

PAIN REGISTRATION

Section 1: Patient Identification & Contact Information

Patient Account

First Name		MI:	Last Name:		Your type of Job Activity/Occupation:		<input type="checkbox"/> I prefer to be addressed as: <input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MISS <input type="checkbox"/> MS. <input type="checkbox"/> DR.	
Last digits of Social Sec. #:		Sex M / F	Age	Birthdate / /	Weight:	Height:	<input type="checkbox"/> I prefer to be addressed by: <input type="radio"/> First Name <input type="radio"/> Nick Name:	
Phone Numbers for Contact You:				In Case of Emergency, Please Call:			Please Provide Your Preferred Pharmacy:	
Day: (____) _____ - _____				Day: (____) _____ - _____			Street / City: _____	
Evening: (____) _____ - _____				Evening: (____) _____ - _____			Day: (____) _____ - _____	
Cell/Pager: (____) _____ - _____								

Section 2: Comprehensive Patient Medical History

Do you have or have ever been treated for:

<input type="checkbox"/> Stoke	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> A Heart Condition
<input type="checkbox"/> Anemia	<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Eyes: Glaucoma/Manicular Deg.
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Keloid/Thick Scar
<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Alzheimer's
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Lyme's Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hearing/Ear Disorder
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nerve Disorder	<input type="checkbox"/> Psychiatric Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Renal/Kidney Disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Dark Urine	<input type="checkbox"/> Chronic Light Stool	<input type="checkbox"/> Unexplained Weight Loss
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV	<input type="checkbox"/> Sexual Difficulties
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> NONE of these

Other(s): _____

Do you have vascular grafts? (If yes, explain below) Yes No

Do you have joint implants? (If yes, explain below) Yes No

Do you have replacement heart valves? Yes No

Are you now under active chemotherapy? Yes No

Have you had any other serious illness? (If yes, explain below) Yes No

Have you had any surgery? (If yes, explain below) Yes No

Have you ever been hospitalized or been under medical care for over 24 hrs? (If yes, explain below)

I Had Surgery for: _____ on date of: _____ w/complications of: _____

Do you have any bowel or bladder problems? Yes No

Do you have any difficulty with walking? Yes No

Do you drop objects, or have difficulty hand writing or fine manipulations? (Such as buttoning a shirt) Yes No **If so, has this change?**

WORKERS COMP INFO:

■ If this is a workman's compensation claim, then please answer the following questions:

How did the injury occur? _____

When? _____

Where? _____

When was your supervisor notified? _____

If you were seen at an acute care/occupational health center? Yes No

If so, which one and where? _____

■ List relationship to you of family members who have had:

Diabetes _____ Foot Problems _____

Arthritis _____ Heart Attack _____

Stroke _____ High Blood Pressure _____

Cancer _____ Birth Defects _____

Medical Problem _____ Reactions to Anesthesia _____

■ # of childbirths ____ **Are you currently pregnant?** Yes No

■ Are you slow to heal after cuts? Yes No

■ Any abnormal bruising, bleeding, or scarring? Yes No

■ Do you smoke now? Yes **Packs/day** ____ **Years** ____ No

■ Did you ever smoke? Yes **Packs/day** ____ **Years** ____ No

If you quit, when did you do so? _____

■ Alcoholic Beverages? (Circle One) None Rarely Moderately Daily Quit

■ Recreational Drugs? (Circle One) None Rarely Moderately Daily Quit

■ Please mark if you take vitamins or supplements that contain

Garlic Gingko Biloba Echinacea Ginseng St. John's Wort

■ Are you currently taking any medications? (List Below) Yes No

■ Are you taking Insulin? If yes, list below Yes No

■ List: Medications	Does?	How Often?	For Treatment of?
_____	_____	<input type="checkbox"/> A, ____ x/ <input type="checkbox"/> D <input type="checkbox"/> W	_____
_____	_____	<input type="checkbox"/> A, ____ x/ <input type="checkbox"/> D <input type="checkbox"/> W	_____
_____	_____	<input type="checkbox"/> A, ____ x/ <input type="checkbox"/> D <input type="checkbox"/> W	_____
_____	_____	<input type="checkbox"/> A, ____ x/ <input type="checkbox"/> D <input type="checkbox"/> W	_____
_____	_____	<input type="checkbox"/> A, ____ x/ <input type="checkbox"/> D <input type="checkbox"/> W	_____

■ Are you taking your medications as prescribed? Yes No

■ Allergies: Is there a history of skin reaction or other outward reaction or sickness following an injection, oral, or tropical administration of: (Check the answer box that applies) **If yes, what happens?**

