North Point Orthopaedics
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Munster, IN 46321
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NEW PATIENT INTAKE FORM

BASIC INFORMATION

Date:_____

First Name:_____ Last Name:_____ MI:____

Sex:_____ DOB:_____ Marital Status:_____ Email:_____

Patient SS#:_____ Preferred Language:_____

Address:_____ City:_____ State:_____ Zip:_____

Main Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell:(_____)_____-_____

Referring Physician:_____

Occupation:_____ Employer Name:_____ Work Status:_____

Employer Address:_____ Spouse's Name:_____

Spouse: Main Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell:(_____)_____-_____

ETHNICITY / RACE

Ethnicity: ◯NO, not Hispanic ◯YES, Hispanic or Latino

Race: ◯American Indian ◯Alaskan Native ◯Black/African American ◯White/Caucasian ◯Asian
◯Native Hawaiian or other Pacific Islander ◯Prefer Not to Say ◯Other:_____

PRIMARY INSURANCE

Insurance Name:_____

Policy Holder Name:_____ Relationship:_____

Address:_____ Contact Phone: (_____)_____-_____

Policy Holder SS#:_____ Sex:_____ Policy Holder DOB:_____

SECONDARY INSURANCE

Insurance Name:_____

Policy Holder Name:_____ Relationship:_____

Address:_____ Contact Phone: (_____)_____-_____

Policy Holder SS#:_____ Sex:_____ Policy Holder DOB:_____

EMERGENCY CONTACT INFORMATION

Name of Relative/Friend Not Currently Living With:_____

Relationship:_____ Address:_____

Main Phone: (_____)_____-_____ Work Phone: (_____)_____-_____ Cell: (_____)_____-_____

ALLERGY HISTORY

Have you ever had a reaction to anesthesia?	**◯ No ◯ Yes (describe):_____**
Do you have any allergies to medications?	**◯ No ◯ Yes:_____**
Do you have a latex allergy?	**◯ No ◯ Yes:_____**
Any food or environmental allergies?	**◯ No ◯ Yes:_____**

Next to where it says yes, please specify your allergen(s).

SOCIAL HISTORY

Do you smoke?	**◯ No**	**◯ Yes, I smoke _____ packs a day.** **◯ I have smoked, but I quit _____ years and/or _____ months ago.**
Do you consume alcohol?	**◯ No**	**◯ Yes, I drink _____ beverages per day/week (circle one). What type of alcoholic beverage? _____** **◯ I have a history of drinking, but I no longer drink.**

MEDICAL HISTORY

◯ Cancer ◯ Neurologic Disease ◯ Kidney Disease ◯ Stomach Ulcer ◯ AIDS/HIV ◯ Major Infection
◯ Strokes ◯ High Blood Pressure ◯ Thyroid Disease ◯ Autoimmune Disorder ◯ Osteoporosis
◯ Lung Disease ◯ Rheumatoid Arthritis ◯ Diabetes ◯ Heart Disease ◯ Bleeding Disorder ◯ Gout
◯ Blood Clots ◯ Liver Disease/Hepatitis ◯ Anxiety/Depression ◯ Blood Transfusion(s)
◯ Other:_____
_____

SURGICAL HISTORY

Type of Surgery	Date	Fill in what you have had...	← Date of Last Exam
		◯ Mammogram	**Or ◯ N/A**
		◯ Colorectal Cancer Screen	**Or ◯ N/A**
		◯ Glaucoma Screen	**Or ◯ N/A**
		◯ Bone Mineral Density Test	**Or ◯ N/A**
		◯ Influenza Vaccine	**Or ◯ N/A**
		◯ Cervical Cancer Screening	**Or ◯ N/A**
		◯ Annual Dental Visit	**Or ◯ N/A**
		◯ Other:_____	**Or ◯ N/A**

FAMILY HISTORY

◯ Diabetes ◯ Hypertension ◯ Cancer ◯ Stroke ◯ Asthma ◯ Heart Attack/Disease ◯ Seizures ◯ Tuberculosis
◯ Other:_____
◯ Family Relationship With the Person Affected (Mom, Dad, etc.):_____

CURRENT MEDICATIONS / HEALTH STATUS

Medication/Dose	Prescribed By...	Medication/Dose	Prescribed By...

