North Point Orthopaedics
9445 Calumet Ave.
Munster, IN 46321
219-836-1060
Fax 219-836-1014

NEW PATIENT INTAKE FORM

BASIC INFORMATION

Date:_____

First Name:_____ **Last Name:**_____

MI:_____ **Sex:**_____ **DOB:**_____ **Marital Status:**_____

Email:_____

Patient SS#:_____ **Preferred**

Language:_____

Referring Physician:_____

Address:_____ **City:**_____ **State:**_____

Zip:_____

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

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

Thank you for choosing North Point Orthopaedics. ☺