Latex, Adhesive tape (circle)..... No Yes _____

Penicillin..... No Yes _____

Other Antibiotics (List below)..... No Yes _____

Empirin, Tylenol (if yes, circle)..... No Yes _____

Asprin, Advil, Aleve, or Motrin (if yes, circle).. No Yes _____

Celebrex..... No Yes _____

Other pain remedies (List below)..... No Yes _____

Morphine..... No Yes _____

Codeine..... No Yes _____

Demerol..... No Yes _____

Other narcotics (List below)..... No Yes _____

Novocaine..... No Yes _____

Other anesthetics (List below)..... No Yes _____

Sulfa drugs..... No Yes _____

Shrimp, Iodine, or Merthiolate..... No Yes _____

Any other drugs or medications..... No Yes _____

Others: _____

■ Anything else that you want to tell the doctor? Yes No

Section 3: Patient's Current Chief Complaints

Patient Account #

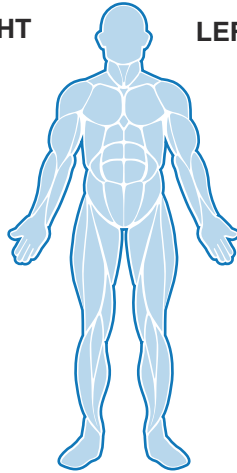
Describe 1 or 2 main problems in greater detail below & mark on the diagrams below the area where you have each problem using numbers 1 & 2 to identify them.

Please indicate the location of the pain, on this diagram with the use of numbers: ➔

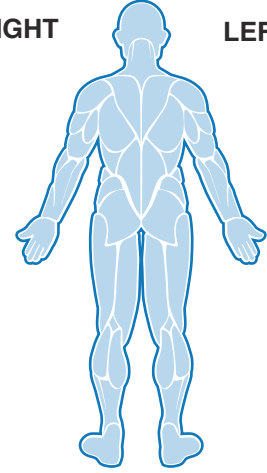
1 2 3

Continue to describe your problem below with further detailed questions. ↓

RIGHT LEFT



RIGHT LEFT



1

Please mark the location of your first problem or pain the diagram above with a number 1. Describe your problem below and its cause if you know.

Please describe associated pain to the right. ➔

My first problem is...

is problem work related? [Y] [N]

Date of injury: ___/___/___ Date of report to employer: ___/___/___

PAIN: Please indicate the severity of your pain or discomfort:

[0] None... [1] Light... [2] Moderate... [3] Strong... [4] Severe

My Pain/Discomfort is: How long ago did the problem (pain) start?:

[] Shooting Pain [] days, [] weeks, [] months, [] years ago

[] Throbbing Pain

[] Sharp Pain

[] Burning Pain

[] Itching

[] Aching Pain

[] Tenderness

[] Dull Pain

[] Tingling

[] Numbness

The pain from my problem occurs:

[] while walking and/or [] while not walking

[] and/or: _____

Any previous medical treatment(s) or home remedies:

2

Please mark the location of your first problem or pain the diagram above with a number 2. Describe your problem below and its cause if you know.

Please describe associated pain to the right. ➔

My first problem is...

is problem work related? [Y] [N]

Date of injury: ___/___/___ Date of report to employer: ___/___/___

PAIN: Please indicate the severity of your pain or discomfort:

[0] None... [1] Light... [2] Moderate... [3] Strong... [4] Severe

My Pain/Discomfort is: How long ago did the problem (pain) start?:

[] Shooting Pain [] days, [] weeks, [] months, [] years ago

[] Throbbing Pain

[] Sharp Pain

[] Burning Pain

[] Itching

[] Aching Pain

[] Tenderness

[] Dull Pain

[] Tingling

[] Numbness

The pain from my problem occurs:

[] while walking and/or [] while not walking

[] and/or: _____

Any previous medical treatment(s) or home remedies:

3

Please mark the location of your first problem or pain the diagram above with a number 3. Describe your problem below and its cause if you know.

Please describe associated pain to the right. ➔

My first problem is...

is problem work related? [Y] [N]

Date of injury: ___/___/___ Date of report to employer: ___/___/___

PAIN: Please indicate the severity of your pain or discomfort:

[0] None... [1] Light... [2] Moderate... [3] Strong... [4] Severe

My Pain/Discomfort is: How long ago did the problem (pain) start?:

[] Shooting Pain [] days, [] weeks, [] months, [] years ago

[] Throbbing Pain

[] Sharp Pain

[] Burning Pain

[] Itching

[] Aching Pain

[] Tenderness

[] Dull Pain

[] Tingling

[] Numbness

The pain from my problem occurs:

[] while walking and/or [] while not walking

[] and/or: _____

Any previous medical treatment(s) or home remedies:

Section 4: Review of Symptoms

Check all that apply:

- Constitutional, Depression, Anxiety, Eyes, Blurred Vision, Trouble Seeing, Ears, Trouble Hearing, Nose, Mouth, Sore Throat, Cardiovascular, Heart Racing, Chest Pain, Respiratory, Breathing Difficulty, Shortness of Breath, Gastrointestinal, Diarrhea, Constipation, Genitourinary, Blood in Urine, Urinary Stones, Integument, Skin Rash, Birth Marks, Neurological, Seizures, Dizziness, Psychiatric, Schizophrenia, Bipolar Illness, Endocrine, Goiter, Thyroid Disease, Hematological, Lymphatic, Anemia, Bleeding Problems, Allergies, Hay Fever, Allergic to Iodine, Allergic to IV Contrast

Section 5: Patient's Doctors - PLEASE TELL US WHOM TO THANK AND WITH WHOM TO COORDINATE YOUR CARE.

