Hand to Shoulder Center of Wisconsin

Chief Complaint Form

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK Appointment Date_____

Last Name_____Jr II III First Name_____M.I._____

Date of Birth_____Social Security #_____

Height_____Weight_____Marital Status: S_____M_____D_____W_____Legally Separated_____Domestic Partner_____

Employer_____Occupation_____Work Phone #_____

Spouse's Name_____Spouse's Date of Birth_____

Spouse's Social Security #_____Spouse's Place of Employment_____

How did you hear about us? Internet_____ Newspaper_____ Other_____ Previous Patient_____ Physician's Referral_____

Radio_____ TV_____ Word of Mouth_____

Extremity Affected Left_____ Right_____ **Hand Dominance** Left_____ Right_____

What type of problem/injury is this? Auto Accident_____ *(State accident occurred in_____)* Other_____

Third Party Liability_____ Worker's Compensation_____

If Worker's Compensation, have you filed a FIRST REPORT of injury with your employer? Yes_____ No_____

When did this injury/problem occur or begin? *(Date of injury/accident or onset of symptoms)*_____

How did the pain that you are currently experiencing occur?

Slow progressive onset_____

Slow progressive onset with acute exacerbation without an accident or definable event_____

Sudden onset without an accident or definable event_____

Sudden onset with accident or definable event_____

Description of how this occurred_____

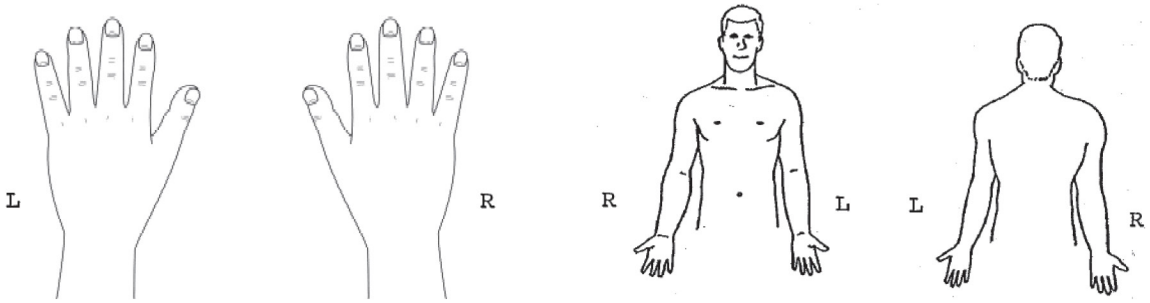
_____

Symptoms you are having_____

_____

Are you having numbness/tingling? Yes_____ No_____

Where is your pain and/or numbness? *(Mark "P" for pain or "N" for numbness on the diagram below.)*



Level of Symptoms: Please circle the appropriate number that your pain level is at *(zero being no pain, 10 being most severe)*.

Left 0 1 2 3 4 5 6 7 8 9 10 Right 0 1 2 3 4 5 6 7 8 9 10

What makes it better/worse?_____

What activities are difficult to perform?_____

What treatment have you had for this? Surgery_____ Therapy_____ Other_____

Has this been associated with any other problems elsewhere on your body? Yes_____ *(If yes, please describe)* No_____

Describe_____

Are you involved in any legal action regarding your physical complaint? Yes_____ No_____

Are you presently receiving psychiatric treatment? Yes_____ No_____ Previous psychiatric treatment_____

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Medical History Form

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK Appointment Date_____

Last Name_____Jr II III First Name_____M.I._____

Current over-the-counter medications *(Including minerals, vitamins and supplements - dosage & time/day: Please list below).*

_____, _____, _____, _____, _____,

_____, _____, _____, _____, _____

Current prescription medications *(Dosage & time/day: Please list below).*

_____, _____, _____, _____, _____,

_____, _____, _____, _____, _____

Have you been told of difficulty with placement of a breathing tube during anesthesia? Yes_____ No_____

Do you have problems with anesthesia? Yes_____ No_____ Do you have a history of a tracheotomy? Yes_____ No_____

Are you pregnant? Yes_____ No_____ Are you breast feeding? Yes_____ No_____

Do you have a personal or family history of Malignant Hyperthermia? Yes_____ No_____

Previous or Present Health Conditions *(Please check if applicable)*

ADHD_____
AIDS/HIV_____
Anemia_____
Anxiety_____
Asthma_____
Blood Clots_____
Blood Thinners_____
Bowel Problems
- Crohn's Disease_____
- Irritable Bowel Syndrome_____

Cancer *(Type)*_____
Chronic Rashes_____
Cirrhosis_____
COPD_____
Depression_____
Diabetes *(Insulin Pump)*_____
- Prediabetes_____
- Type 1_____
- Type 2_____

