Comprehensive Orthopaedics, S.C.

Raymond Rybicki, M.D. FABEM

•Neurology • Spine • Peripheral Nerve • Carpal Tunnel Syndrome • Low Back Pain • Neck Pain • Peripheral Neuropathy • Tarsal Tunnel Syndrome • EMG/NCV Procedures • EEG Procedures • Evoked Potentials •

PATIENT MEDICAL HISTORY – LONG FORM

Today's Date ________________

Last Name ______________________________ First ______________________ MI ______

Date of Birth ______________________Age______ Height ________ Weight ______ ☐ Male ☐ Female

Occupation ____________________________

CURRENT MEDICAL ISSUE (S)

____

____

____

2 MEDICATIONS AND ALLERGIES

CURRENT MEDICATIONS

List all medications that you are taking (prescriptions and over-the-counter) including aspirin, vitamins, etc.

Medication	Mg	Daily Dose	How Often
1			
2			
3			
4			
5			
6			
7			
8			

ALLERGIES

List medications or injections that have given you bad reactions. List the reaction (hives, welts, rash, itching, headache, nausea, diarrhea, passing out, shock, shortness of breath)

Medication or injection	Reaction	Year
1		
2		
3		
4		

3 PAST MEDICAL HISTORY

Operations/Accidents	Hospital	Year
1		
2		
3		
4		
5		

Hospitalizations	Hospital	Year
1		
2		
3		
4		

List medical problems not requiring hospitalization such as chronic headaches, rheumatic fever, diabetes, high blood pressure, tuberculosis, hepatitis, kidney stones, gallstones, ulcers, etc.

Problem	Treatment	Year
1		
2		
3		
4		
5		

4 SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes How Long: ____________ How Much: ____________

What do you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe

Have you stopped? ☐ No ☐ Yes When: ____________

Do you drink alcohol? ☐ No ☐ Yes How Long: ____________

How Much? ☐ 1 drink/day ☐ 2 oz./day ☐ 4 oz./day ☐ More

Have you ever used: ☐ Marijuana ☐ Heroine ☐ Cocaine ☐ LSD/PCP ☐ Other

Have you visited outside the U.S. in the last 6 months? ☐ No ☐ Yes

5 FAMILY MEDICAL HISTORY

	Male	Fem	Age	Health Problems	Age/death	Cause/death
Father						
Mother						
Spouse	☐ M	☐ F				
Siblings	1 ☐ M	☐ F				
	2 ☐ M	☐ F				
	3 ☐ M	☐ F				
	4 ☐ M	☐ F				

FAMILY MEDICAL HISTORY-continued

	Male	Fem	Age	Health Problems	Age/death	Cause/death
Children	1 ☐ M	☐ F	____	____________________	_____	____________
	2 ☐ M	☐ F	____	____________________	_____	____________
	3 ☐ M	☐ F	____	____________________	_____	____________
	4 ☐ M	☐ F	____	____________________	_____	____________

IMMEDIATE FAMILY MEDICAL ISSUES – Include relationship to you

☐ Anemia ____________________

☐ Bleeding Disorders ____________________

☐ Cancer ____________________

☐ Heart Problems ____________________

☐ Migraines ____________________

☐ Muscle Disease ____________________

☐ Seizures ____________________

☐ Alcoholism ____________________

☐ Brain Tumor ____________________

☐ Diabetes ____________________

☐ High Blood Pressure____________________

☐ Multiple Sclerosis____________________

☐ Muscular Dystrophy____________________

☐ Stroke ____________________

6 REVIEW OF SYSTEMIC SYSTEMS

CONSTITUTIONAL

Check Yes or No to any of the following that you have now or have recently had:

