt of statement. In the event that legal action must be taken to collect to any balance due, I will be responsible for the cost of collection and reasonable attorneys' fees related to my account.

4. Disclosure of Financial Interest and Acknowledgement. Elmhurst Orthopaedics offers in-office dispensing of certain pharmaceuticals, as well as certain items of durable medical equipment, and owns and operates certain imaging equipment, including an MRI. In addition, Elmhurst Orthopaedics or its physician members may have ownership interests in one or more ambulatory surgery centers and consulting or other arrangements with certain implant or device manufacturers. As such, Elmhurst Orthopaedics and/or its physicians have a financial interest in these facilities, items and services. Elmhurst Orthopaedics offers these facilities, items and services for your convenience only and does not require that you use its in-office pharmacy, DME company, imaging equipment or any particular surgery center to fulfill any of your prescriptions, or that you use any particular implant or device in which it or its physicians have an interest. Elmhurst Orthopaedics will be happy to provide you with recommendations of alternatives upon request and does not condition your care upon your use of any of Elmhurst Orthopaedics' or its physicians' owned ancillary services. By signing where indicated below, I acknowledge that any use of Elmhurst Orthopaedics' ancillary services is voluntary.

____
Name of patient (please print)

____ ____________________
Signature of patient or authorized representative Date

____ ____________________
Name of authorized representative Relation to patient