GERD/Acid Reflux_____
Gout_____
Hearing Impaired_____
Heart Disease_____
- Atrial Fibrillation_____
- Bypass Surgery_____
- Defibrillator_____
- History of Heart Attack_____
- Irregular Heartbeat_____
- Pacemaker_____
- Stent for Blockage_____

Hepatitis *(Type)*_____
High Blood Pressure_____
High Cholesterol_____
High Triglycerides_____
Malignant Hyperthermia_____
Mental Illness_____
Multiple Sclerosis_____
Paralysis_____
Paralyzed Diaphragm_____
Peripheral Vascular Disease_____
Rheumatoid Conditions_____
Seizures_____
Shingles_____
Sleep Apnea/CPAP_____
Stroke_____
Stroke *(Resulting Weakness/Paralysis)*_____
Thyroid Problems_____
Transient Ischemic Attack *(Tia/Mini Stroke)*_____
Tuberculosis_____
Varicose Veins_____
Visually Impaired_____
Wheelchair Needs_____
Other_____

Are you allergic to any medications? Yes_____ *(If yes, please list below)* No_____

_____, _____, _____, _____, _____

Are you allergic to latex? Yes_____ No_____

Are you allergic to food/environment/other? Yes _____ *(If yes, please list below)* No_____

_____, _____, _____, _____, _____

Have you ever tested positive for MRSA? Yes _____ *(If yes: Location_____ Date_____ Active Now_____)* No_____

Surgeries *(Please list below: Provide surgery procedure and date)*

_____Date_____,_____Date_____,_____Date_____

_____Date_____,_____Date_____,_____Date_____

Family Health History *(Please check if applicable)* Are you adopted? Yes_____

	Father	Mother	Siblings	Children		Father	Mother	Siblings	Children
Anesthetic Problems					Heart Disease				
Autoimmune Disease					High Blood Pressure				
Bleeding Disorder					Kidney Disease				
Cancer					Lupus				
Circulation Problems					Malignant Hyperthermia				
Diabetes					Rheumatoid Arthritis				
Dupuytren's Disease					Stroke				
Epilepsy/Convulsions					Thyroid Disease				

Hand to Shoulder Center of Wisconsin

Review of System Form

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK

Appointment Date_____

Last Name_____Jr II III First Name_____M.I._____

For statistical purposes only as required by the State of Wisconsin

Race: American Indian/Alaskan Native_____ Asian_____ Black/African American_____Native Hawaiian/Pacific_____ White_____Other_____

Ethnicity: Hispanic or Latino Origin_____ Not of Hispanic or Latino Origin_____Choose not to Disclose_____ Other_____

Social History

Current Smoker: Every Day_____ *(# Of Packs Per Day_____)* Some Days_____ Former Smoker_____ Never Smoked_____

History of Substance Abuse: Yes_____ No_____ Alcohol Use: Daily_____ 1-2 x/week_____ 1-2 x/month_____ None_____

Special Diet: Yes_____ No_____ Exercise: Yes_____ No_____

Previous or Present Health Conditions/Symptoms *(Please check if applicable)*

Cardiovascular
Chest Pains_____
Defibrillator *(Copy card)*_____
Heart Murmur_____
Heart Problems_____
*(Explain)*_____
Irregular Heartbeat_____
Pacemaker *(Copy card)*_____

Constitutional
Chills_____
Fever_____
Night Sweats_____
Weight Gain_____
Weight Loss_____

Endocrine
Diabetic_____
Type 1_____
Type 2_____
Insulin Pump *(Copy card)*_____
Prediabetic_____

HEENT
Hearing Problems_____
Problem with Eyes_____
*(Explain)*_____

Gastrointestinal
Bowel Problems_____
Intestinal Problems_____

Genitourinary
Dialysis_____
Kidney Problems_____
Urinary Tract Problems_____

Hematologic
Bleeding/Clotting Disorders_____
Circulation Problems_____
Easy Bleeding_____
Easy Bruising_____
Frequent Infections_____
On Blood Thinners_____

Immunization
Last Tetanus Shot_____
*(Date)*_____

MRSA
History of MRSA_____
*(Location)*_____
*(Date)*_____
MRSA is Active Now_____

Musculoskeletal
Arthritis_____
Fracture_____
Joint Pain or Stiffness_____
Joint Replacement_____
Neck/Back Pain_____
Osteoporosis_____
Swelling of Hands, Feet or Ankles_____
Swollen Joints_____

Neurologic
Dizziness/Fainting_____
Headache_____
Nerve Problems_____
Neurological Problems_____
Numbness/Tingling_____
*(Location)*_____
Paralysis_____
Seizure_____
Stroke/TIA *(Mini stroke)*_____

Psychiatric
Nervousness/Anxiety_____
Depression_____

Respiratory
Breathing Problems_____
Oxygen Therapy_____
*(Explain/liters)*_____
Paralyzed Diaphragm_____
Shortness of Breath_____
Sleep Apnea/CPAP_____