☐ Yes ☐ No Chills

☐ Yes ☐ No Fever

☐ Yes ☐ No Weight Loss

☐ Yes ☐ No Decline in Health

☐ Yes ☐ No Weakness

☐ Yes ☐ No Fatigue

☐ Yes ☐ No Weight Gain

GENITOURINARY – WOMEN ONLY

☐ Yes ☐ No Birth Control

☐ Yes ☐ No Change in Periods-Flow

☐ Yes ☐ No Difficult Pregnancy

☐ Yes ☐ No Postmenopausal Bleeding

☐ Yes ☐ No Sexual Problems

☐ Yes ☐ No Bleeding Between Periods

☐ Yes ☐ No Recent Pap Smear

☐ Yes ☐ No Venereal Disease

☐ Yes ☐ No Change in Periods-Duration

☐ Yes ☐ No DES Exposure

☐ Yes ☐ No Hernias

☐ Yes ☐ No Menopause

☐ Yes ☐ No Menstrual Pain

☐ Yes ☐ No Change in Periods-Interval

☐ Yes ☐ No Discharge

☐ Yes ☐ No Itching

☐ Yes ☐ No Fertility Problems

☐ Yes ☐ No Lesions

☐ Yes ☐ No Pain on Intercourse

☐ Yes ☐ No Recent Pregnancy

GENITOURINARY – MEN ONLY

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Impotence	☐ Yes	☐ No	Fertility Problems
☐ Yes	☐ No	Prostate Problems	☐ Yes	☐ No	Lesions
☐ Yes	☐ No	Scrotal Masses	☐ Yes	☐ No	Pain
☐ Yes	☐ No	Hernias	☐ Yes	☐ No	Sexual Problems

URINARY

☐ Yes	☐ No	Awakening to Urinate	☐ Yes	☐ No	Infections
☐ Yes	☐ No	Burning	☐ Yes	☐ No	Stones
☐ Yes	☐ No	Flank Pain	☐ Yes	☐ No	Urine Odor
☐ Yes	☐ No	Bed Wetting	☐ Yes	☐ No	Pain on Urination
☐ Yes	☐ No	Difficulty Starting Stream	☐ Yes	☐ No	Urgency
☐ Yes	☐ No	Frequency	☐ Yes	☐ No	Blood in Urine
☐ Yes	☐ No	Excessive Urination	☐ Yes	☐ No	Retention
☐ Yes	☐ No	Incontinence	☐ Yes	☐ No	Urine Discoloration

HEAD

☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Head Injury
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Sweats
☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Pain

PSYCHIATRIC

☐ Yes	☐ No	Depression	☐ Yes	☐ No	Excessive Stress
☐ Yes	☐ No	Disturbing Thoughts	☐ Yes	☐ No	Mood Changes
☐ Yes	☐ No	Memory Loss	☐ Yes	☐ No	Disorientation
☐ Yes	☐ No	Psychiatric Disorders	☐ Yes	☐ No	Hallucinations
☐ Yes	☐ No	Behavioral Change	☐ Yes	☐ No	Nervousness

NEUROLOGICAL

☐ Yes	☐ No	Loss of Consciousness	☐ Yes	☐ No	Blackouts
☐ Yes	☐ No	Dizziness	☐ Yes	☐ No	Fainting
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Memory Loss
☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	Speech Disorders

NEUROLOGICAL continued

☐ Yes	☐ No	Tingling	☐ Yes	☐ No	Tremors
☐ Yes	☐ No	Burning	☐ Yes	☐ No	Head Injury
☐ Yes	☐ No	Numbness	☐ Yes	☐ No	Strokes
☐ Yes	☐ No	Unsteady Gait			

RESPIRATORY

☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Coughing of Blood
☐ Yes	☐ No	Bronchitis	☐ Yes	☐ No	Pain
☐ Yes	☐ No	Pleurisy	☐ Yes	☐ No	Positive TB Test

RESPIRATORY-continued

☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Cough
☐ Yes ☐ No Recent Chest X-Ray
☐ Yes ☐ No Sputum
☐ Yes ☐ No Wheezing
☐ Yes ☐ No Tuberculosis

