MOGL
milwaukee orthopaedic group limited

Welcome to Our Practice

Today's Date _____

Patient Name _____
First Middle Last

Birthdate _____ Age _____ Social Security # _____

Home Address _____

City _____ State _____ Zip Code _____

Home Telephone _____ Cell Phone or Pager _____

Employer _____ Occupation _____

Employer Address _____ Work Telephone _____

City _____ State _____ Zip Code + 4 _____

Guarantor / Responsible Party _____ Relation to Patient _____

Birthdate _____ Age _____ Social Security # _____

Address _____ Telephone _____

City _____ State _____ Zip Code _____

Employer _____ Occupation _____

Employer Address _____ Work Telephone _____

City _____ State _____ Zip Code _____

Emergency Contact _____ Relation to Patient _____

Home Telephone _____ Work Telephone _____

Did your physician suggest you see the MOGL Doctor? ☐ Yes ☐ No

If yes, please provide the physician's name and address:

Doctor Name _____

Address _____

City _____ State _____ Zip Code _____

Specialty _____

Would you be interested in receiving medical information updates by email? ☐ Yes ☐ No

Email Address _____

Insurance Information / Privacy Practice Notice

MOGL
milwaukee orthopaedic group limited

Patient Name _____ (First) _____ (Middle) _____ (Last)

This visit is due to? ☐ a work injury ☐ an auto accident ☐ other accident

Date of Accident _____ Claim Number _____

Are you represented by an attorney for this accident? ☐ Yes ☐ No

If Yes, his or her name is _____ Phone Number _____

☐ **Card Scanned**

Primary Insurance Name _____ Insurance Phone # _____

Address _____ City _____ State _____ Zip Code _____

Insured's Name _____ Insured's Birthdate _____

Effective Date _____ ID/Policy Number _____ Group Number _____

☐ **Card Scanned**

Secondary Insurance Name _____ Insurance Phone # _____

Address _____ City _____ State _____ Zip Code _____

Insured's Name _____ Insured's Birthdate _____

Effective Date _____ ID/Policy Number _____ Group Number _____

☐ I authorize payment of medical benefits to **Milwaukee Orthopaedic Group, LTD.** I authorize the release of any medical information necessary to process any claim. I understand and agree that I am financially responsible for all services provided by **Milwaukee Orthopaedic Group, LTD.**

☐ **Medicare Authorization**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize **Milwaukee Orthopaedic Group, LTD** to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for medical services to **Milwaukee Orthopaedic Group, LTD** and authorize them to submit a claim to Medicare for payment.

This authorization is in effect until I choose to revoke it.

Patient Signature _____ Date _____

☐ I acknowledge that I have received **Milwaukee Orthopaedic Group, LTD** Privacy Practices Notices.

☐ **To My Patient:**

I hereby agree that my **Milwaukee Orthopaedic Group, LTD** doctor may leave messages for me, at home or at work, on my voice mail or answering machine regarding any diagnosis information or test results. I also agree that any results may be given to a family member. I understand that I can revoke this waiver by sending a letter to my doctor stating that I no longer want this waiver to be in effect.

I, _____ (please print), give **Milwaukee Orthopaedic Group, LTD** permission to discuss the information contained in my medical and/or billing records to the following people:

Name _____ Relationship _____

Name _____ Relationship _____

Patient Signature _____ Date _____

For office use only:

Pt. Acct. #: _____

milwaukee orthopaedic group limited

Patient Account # _____

MEDICAL STAFF TO COMPLETE

HT _____ WT _____

BP _____ Pulse _____ Temp. _____

Both sides of this form (history and review of systems) reviewed by:

Physician Signature _____ Date _____

Name: _____ Date: _____

Age: _____ Circle: RIGHT or LEFT handed

Occupation: _____ Marital Status: S M W D

Reason for being seen: _____

Circle: RIGHT or LEFT side

How did it start? _____

_____

When did it start? List date of injury or first symptom: _____

_____

What makes it better? _____

_____

What makes it worse? _____

_____

Work Related? YES or NO

Previously related problems: _____

Primary Care Physician: _____

Did he or she send you to us? YES or NO

MEDICAL HISTORY: *(Please circle when appropriate)*

Medical Illness:

High Blood Pressure	Heart Disease	HIV	Asthma
Kidney Disease	Diabetes	Infection	Cancer
Abdominal Disease	Hepatitis	Ulcer or GI Difficulty	Osteoporosis

Other _____

Previous Surgery: _____

_____

Medications: _____

_____

Allergies: _____

Alcohol Intake: YES NO

How much? _____

How long? _____

Tobacco Use: YES NO

How much? _____

How long? _____

Recreational Drugs: YES NO

How much? _____

How long? _____

Do you have a family history of any hereditary diseases? If yes, please specify _____

Have you had a bone density test? YES NO If yes, when: _____

How did you hear about the Milwaukee Orthopaedic Group? _____

OVER

Rev (3/10)

MOGL

milwaukee orthopaedic group limited

REVIEW OF SYSTEMS

HAVE YOU HAD, OR ARE YOU HAVING PROBLEMS WITH:

NAME _____

SKIN
- ____ abnormal color changes
- ____ itching
- ____ easy bruising
- ____ rashes
- ____ infections
- ____ none of the above

BLEEDING PROBLEMS
- ____ any history of anemia
- ____ any blood transfusions
- ____ problems with blood transfusions
- ____ chronic nose bleeds
- ____ any enlarged lymph nodes
- ____ none of the above

HEAD
- ____ chronic headaches
- ____ facial trauma
- ____ none of the above

EARS
- ____ hearing aids
- ____ ear pain
- ____ ringing in ears
- ____ deafness
- ____ none of the above

EYES
- ____ glasses/contacts
- ____ double vision
- ____ blurred vision
- ____ burning
- ____ infections
- ____ none of the above

NOSE/SINUSES
- ____ chronic nose bleeds
- ____ nasal obstruction
- ____ fractured nose
- ____ trouble breathing
- ____ post nasal drip
- ____ chronic drainage
- ____ none of the above

MOUTH/THROAT
- ____ sores
- ____ bleeding gums
- ____ dentures/bridges
- ____ sore throat
- ____ missing teeth
- ____ none of the above

RESPIRATORY
- ____ chronic cough
- ____ cough up phlegm
- ____ cough up blood
- ____ wheezing
- ____ night sweats
- ____ no. of pillows to sleep
- ____ none of the above

CARDIAC
- ____ chest pain
- ____ shortness of breath
- ____ chest pain with exertion
- ____ leg swelling
- ____ palpitations
- ____ heart murmur
- ____ calf pain with exertion
- ____ varicose veins
- ____ none of the above

GASTROINTESTINAL
- ____ decreased appetite
- ____ chronic thirst
- ____ chronic nausea
- ____ vomiting
- ____ vomiting blood
- ____ chronic gas
- ____ chronic belching
- ____ trouble swallowing
- ____ heartburn
- ____ stomach pain
- ____ jaundice
- ____ irregular bowel movements
- ____ diarrhea
- ____ constipation
- ____ hemorrhoids
- ____ hernias
- ____ none of the above

URINARY TRACT
- ____ pain with urination
- ____ burning with urination
- ____ blood in urine
- ____ history of kidney stones
- ____ frequency at night
- ____ frequency during the day
- ____ infections
- ____ none of the above

GENITAL TRACT (MALE)
- ____ unusual discharge
- ____ lesions
- ____ hernias
- ____ masses
- ____ pain
- ____ none of the above

GENITAL TRACT (FEMALE)
- ____ last menstrual period
- ____ menopause
- ____ no. of pregnancies
- ____ no. of children
- ____ history of UTIs
- ____ none of the above

NERVOUS SYSTEM
- ____ convulsions
- ____ dizziness
- ____ passing out
- ____ tremors
- ____ speech difficulty
- ____ weakness/paralysis
- ____ none of the above

ENDOCRINE
- ____ goiter
- ____ heat or cold intolerance
- ____ chronic sweating
- ____ voice change
- ____ painful swallowing
- ____ none of the above

PSYCHIATRIC
- ____ irritability
- ____ memory loss
- ____ depression
- ____ insomnia
- ____ nightmares
- ____ criminal or sociopathic behavior
- ____ none of the above

If no changes to the above information:

Initial	Date	Initial	Date	Initial	Date	Initial	Date
_____	_____	_____	_____	_____	_____	_____	_____

X _____
(Patient Sigature) (Date)