Today's Date: _____ Co-Pay: _____

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

How did you learn about our practice? _____

Patients Name: _____
Last First Middle

Patients Home Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Birth date: _____ Age: _____ Sex: M F

Home Phone: (_____) _____ Cell Phone: (_____)_____ _____

Email address: _____

Occupation: _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (_____) _____ Ext: _____ Pharmacy Location: _____

Race: _____ Language: _____ Ethnicity: Hispanic Non-Hispanic Decline to Answer

PLEASE PROVIDE THE RECEPTIONIST WITH CURRENT INSURANCE CARDS AND DRIVERS LICENSE

Primary Insurance Plan: _____ **Secondary Insurance Plan**: _____

Plan ID#: _____ Plan ID#: _____

Subscriber: _____ DOB: _____ Subscriber: _____ DOB: _____

FINANCIALLY RESPONSIBLE PARTY (SIGNER OF FINANCIAL POLICY IF NOT THE PATIENT)

Name: _____ Relationship to Patient: _____
Last First Middle

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

Birthdate: _____ Age: _____ SSN: _____ Phone: (____) _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: (____) _____ Ext: _____

How did your injury occur? _____

On what date did the injury occur? _____ Where did it happen: _____

Did your injury happen on the job? Yes No If yes, did you report the accident to your employer? Yes No

Primary/Family Physician: _____ Drug Allergies: _____

In case of emergency, contact: _____ *Relationship:* _____

Home Phone: (_____) _____ *Work or Cell Phone:* (_____) _____

Signature of Patient or Responsible Party: _____

Financial Policies

St. Charles Orthopaedic Surgery Associates, a Division of Signature Medical Group (SMG)

We accept cash, check, Visa, MasterCard, Discover and most insurance programs. You may consent to automated payment card payments by signing a separate authorization.

IF THE PATIENT IS COVERED BY INSURANCE, THE FOLLOWING APPLY:

- The patient/responsible party or guarantor signing below ("you") must provide us with current and correct information about the patient's medical coverage/insurance/health plan (health plan).
- We file group health plan claims and by law, must file Medicare claims.
- **You must follow the rules of your health plan such as providing a valid referral form** and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).
- You are responsible for paying any deductibles, co-payments, non-covered services or other costs not covered by the health plan at the time of service.
- Amounts are due for a child regardless of parental custody, divorce or separation terms.

WORK RELATED INJURIES

- If you have submitted an injury to your employer AND the employer has approved treatment, you will not be charged or billed for medical services. Disability form completion is not included and the fee is due by you.
- If the patient's employer does not approve treatment and YOU SELECT US FOR YOUR TREATMENT, you may be billed and you may be responsible for payment of service not approved by the employer.

LIABILITY OR LEGAL CASES

- If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for prompt payment of our regular fees.

CONTACT OUR BILLING OFFICE AT 636-561-5030 IF:

- You think your bill is wrong or if you need more information about an item on your bill,
- You need to arrange an alternative payment plan for your financial obligation.

COLLECTION FEES

- In the event of non-payment you will be responsible for any legal and collection fees. Legal/Collection fees are in addition to the outstanding balance and will apply should the account be referred to an outside agency.

AUTHORIZATION FOR ELECTRONIC STATEMENTS

I authorize SMG to send electronic account statements and invoices to my email address on file. I understand that I will not receive a copy of any such invoice via U.S. Mail. I understand that it is my responsibility to maintain a current email address on file with the practice at all times. **Initial here_____ to DECLINE electronic account statements; your statements will arrive by U. S. Mail**

CONSENT TO TREAT

I consent to SMG physicians, their assistants and other SMG staff to provide medical and/or surgical treatment, testing, supplies, medications, services, equipment and other items deemed necessary for my treatment. I have been informed of the nature and purpose of the proposed treatment, common side effects, risks, benefits, alternatives and estimated duration of treatment as applicable. I understand that I may withdraw consent to treatment and will inform the physician of any decision to terminate treatment. In the event of an emergency while receiving care at SMG I authorize SMG staff to arrange for care and treatment necessary to address the emergency medical conditions.

ASSIGNMENT OF BENEFITS

I acknowledge that the patient or guarantor signing below is financially responsible for all charges for medical services provided by SMG and payment is due on the date of service. If an insurance/health plan claim is filed by SMG I request that payment of all benefits be made directly to SMG. I agree to pay for any services or out-of-pocket expenses which are not covered by insurance. I acknowledge receipt and acceptance of SMG's financial policies as set forth on this form.