CARDIOVASCULAR

☐ Yes ☐ No Chest Pain
☐ Yes ☐ No Extremities (cool)
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No History of Heart Attack
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Shortness of Breath-Sleeping
☐ Yes ☐ No Ulcers on Legs
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Extremities Discolored
☐ Yes ☐ No Thrombophlebitis
☐ Yes ☐ No Heart Tests (Not EKG)
☐ Yes ☐ No Leg Pain-Walking
☐ Yes ☐ No Shortness of Breath-Exertion
☐ Yes ☐ No Swelling of Legs
☐ Yes ☐ No Varicose Veins
☐ Yes ☐ No Hair Loss on Legs
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Recent Electrocardiogram
☐ Yes ☐ No Shortness of Breath-Lying Flat

GASTROINTESTINAL

☐ Yes ☐ No Abdominal Pain
☐ Yes ☐ No Heartburn
☐ Yes ☐ No Rectal Bleeding
☐ Yes ☐ No Black Tarry Stools
☐ Yes ☐ No Swallowing Problems
☐ Yes ☐ No Constipation
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Abdominal X-Ray Tests
☐ Yes ☐ No Nausea
☐ Yes ☐ No Vomiting
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Infections
☐ Yes ☐ No Vomiting Blood
☐ Yes ☐ No Change in Stool Color
☐ Yes ☐ No Excessive Hunger
☐ Yes ☐ No Hemorrhoids
☐ Yes ☐ No Laxative Use
☐ Yes ☐ No Change in Frequency of BM
☐ Yes ☐ No Change in Stool Consistency
☐ Yes ☐ No Excessive Thirst
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Antacid Use
☐ Yes ☐ No Change in Stool Caliber
☐ Yes ☐ No Decreased Appetite
☐ Yes ☐ No Gallbladder Disease
☐ Yes ☐ No Rectal Pain

MUSCULOSKELETAL

☐ Yes ☐ No Arthritis
☐ Yes ☐ No Muscle Cramps
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Muscle Stiffness
☐ Yes ☐ No Gout
☐ Yes ☐ No Paralysis
☐ Yes ☐ No Back Problems
☐ Yes ☐ No Restricted Motion
☐ Yes ☐ No Deformities
☐ Yes ☐ No Weakness
☐ Yes ☐ No Joint Stiffness

ENT

NOSE

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Nasal Obstruction
☐ Yes	☐ No	Infections	☐ Yes	☐ No	Hay Fever
☐ Yes	☐ No	Sinus Infections	☐ Yes	☐ No	Nose Bleeds
☐ Yes	☐ No	Frequent Colds			

MOUTH

☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No	Tongue Burning
☐ Yes	☐ No	Post Nasal Drip	☐ Yes	☐ No	Hoarseness
☐ Yes	☐ No	Change in Dentition	☐ Yes	☐ No	Voice Changes

EARS

☐ Yes	☐ No	Discharge	☐ Yes	☐ No	Dizziness
☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No	Infections
☐ Yes	☐ No	Ringing in Ears	☐ Yes	☐ No	Hearing Aid
☐ Yes	☐ No	Pain			

THROAT NECK

☐ Yes	☐ No	Frequent Sore Throats	☐ Yes	☐ No	Lumps
☐ Yes	☐ No	Tonsils Enlarged	☐ Yes	☐ No	Tenderness

ALLERGIC/IMMUNOLOGIC

☐ Yes	☐ No	Coughing	☐ Yes	☐ No	Sneezing
☐ Yes	☐ No	Itchy Eyes	☐ Yes	☐ No	Wheezing
☐ Yes	☐ No	Runny Nose	☐ Yes	☐ No	Hives
☐ Yes	☐ No	Watery Eyes	☐ Yes	☐ No	Recurrent Infections
☐ Yes	☐ No	Coughing With Exercise	☐ Yes	☐ No	Stuffy Nose
☐ Yes	☐ No	Itchy Nose	☐ Yes	☐ No	Wheezing With Exercise

