

Crystal Lake Professional Center
750 E. Terra Cotta (Route 176)
Crystal Lake, IL 60014



Crystal Lake Orthopedics

Regency Park Condominiums
12519 Regency Pkwy., Suite E
Huntley, IL 60142

p: 815.455.0800 • f: 815.455.2895
www.crystallakeortho.com

Acct# _____
X-Ray# _____

PATIENT INFORMATION

Legal Name (Last, First, M.I.) _____ Sex: M F

Date of Birth _____ Age: _____ Social Security # _____

Home Address _____ City/State/Zip _____

Home Telephone _____ Cell Telephone _____

Employer _____ Occupation _____

Employer Address/City/State/Zip _____

Employer Telephone _____ School Attending _____

Who Referred You: _____

Marital Status: M S D Spouse Name: _____

May we give information to your spouse/parent: Yes No Parents Name: _____

MEDICAL INFORMATION:

Medical Physician's Name _____ Did this physician refer you? Y N

City/State/Zip _____

Medication Allergies _____

INSURED PARTY INFORMATION

Please complete the information below if someone other than the patient holds the health insurance plan.

Legal Name _____ Social Security# _____ Birth Date _____

Relationship to patient _____ Telephone _____

Address/City/State/Zip (if different than patient) _____

Employer _____ Employer Telephone _____

Employer Address/City/State/Zip _____

I understand that, under the Health Insurance Portability & Accountability Act of 1996. I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to – conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physician certifications. I understand that Crystal Lake Orthopaedic Surgery & Sports Medicine, LTD reserves the right to modify the privacy practices outlined in the notice. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent. I also have read the Financial Policy provided by Crystal Lake Orthopaedic Surgery & Sports Medicine, LTD and understand and accept the policy. I also have been provided with the financial statement and understand that it is the patient's responsibility to address any outstanding claims on my account.

Date: _____ Signature _____

Relationship to Patient _____

Medical History Form

Today's Date: _____

Name: _____
First MI Last

Height: _____ Weight: _____ Heart Rate: _____

Hand Dominance: Left Right Both

What is your pain on a scale of 0-10 (10 being the worst) ___/10 Activity ___/10 Rest

Chief Complaint:

Problem that brings you to our facility: _____

Previous treatment for this problem: _____

List the Body Part (Example: Knee, Wrist): _____ Left-side Right-side

Date of Injury/Onset: _____ Is this a Workman's Compensation injury? Yes No
MM/DD/YYYY

General Medical History:

Neurological

Stroke	YES	NO
Migraine	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy	YES	NO

Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO

Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO

Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO

Skin

Psoriasis	YES	NO
Eczema	YES	NO

Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

Pulmonary

Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO

Cancer

Type:	YES	NO

Musculoskeletal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

Psychological

Depression	YES	NO
Anxiety	YES	NO
ADHD	YES	NO
Bipolar	YES	NO
Claustrophobia	YES	NO

Problem Not Listed

Explain:	YES	NO

Medical History Form

Previous Surgery/Hospitalizations:

No history of surgery.

<i>List surgery/Reason for hospitalization:</i>	<i>Hospital/Facility:</i>	<i>Date:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____

Have you ever had General Anesthesia? YES NO

Have you ever had any problems with anesthesia? YES NO

If YES, please explain: _____

Current Medications: (List any prescription, drugs, and/or non-prescription medications, including vitamins, nutritional supplements, or anything taken orally.)

I do not take any medications.

<i>List names of medications:</i>	<i>Dose or strength:</i>	<i>Reason for medication:</i>
1. _____	a. _____	b. _____
2. _____	a. _____	b. _____
3. _____	a. _____	b. _____
4. _____	a. _____	b. _____
5. _____	a. _____	b. _____
6. _____	a. _____	b. _____
7. _____	a. _____	b. _____
8. _____	a. _____	b. _____
9. _____	a. _____	b. _____
10. _____	a. _____	b. _____

Allergies:

I have NO Allergies to Medications.

<i>List medications or Allergens:</i>	<i>Describe reaction:</i>
1. _____	a. _____
2. _____	a. _____
3. _____	a. _____
4. _____	a. _____

Are you allergic to Latex? YES NO

Medical History Form

Family History: Do your parents or siblings have any of the following problems?

I do not know my family medical history.