My: Physician's Name: Phone Number City Date Last Seen Referred me: I was sent or came in especially for: Family/Primary, Specialist, Other Podiatrist

Section 6: For Doctor's Use - OBSERVATIONS & COMMENTS

- Patient was assisted in completion of this record by or was Unable to complete without help of: Translation was done by: in Spanish, Other, List: Additional Information obtained from Family/Care Giver(s) and/or Physician(s) Lab Reports and/or Previous Medical Records were reviewed. X-Rays brought by patient from were reviewed. Elaborations:

I have reviewed the information provided above. My annotations to patient's entries are marked in: Doctor's Signature x Date See Additional Documentation (INK COLOR) Confidential Office Medical Record QA Review by on Only Changes to the Previous History Information Are Noted

PLEASE CONTINUE ON THE OTHER PAGES.

Patient Account #

DETAILED INSURANCE INFORMATION

PATIENT INFORMATION

■ Name _____ Birthdate: ____/____/_____
 (Last Name, First Name, Initial)

■ Social Security # _____ ■ Driver's License # _____

■ Insured Name _____ ■ Relationship to Insured _____
 (Last Name, First Name, Initial) Self Spouse Child Other _____

■ Condition/ Illness Related To: Illness Auto Employment Other: _____

■ Company Name _____ ■ Occupation _____

■ How and where did you learn about this facility? Web Newspaper Article Family/Friend

Other: _____

EMPLOYER

Address _____ City _____ State _____ Zip _____

Years Employed: _____ Phone _____ Full-time Part-time

PATIENT INSURANCE INFORMATION

■ Name _____ Birthdate _____

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name: _____

■ Policy/Group #: _____ Effective Date: _____

■ Name of Insured: _____ ID #: _____

MEDICAL AND LEGAL INFORMATION

■ Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? Yes No ■ Your Initials: _____

If you answered yes, please fill out accident specific form, available at the front desk.

Pregnant: Yes No **Pacemaker:** Yes No

Allergies _____

Family Physician _____

Address _____ City _____ State _____ Zip _____

Telephone: _____ Date of Last Visit _____

Person to contact in emergency Name: _____ Phone: _____

SPOUSE (PARENT)

■ Name _____ Birthdate: ____/____/_____
 (Last Name, First Name, Initial)

■ Social Security # _____ ■ Employer Name _____

■ Occupation: _____ ■ Phone: _____

■ Address: _____

SPOUSE COINSURANCE INFORMATION

Name _____ Birthdate _____

Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name: _____

Policy/Group #: _____ Effective Date: _____

Name of Insured: _____ ID #: _____

PLEASE CONTINUE ON THE OTHER PAGES.

Patient Account # _____

NOTICE OF PRIVACY PRACTICES

This notice Describes How Medical Information About You May Be Used and Disclosed, and How You Can Get Access to this Information. **PLEASE REVIEW CAREFULLY.**

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your; health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations: Your health information may be used, as necessary, to support the day-to-day activities and management of Northwest Surgical Specialists. For Example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting. Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of you decision.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to gain access to your records by contacting our receptionist or privacy officer.

Northwest Surgical Specialists' Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer

*Northwest Surgical Specialists
3100 W. Higgins Rd., Suite 150
Hoffman Estates, IL 60195*

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filling a complaint.

How to Contact The Joint Commission to Report Concerns About Safety Quality of Care:

The Joint Commission
800-994-6610
www.jointcommission.org

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

SIGN HERE

Patient's Name (Please Print)

Date

Authorized Representative (If Applicable)

Signature

PATIENT AGREEMENT

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Northwest Surgical Specialists all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and facility. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and facility any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and facility in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and facility to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and facility and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and facility in any attempts by such doctor and facility to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and facility against such insurers and/or employee health care plan in my name but at such doctor and facility's expenses.

Should this assignment be prohibited in part or in whole under any anti-assignment provision of my policy/plan, please advise and disclose to my provider in writing such anti-assignment provision within 30 days upon receipt of my assignment, otherwise this assignment should be reasonably expected to be effective and such anti-assignment is waived.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

SIGN HERE

Signature of Insured / Guardian

Date

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of your protected health information will be used by Northwest Surgical Specialists, or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the organization.

Notice of Privacy Practices

I have had an opportunity to review the Notice of Privacy Practices on how my protected health information may be used or disclosed. I understand that I may revoke this consent at any time, but it must be in writing. Any use or disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected.

Consent to Disclose Patient Information

I give my permission to Northwest Surgical Specialists, P.C. to use and disclose my health information to the following:

Name	Relationship	Phone Number

Signature

I have reviewed this consent form and give my permission to Northwest Surgical Specialists P.C. to use and disclose my health information in accordance with it.

SIGN HERE

Name of Patient (Print): _____ Date: _____

Signature of Patient: _____

Signature of Patient Representative: _____

Relationship of Patient Representative to Patient: _____

Internal Use Only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (Date): _____ Time: _____ (circle) a.m. p.m.

By (Name & Title): _____