ENDOCRINE

☐ Yes	☐ No	Weakness	☐ Yes	☐ No	Heat Intolerance
☐ Yes	☐ No	Cold Intolerance	☐ Yes	☐ No	Sweats
☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Weight Loss
☐ Yes	☐ No	Neck Pain	☐ Yes	☐ No	Fatigue
☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No	Increased Thirst
☐ Yes	☐ No	Excessive Urination	☐ Yes	☐ No	Thyroid Trouble

HEMATOLOGIC/LYMPH

☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Bleeding Easily
☐ Yes	☐ No	Easily Bruised	☐ Yes	☐ No	Lumps
☐ Yes	☐ No	Swollen Glands	☐ Yes	☐ No	Transfusion Reaction
☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No	Radiation Exposure

SKIN

☐ Yes ☐ No Eczema

☐ Yes ☐ No Easily Bruised

☐ Yes ☐ No Hives

☐ Yes ☐ No Nail Appearance Change

☐ Yes ☐ No Skin Color Change

☐ Yes ☐ No Itching

☐ Yes ☐ No Rashes

☐ Yes ☐ No Hair Dye

☐ Yes ☐ No Lumps

☐ Yes ☐ No Nail Texture Change

☐ Yes ☐ No Dryness

☐ Yes ☐ No Hair Texture Change

☐ Yes ☐ No Mole Increased Size

EYES

☐ Yes ☐ No Blurry Vision

☐ Yes ☐ No Double Vision

☐ Yes ☐ No Unusual Sensations

☐ Yes ☐ No Cataracts

☐ Yes ☐ No Excessive Tearing

☐ Yes ☐ No Glaucoma

☐ Yes ☐ No Recent Injury

☐ Yes ☐ No Eyeglass Use

☐ Yes ☐ No Pain with Light

☐ Yes ☐ No Vision Loss

☐ Yes ☐ No Discharge

☐ Yes ☐ No Eye Pain

☐ Yes ☐ No Infections

☐ Yes ☐ No Redness

BREASTS

☐ Yes ☐ No Discharge

☐ Yes ☐ No Self-Examination

☐ Yes ☐ No Lumps

☐ Yes ☐ No Tenderness

☐ Yes ☐ No Pain

ADDITIONS, OTHER COMMENTS OR NOTES:

____

____

____

____

____

Comprehensive
Orthopaedics, S.C.

7401 104th Avenue, Suite 110
Kenosha, WI 53142

Today's Date:______________________________

Patient Name: ______________________________

Date of Birth: ______________________________

Body Part: ________________________________

Is this a work related injury?

_____:Yes _____:No

If Yes, please complete the following:

What is the date of injury? ____________________

How did the injury occur? ____________________

Have you filed a claim with your company? __________

What is your claim number? ____________________

Which company is the claim paid through? __________

What is the name and phone number of your adjuster?

____

To be completed by the front desk:

FD Representative name: ____________________
*Patient Scheduled with:*____________________
WC details entered on fee ticket/appointment notes? ______________
WC info entered into insurance field? ____________________
WC info verified open and active? ____________________
WC alert entered onto chart? ____________________

COMPREHENSIVE ORTHOPAEDICS, S.C.
Patient HIPAA Acknowledgement & PHI Disclosure

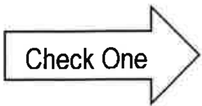
This form MUST be filled out NEATLY & COMPLETELY or it will be considered VOID.

I, ______________________ , ______________________ acknowledge that I have received, and/or
Patient Name — Date of Birth

been advised of the written Notice of Privacy Practices from Comprehensive Orthopaedics, SC.

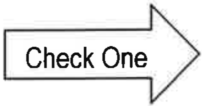
Please fill out complete addresses and phone numbers and select how you wish to be contacted.