Diabetes	YES	NO
Heart Disease	YES	NO
Bleeding Problems	YES	NO
Lung Disease	YES	NO

Blood Clots	YES	NO
Stroke	YES	NO
Cancer	YES	NO

Social History:

Marital Status: Single Married Other: _____

Do you live alone: YES NO If not with whom? _____

Work Status: Employed Unemployed Disabled Student Retired

Do you use tobacco products? Never YES How many packs/day? _____

Quit-Smoked _____ packs/day for _____ years

Do you drink alcohol? Never Daily 1-2x/week 1-2x/month 1-2x/year

Do you currently use or have a history of illicit substance use? YES NO

Review of Systems: Are you experiencing any of the following:

Neurological

Seizures	YES	NO
Migraine	YES	NO
Balance Problems	YES	NO
Fainting	YES	NO

Cardiovascular

Chest Pain	YES	NO
Abnormal Heartbeat	YES	NO
Poor Heart Function	YES	NO

Psychiatric

Depression	YES	NO
Stress	YES	NO

Musculoskeletal

Joint Swelling or Pain	YES	NO
Muscle Aches	YES	NO

Skin

Frequent Rashes	YES	NO
Frequent Itching	YES	NO
Easy Bruising	YES	NO

Lung

Cough	YES	NO
Shortness of Breath	YES	NO
Sleep Apnea	YES	NO

General

Unexplained Weight Loss	YES	NO
Fevers, Chills, Sweats	YES	NO
Marked Fatigue	YES	NO
Difficulty Sleeping	YES	NO

Gastrointestinal

Nausea/Vomiting	YES	NO
Heartburn or Ulcers	YES	NO
Constipation	YES	NO
Blood in Stool	YES	NO
Stomach Pain	YES	NO

Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO

Eye, Ear, Nose Throat

Difficulty Swallowing	YES	NO
Hoarseness	YES	NO
Nasal Congestion	YES	NO
Hearing Loss	YES	NO
Vision Loss	YES	NO

Genital-Urinary

Burning with Urination	YES	NO
Urinary Incontinence	YES	NO
Urinary Frequency	YES	NO
Pelvic Pain	YES	NO

X _____
Patient Signature Date

X _____
Physician's Signature Date

Patient Financial Policy

Thank you for choosing the physicians of Crystal Lake Orthopedics as your health care provider. We are committed to providing our patients with the best medical care possible. Please understand that payment of our medical bill is also a part of your treatment and care. Our Business Office staff are experts working with commercial insurance companies, Medicare and Workers' Compensation carriers. They are available during clinic hours to answer any questions or to assist you in any financial concerns. Patients are responsible to notify CLO on insurance updates or changes.

Commercial Health Insurance

- Co-Payments
 - Insurance companies require that co-payments are collected prior to service.
 - Please make sure you bring payment at the time of your appointment.
- Co-Insurance/Deductibles
 - New co-insurance or deductible amounts will be billed after the date of service.
 - These amounts can only be calculated after your appointment.
- Non-Participating Insurance
 - Patients are responsible for asking if CLO is a participating provider with their insurance company.
 - CLO will bill non-participating insurances as a service to our patients, however, outstanding balances are the responsibility of the patient.
- Secondary Insurance – as a courtesy CLO will file to your secondary insurance carrier one time.
- HMO – Patient must present necessary valid referral at appointment check-in or be rescheduled.

Medicare

- CLO will submit claims to Medicare, however you may need to sign an ABN form for non-covered services.
- CLO will submit to Medicare as your secondary insurance carrier one time.

Workers' Compensation

- Patients shall be financially responsible for medical services related to Worker's Comp.
- Patients shall supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability

- Patients shall be financially responsible for medical services related to motor vehicle accidents.
- Motor vehicle accidents and third party liability cases will be liened by CLO, and settlements will be primary.
- Patients shall supply auto insurance, third party, and/or attorney information as requested by CLO.
- A copy of patients' regular insurance carriers' card and a copy of the letter of denial would be necessary to file any denied or exhausted benefits.

Self-Pay

- A payment of \$150.00 is required prior to your physician appointment. Balance on account will be billed.

Statements/Payments

- Statements
 - Statements are sent to patients on a monthly basis and will show outstanding balances.
 - After insurance pays, patients are responsible for all outstanding balances.
- Payment Methods
 - We accept all major credit cards, checks, money orders, and cash.
 - Low interest payment plans are available.
- Returned Check Fees – a fee of \$25.00 will be charged for all returned checks.

I hereby assign, to Crystal Lake Orthopedics, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments or co-insurance.

Printed Name

Responsible Party Signature

Date