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 J. ANTHONY DUSTMAN, M.D.  
 GEORGE S. IRWIN, M.D.  
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 JOHN G. ATWATER, M.D.  
 CRAIG W. CARMICHAEL M.D.  
 MARK J. HANSON, M.D.  
 JEROME W. OAKEY, M.D.  
 GERALD W. PAUL, D.P.M.

**PATIENT INFORMATION RECORD (please print or write legibly)**

PATIENT'S NAME					TODAY'S DATE	HOME PHONE NUMBER (INCLUDING AREA CODE)	
MARITAL STATUS		DATE OF BIRTH	SEX	AGE	EMAIL	CELLULAR PHONE	
S	M	W	D	SEP	M	F	
STREET ADDRESS (PERMANENT)				CITY AND STATE	ZIP CODE	SOCIAL SECURITY NUMBER	
PATIENT'S EMPLOYER NAME							
ADDRESS				CITY AND STATE	ZIP CODE	PHONE NUMBER (INCLUDE AREA CODE)	
SPOUSE'S NAME				SOCIAL SECURITY NUMBER		SPOUSE'S DATE OF BIRTH	
SPOUSE'S EMPLOYER NAME							
ADDRESS				CITY AND STATE	PHONE NUMBER (INCLUDE AREA CODE)		
EMERGENCY CONTACT (NAME & PHONE NUMBER)							

ARE YOU COLLECTING SOCIAL SECURITY DISABILITY? YES NO			SOCIAL SECURITY START DATE _____ / _____ / _____		
CURRENT WORK STATUS: WORKING DISABLED UNEMPLOYED RETIRED SICK LEAVE			WORK RESTRICTIONS? YES NO		
WHAT TYPE OF WORK DO YOU DO?			DOES YOUR JOB CONTRIBUTE TO YOUR PAIN? YES NO		

**RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)**

MOTHER'S NAME		STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO. & AREA CODE	
MOTHER'S SOCIAL SECURITY NO.		MOTHER'S DATE OF BIRTH			
MOTHER'S EMPLOYER			OCCUPATION		BUSINESS PHONE NO. & AREA CODE
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE
FATHER'S NAME		STREET ADDRESS, CITY, STATE AND ZIP CODE		HOME PHONE NO. & AREA CODE	
FATHER'S SOCIAL SECURITY NO.		FATHER'S DATE OF BIRTH			
FATHER'S EMPLOYER			OCCUPATION		BUSINESS PHONE NO. & AREA CODE
EMPLOYER'S STREET ADDRESS		CITY AND STATE			ZIP CODE

NAME OF HOSPITAL OR PHYSICIAN WHO REFERRED YOU TO OUR PRACTICE			
FAMILY PHYSICIAN (FIRST & LAST NAME)		STREET ADDRESS	CITY, STATE AND ZIP CODE
WHICH PHYSICIAN IN OUR PRACTICE ARE YOU SEEING TODAY? <input type="checkbox"/> DR. BRATBERG <input type="checkbox"/> DR. DUSTMAN <input type="checkbox"/> DR. IRWIN <input type="checkbox"/> DR. NOVOTNY <input type="checkbox"/> DR. ATWATER <input type="checkbox"/> DR. CARMICHAEL <input type="checkbox"/> DR. HANSON <input type="checkbox"/> DR. OAKEY <input type="checkbox"/> DR. PAUL			
HAVE YOU EVER BEEN TREATED BY ANY OTHER PHYSICIAN AT MCLEAN COUNTY ORTHOPEDICS, LTD.? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF SO, WHO AND WHAT YEAR?			

**INSURANCE INFORMATION**

PRIMARY INSURANCE COMPANY (MEDICARE, IDPA, SELF EMPLOYED, PRIVATE, ETC.)		
ADDRESS	GROUP NUMBER	POLICY NUMBER
SECONDARY INSURANCE COMPANY (MEDICARE, IDPA, SELF EMPLOYED, PRIVATE, ETC.)		
ADDRESS	GROUP NUMBER	POLICY NUMBER

IS THIS A <b>WORK INJURY</b> ?      YES      NO	<b>WORKMAN'S COMPENSATION INSURANCE CO. NAME:</b>
WORK COMP INSURANCE ADDRESS	ADJUSTOR'S NAME & PHONE #:
WORK COMP NURSE MANAGER NAME:	PHONE #:

IS THIS A <b>LIABILITY CLAIM</b> (I.E. CAR ACCIDENT)?      YES      NO	
LIABILITY INSURANCE NAME:	CLAIM #:
LIABILITY INSURANCE ADDRESS	
<b>POLICY HOLDER NAME:</b> FIRST                      LAST	DATE OF BIRTH
<b>POLICY HOLDER ADDRESS</b>	
INSURANCE CONTACT PERSON? NAME:	PHONE #:

DID AN **INJURY** CAUSE OR AGGRAVATE YOUR PROBLEM?      CAUSED      AGGRAVATED      NO INJURY  
WHEN WAS THE FIRST OR MOST SERIOUS INJURY? \_\_\_\_\_

PLEASE DESCRIBE THE INJURY, YOUR MAIN SYMPTOM (INDICATE LEFT OR RIGHT) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ANY <b>SURGERIES</b> YOU HAVE HAD <b>IN RELATION TO THIS PROBLEM</b> (INCLUDE DATE / TYPE) :
_____
_____
_____

DO YOU HAVE AN ATTORNEY WHO WILL BE REPRESENTING YOU REGARDING THIS INJURY?      YES      NO
IF SO, PLEASE INDICATE ATTORNEY'S NAME, ADDRESS, AND PHONE NUMBER:

**AUTHORIZATION**

The undersigned authorizes McLean County Orthopedics, Ltd. to release and/or obtain information in the course of treatment regarding medical condition of (patient's name) \_\_\_\_\_ to the previously named Insurance Company(s) and Physician(s).