Telephone Number: ______________________ Cell / Home *(Circle One)*



- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Alternate Telephone: ______________________ Cell / Home *(Circle One)*



- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

Written Communication: *Please write full mailing and email address*

Home address: ______________________

Email address: ______________________

I consent to have my personal health information disclosed to: (3rd party friend/family or other)

Name: ______________________ Phone#: ______________ Relationship: ______________

Name: ______________________ Phone#: ______________ Relationship: ______________

____

Patient Signature **Date**

____

Guardian/Legal Representative Signature **Relationship to Patient** **Date**

Comprehensive Orthopaedics, S.C.

Patient Financial Policy

At Comprehensive Orthopaedics, S.C. we are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Our fees for services are based on the level of professional skill required, the severity and complexity of the injury or illness, as well as the time spent treating you. The **patient or guarantor** is responsible for seeing that the entire bill is paid in full. Your clear understanding of our Financial Policy is important to our professional relationship.

Insurance: Billing of insurance is a courtesy we provide our patients and is not required by law. Please notify us if your insurance carrier or policy has changed.

Copayments: Your insurance contract REQUIRES that we collect your designated co-pay at the time of service. Please be prepared to pay your co-pay at the time of check-in for each visit.

Non-Covered Services: If your insurance plan determines that a service is not covered for any reason you will be responsible for payment of the charges. **Durable Medical Equipment (DME):** Some DME items may not be covered by your insurance plan and you will be asked to pay a portion at the time of service. All items are new when given and cannot be returned.

Non-Participating Insurance Plans or "Out of Network": It is the responsibility of the patient to verify whether Comprehensive Orthopaedics, S.C. contracts with your insurance plan. Any outstanding balances are the responsibility of the patient. Insurance companies sometimes use the phrase "usual and customary" or "out of network" when discussing our fees. Insurance companies set their own "usual and customary" rates based on a wide geographic area and the fees we charge may differ.

Referrals: If your insurance plan requires a referral from your primary care physician it is your responsibility to obtain this prior to your appointment and have it with you at the time of the appointment. If you do not have your referral you may be required to reschedule.

Workers Compensation/Other Accident Cases: In order for us to file a claim with your work comp or other liability carrier you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We will bill major medical insurance.

Self-Pay/Uninsured: Payment in full is required for all self-pay/uninsured patients. For new patients, a deposit of $200 is required on the day of your appointment **before** being seen by the provider and $75 copays at any follow up appointments. Any fees remaining will be billed to you following your appointment.

Urgent Care: During our after-hours Urgent Care, our financial policy will revert back to a self-pay/Uninsured status until your Insurance can be verified.

Minors of Divorced Parents and Child Custody Cases: Both parents are financially responsible for care rendered to minor children. We do not get involved in divorce situations and the parent with whom the child resides with will be financially responsible and any statements will be mailed directly to that parent.

Post-Operative Surgery Charges: Following most surgical procedures, related office visits are included and will not be charged during 90 day post-operative period. Services such as x-rays, casting and materials, Durable Medical Equipment, and injections are not included in the post-operative period.

Responsible Party: I have read the financial policy and understand that I will be responsible for all Comprehensive Orthopaedics, S.C. charges incurred regardless of my insurance status including expenses incurred in collecting the amounts owed, including attorney's fees, court costs and/or the collection agency fee. Any returned check from the bank for non-payment (insufficient funds) shall result in the patient's account being assessed a $25 fee per check returned.

COMPREHENSIVE ORTHOPAEDICS, S.C. RESERVES THE RIGHT TO TERMINATE MY CARE FOR NON-COMPLIANCE AT ANY TIME.

Payment for services may be paid by cash, personal check, Visa, MasterCard, Discover, American Express, or Care Credit.

Please sign that you have read and agree to this Financial Policy.

Patient Name (Print): ______________________________

Patient or Parent Signature: ______________________________ Date: ______________