

PRIVACY POLICY

PLEASE SIGN AND DATE THE FOLLOWING INFORMATION

Midwest Bone & Joint Institute's Privacy Policy has been made available to me.

X _____
Patient Signature (Parent if patient is a minor)

Confidential Communication Request

May we leave a message regarding medical information:

On answering machine at home? Yes No

With person at your home? Yes No

On your voice mail at work? Yes No

May we speak to a family member regarding your medical status? If so, whom?

X _____
Patient Signature (Parent if patient is a minor)

May we speak to a family member regarding your financial status? If so, whom?

X _____
Patient Signature (Parent if patient is a minor)

Release of Laboratory & X-ray Information

I hereby authorize Midwest Bone & Joint Institute to give lab, x-ray, MRI and CT results to a family member.

X _____
Patient Signature (Parent if patient is a minor)

Acknowledgement Regarding Medical Equipment

Not all medical equipment may be paid for by insurance company. If my Insurance Carrier does deny payment; I agree to be personally and fully responsible for payment.

X _____
Patient Signature (Parent if patient is a minor)

PATIENT INFORMATION

Today's Date _____ Injury/Accident Date _____

Name _____ Age _____ Height _____ Weight _____ M or F _____

What problem are you seeing us for today? _____ Right or Left? _____

Was this injury related to work? _____ Auto Accident _____ Other _____

How did it happen? _____

Were x-ray's taken? Yes No If yes, did you bring them with you? _____

Were you treated in an emergency room? Yes No

Date & Place _____

Do you smoke? _____ Packs per day _____

Do you drink alcohol? Social Moderate Excessive Coffee/Tea? _____

Do you exercise? Yes No Regularly or Occasionally? _____

Are you pregnant? _____ Number of children _____

Patients past surgeries _____

Family history of illness (Cancer, Diabetes, etc.) _____

Do you have or have you ever had (Please check all that apply)

- | | | | |
|---|--|---------------------------------------|--|
| <input type="checkbox"/> Lung Trouble | <input type="checkbox"/> Angina | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Kidney or Bladder Trouble | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease | <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other |

What medications are you presently taking? _____

Allergic to any medications? _____

If accident, give attorney's name, address, phone _____

Who is your family/referring physician? _____

Their address & phone? _____

Have you or any member of your family been seen here before, if so, who? _____

X _____
Signature