The undersigned also authorizes that medical benefit payments be made directly to McLean County Orthopedics, Ltd. for this care to the extent of their bill without necessity of their name being on the check or draft. The undersigned is aware it is their responsibility to check on coverage from their insurance company. They are also aware and accept they are responsible for ALL services.

In order to control our costs of billing, we request that copays be paid at the time service is rendered. If the undersigned fails to pay any remaining balance for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs incurred. The undersigned also agrees to be responsible for a finance charge of 1 1/2% per month on any unpaid balance.

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Signature \_\_\_\_\_

This is a confidential record and will be kept in our office. Information contained here will not be released to anyone without your authorization to do so.

NAME (LAST, FIRST, MI)		TODAY'S DATE
DATE OF BIRTH	REFERRING PHYSICIAN	

**HISTORY OF PRESENT COMPLAINT:** APPROXIMATE HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

WHY ARE YOU HERE TODAY?

SEVERITY OF PAIN: (NONE) 0 1 2 3 4 5 6 7 8 9 10 (WORST IMAGINABLE)

PROBLEM FIRST NOTICED WHEN:

WHAT MAKES IT WORSE OR BETTER?

HOW LONG DOES IT LAST?

HAVE YOU HAD RECENT X-RAYS?  YES  NO IF SO, WHERE WERE THEY TAKEN?

ARE YOU CURRENTLY BEING TREATED FOR THIS ILLNESS/INJURY BY ANOTHER PHYSICIAN?  YES  NO

IF YES, WHAT TREATMENT HAS BEEN DONE? (MEDS, THERAPY, ETC.)

**MEDICAL HISTORY:**

MEDICAL PROBLEMS: LIST ALL YOU HAVE/HAVE HAD: (DIABETES, HYPERTENSION, CANCER, GLAUCOMA, HEART ATTACK, BLOOD CLOTS, ETC.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  NONE

**MEDICATIONS:**

LIST PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL REMEDIES:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MIGHT YOU BE PREGNANT?  YES  NO

**LIST ALL SURGERIES**, WITH APPROXIMATE DATES:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  NONE

**ALLERGIES:**

ARE YOU ALLERGIC TO ANY MEDICATIONS, LATEX, RUBBER, OR X-RAY CONTRAST?  YES  NO

IF YES, PLEASE LIST ALLERGY (INCLUDING TYPE OF REACTION):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY:**

DO YOU DRINK ALCOHOLIC BEVERAGES?  YES  NO

DO YOU SMOKE?  YES  NO IF SO, HOW MANY PACKS? \_\_\_\_\_

HAVE YOU EVER SMOKED?  YES  NO IF SO, HOW MANY YEARS? \_\_\_\_\_

IF YES, WHEN DID YOU QUIT? \_\_\_\_\_

**FAMILY HISTORY:**

LIST ANY SIGNIFICANT FAMILY HISTORY (DIABETES, HEART DISEASE, CANCER, HYPERTENSION, BLOOD CLOTS, ETC.)

\_\_\_\_\_

\_\_\_\_\_  NONE

**REVIEW OF SYSTEMS:**

<b>CONSTITUTIONAL:</b> Do you have any fever, chills, headache, general tiredness or weakness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>INTEGUMENTARY:</b> Do you have any skin rashes, persistent itching or other skin problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>EYES:</b> Do you have any blurred vision, double vision, blind spots, glaucoma or eye pain?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ENT:</b> Do you have any chronic or persistent ear, sinus, or throat infections or problems?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>CARDIOVASCULAR:</b> Do you have any history of chest pain/angina, high blood pressure, or heart murmurs?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PULMONARY:</b> Do you have any history of persistent cough, wheezing, shortness of breath, or pneumonia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>GASTROINTESTINAL:</b> Do you have any chronic nausea, vomiting, indigestion, heartburn, or stomach pains?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>MUSCULOSKELETAL:</b> Do you have any history of back, neck or joint pain or injury?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>NEUROLOGICAL:</b> Do you have any history of tremors, dizzy spells, numbness, or tingling?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>ENDOCRINE:</b> Do you have any history of excessive thirst, weight loss/gain, or too hot/too cold?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>HEMATOLOGICAL:</b> Do you have any swollen glands, excessive bleeding, or blood clots?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PSYCHOLOGICAL:</b> Do you have any history of depression, anxiety attacks, or suicidal thoughts?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**PROVIDER'S NOTES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE: \_\_\_\_\_ PROVIDER'S SIGNATURE \_\_\_\_\_