Skin
Skin Disorders_____

Who referred you? _____Physician_____NP/PA_____Other_____

Primary Care Physician_____Clinic Name_____

Preferred Pharmacy_____Phone #_____

Address_____City_____State_____

Hand to Shoulder Center of Wisconsin

Authorization Form

PLEASE PRINT CLEARLY WITH BLUE OR BLACK INK Appointment Date_____

Last Name_____Jr II III First Name_____M.I._____

Prescription Refills - Hand to Shoulder Center of Wisconsin will not provide narcotic prescription refills between the hours of 5:00 p.m. and 8:00 a.m. weekdays or on weekends. If you need to have your prescription refilled, please notify your physician during your visit or call during business hours. Calls received late in the day may not be addressed until the following day. As a patient, I understand that prescription refills will not be provided during non-business hours.

Assignment of Benefits - Medical Facility - I do hereby transfer, assign, and convey all my rights, title, and interest in all medical benefits provided by any contract or policy of insurance under which I may be insured. I direct that all benefits be paid directly to Hand to Shoulder Center of Wisconsin and/or Woodland Surgery Center (collectively "Provider") for payment of services rendered. I agree to pay the Provider any remaining balance after insurance payments or denial of coverage under said contracts or policies.

Worker's Compensation Claims - In the event of a Worker's Compensation claim, I understand I am responsible for providing the correct insurance information to the "Provider" and that if complete information is not provided I may be balance-billed for services. All medical information may be furnished to the carrier and/or employer with or without written consent from the patient according to the Wisconsin Worker's Compensation Action, Sec. 102.12(2). I further understand that my opinion and/or Doctor's diagnosis does not necessarily insure payment of my claims by the Worker's Compensation carrier. Should Worker's Compensation deny my claims, I agree to pay all charges incurred by the Provider. If I decide to dispute the decision of the Worker's Compensation carrier, I agree to make good faith payments each month while I pursue this claim.

Medicare Authorization and Assignment - If I am a Medicare patient, I allow the Provider to submit Medicare claims in my behalf without signing a Medicare form at each visit. This authorization extends for a period of two (2) years, or for as long as I remain a patient of the Provider.

Third Party Payers - I understand that I am responsible for providing correct insurance to the provider and if complete information is not provided my medical insurance may be billed for services. Should the third party insurance deny, or if the maximum benefits are reached, my claims will be sent to my medical insurance for payment. If I decide to dispute the decision of the third party payers I agree to make good faith payments each month while I pursue this claim.

Patient Valuables - All parties are advised that the Provider is not responsible for any valuables brought onto the premises. You are strongly urged not to bring such items with you or to keep personal items of significant value in your possession at all times.

Authorization/Pre-certification/HMO Referrals - I agree to furnish any and all personal and insurance information required by the Provider for purposes of filing claims, pre-certification, authorization, or any other purpose. It is the policy of the Provider and Managed Health Care plans that the patient is responsible for obtaining referrals for all visits; Worker's Compensation or otherwise.

Outside Referrals - I understand that all referrals for diagnostic testing, treatment, and/or other services not offered by this provider, are offered at my discretion. Payment of said services is my sole responsibility. Lab work, anesthesiologist, and hospital fees are billed separately by offices outside the Hand to Shoulder Center of Wisconsin and Woodland Surgery Center.

Financial Responsibility/Delinquent Accounts - I understand that I am responsible for payment of all services rendered to me by the Provider and that any and all fees not paid by my insurance are my sole financial responsibility. The Provider reserves the right to impose a late charge of 1% per month on any accounts not paid within 30 days. I agree to pay all costs of collection for the Provider including attorneys fees in the event that my account is placed in legal collection. I understand and agree that I am responsible for any part of the fees for my treatment at Woodland Surgery Center, including charges for surgeons, anesthesiologists, or other treating physicians.

Non-Sufficient Funds (NSF) Checks - A $35 charge will be assessed for all returned checks. NSF checks not redeemed within ten (10) days of notification will be subject to legal action.

No Shows - We reserve the right to charge a **no show fee** for missed appointments or cancellations within 24 hours of appointments.

Medical Records - I authorize that any medical, mental health, HIV testing and status, and/or substance abuse information be released in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines and Wisconsin State Statutes. I understand and agree that no liability of any nature shall attach to any person, physician, surgeon, or employee of the Provider, following such release of information.

Language Assistance Services/Notice of Nondiscrimination - Hand to Shoulder Center of Wisconsin complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex. Hand to Shoulder Center of Wisconsin does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Please visit our website at *www.handtoshoulderwisconsin.com* for more information on free sign language services and free language interpreter services for those whose primary language is not English.

CONSENT TO TREAT - By signing this document, I agree to all items contained in this authorization and give my consent to the provider to furnish medical care and treatment.

Patient/Guarantor Signature_____**Date**_____