Primary Care Physician:_____

Other Treating Physician(s):_____

Cardiologist:_____ **Current Height:**_____ **Current Weight:**_____

Are you currently taking any weight loss medications? If so, please specify:_____

Preferred Pharmacy:_____ **Location/City:** _____

HIPAA RELEASE OF INFORMATION

I, _____ **DOB:**_____

(Please Print Name)

As required by the privacy regulations created as a result of HIPAA, North Point Orthopaedics is dedicated and committed to your health information. In conducting business, North Point Orthopaedics will comply with all legal duties and responsibilities that apply with HIPAA. I have been offered a copy of the HIPAA privacy practice and policy. I have previously read the office policy. I understand that I am responsible for all charges not paid by my insurance company. Should it be necessary for North Point Orthopaedics to submit my account to a collection agency or attorney, I understand I will be responsible for any costs of collection services, including reasonable attorney fees. I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, for this date forward until revoked in writing.

Messages related to my care may be left on my...

◯ **Cell Phone: (_____)_____-_____** ◯ **Texts to Cell Phone** ◯ **Home Phone: (_____)_____-_____**

◯ **Work Phone: (_____)_____-_____**

◯ **Email:**_____

Do you give our medical or billing staff permission to discuss your medical/billing information including laboratory findings with family members or other care providers?

◯ **No** ◯ **Yes (if yes, please provide name(s) and phone number(s) below)**

Name:_____ **Relationship:**_____ **Phone: (_____)_____-_____**

Name:_____ **Relationship:**_____ **Phone: (_____)_____-_____**

Name:_____ **Relationship:**_____ **Phone: (_____)_____-_____**

I have given the information above freely. I am not withholding any medical/billing information at this time.

Patient Signature:_____ **Date:**_____

I have reviewed the above information with the patient.

Provider Signature:_____ **Date:**_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

Authorization for Treatment: I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this authorization form. I also certify that no guarantee has been made as to the results that may be obtained.

Release of Information/Medical Records Diagnosis: I hereby authorize the physician(s) providing service and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance, or any other category/third party payor, the Social Security Administration under Title IVII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, details of treatment, and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving a written notice. I understand that if I refuse to consent to the release of information, I will be held responsible for payment of all charges for services rendered. I give permission to North Point Orthopaedics and all clinical providers who have provided care for me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits/Financial Obligation: In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including medicare part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full, my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to insufficient funds.

Co-Payments: I understand that if my medical insurance requires a co-pay or encounter fee, the payment is due at the time of service.

Precertification: If my insurance requires precertification, it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification is not obtained.

H.H.S. Pursuant to Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of Notice of Privacy Practices.

Patient Signature	Date	Responsible Party Signature	Date
Witness Signature	Date	Relationship to Patient	

(1) Authorization to Request Service or Treatment of a Minor: I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent the action has already been taken in reliance on the consent.

Name	Relationship	Name	Relationship

I understand I may revoke the privilege listed in (1) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature	Date

ADVANCE DIRECTIVE

Have you appointed a Health Care Representative?	◯ Yes	◯ No
Have you given anyone your Power of Attorney?	◯ Yes	◯ No
Do you have a living will?	◯ Yes	◯ No
Is this related to an auto accident?	◯ Yes	◯ No
Is this a Work Comp injury?	◯ Yes	◯ No

Appointment Cancellation/ No Show & Late Arrival Policy

North Point Orthopaedics, LLC goal is to provide quality individualized medical care in a timely manner. “No Shows” and late cancellations inconvenience those individuals who are in need of medical treatment. We would like to remind you of our office policy regarding missed appointments.

Late Arrivals & Charge for Late Cancellations and No Show’s

North Point Orthopaedics, LLC, understand that delays may occur, however, we strive to see patients at their scheduled time. Patients arriving 30 minutes after their scheduled appointment time **may** be asked to reschedule. This will be evaluated on a case by case basis per the physician discretion.

Failure to give 24 hour advance cancellation or being a “No Show” will result in a nonrefundable administrative charge of $40.00. This fee will not be covered by your insurance company. If you have any questions regarding this policy, please ask our staff and we will be glad to clarify your questions. We thank you in advance for your cooperation and understanding.

**I acknowledge that I have been presented with the Appointment Cancellation/ No Show Policy and that I understand the policy.*

_____	_____	_____
Print Name	**Sign Name**	**Date**

Thank you for choosing North Point Orthopaedics. ☺