_____ _____

Printed Patients Name Patient/Legal Representative or Guarantor Signature

_____ _____

Date Printed Legal Representative or Guarantor Name

St. Charles Orthopaedic Surgery Associates, Inc.
Patient Medical History Sheet

Name: _____ Date of Birth: _____ Age: _____

Reason for Today's Visit: _____

Height: ft. in. Weight: lbs. Preferred Pharmacy (name and location): _____

Current Medications: ❍ **I do not take any Medications** *(or provide copy of medication list)*

Drug Name	**Dosage**	**How often taken**	**Reason or Condition for taking the Medication**

Allergies ❍ **No Allergies** 1) Drug: _____ Reaction: _____ 2) Drug: _____ Reaction: _____

Other Allergies: ❍ Latex ❍ Eggs ❍ Shellfish ❍ Metal Reaction: _____

Review of Systems Have you experienced or currently experiencing any of the following?

❍ Chills	❍ Known TB exposure	❍ Vomiting	❍ Seizures
❍ Fatigue	❍ Wheezing	❍ Dysuria (painful urination)	❍ Anxiety
❍ Fever	❍ Chest Pain (non-respiratory)	❍ Frequent urination	❍ Depression
❍ Night sweats	❍ Heart Murmur	❍ Hematuria (blood in urine)	❍ Rash
❍ Weight Gain	❍ Irregular heartbeat/palpitations	❍ Urinary Incontinence	❍ Nail changes
❍ Weight Loss	❍ Abdominal Pain	❍ Difficulty walking	❍ Bleeding
❍ Chest Pain (respirator	❍ Constipation	❍ Poor coordination	❍ Bruising
❍ Cough	❍ Diarrhea	❍ Muscle weakness	
❍ Other: _____		❍ **I have none of these symptoms**	

Have you ever had MRSA or MSSA that you know of? ❍ Yes ❍ No

Previous Hospitalizations and/or Surgeries:

	Hospital	**Reason or Condition**
Year _____		
Year _____		
Year _____		

Diagnostic Studies Performed Have you had any of the following studies performed on the body part being examined today? ❍ **No**

	Location	**Date**		**Location**	**Date**
❍ X-Ray		____/____/_____	❍ Arthrogram		____/____/_____
❍ CT		____/____/_____	❍ EMG		____/____/_____
❍ MRI		____/____/_____	❍ Other		____/____/_____

Past Medical History Check any medical conditions you or your immediate family have now or have had in the past:

	Self	Family		Self	Family		Self	Family
Anemia	❍	❍	Gout	❍	❍	Sleep apnea	❍	❍
Arthritis	❍	❍	Hepatitis Type____	❍	❍	*If patient has sleep apnea is a C-PAP or BI-PAP used?*____		
Cancer	❍	❍	HIV	❍	❍		Self	Family
Type: _____			High Blood Pressure	❍	❍	Other:		
COPD	❍	❍	Kidney Disease	❍	❍			
Diabetes	❍	❍ Type_____	Liver Disease	❍	❍			

No Medical History Self or Family ❍

Social History

	Yes	No		Yes	No
Have you ever smoked?	❍	❍	Do you consume alcohol?	❍	❍
Do you smoke now?	❍	❍ Age quit ____	Do you follow a routine exercise program?	❍	❍
How many packs per day? _____			Exercise Program: Type		Frequency

Occupation: _____

_____ _____

Patient or Guardian Signature Date

St. Charles Orthopaedic Surgery Associates, Inc.

DR. ANTHONY BERNI PATIENT HISTORY SHEET

Date: _____ Name: _____ D.O.B.: ____/_____/_____

PERSONAL & SOCIAL HISTORY

Occupation: _____ Height: _____ft. _____in. Weight: _____lbs.

Children: _____ Marital Status: _____

Tobacco: _____packs/day for _____years Alcohol: _____ weekday _____ weekend

Do you have any medical conditions such as:

- ❑ Stomach Problems
- ❑ Diabetes
- ❑ Heart Failure/Attacks
- ❑ Epilepsy
- ❑ Mental Health Problems
- ❑ Cancer
- ❑ Gout
- ❑ Bowel or Bladder Problems
- ❑ High Blood Pressure
- ❑ Arthritis
- ❑ Lung Problems
- ❑ Congestive Heart Failure
- ❑ Circulation Problems
- ❑ MRSA If so, when_____
- ❑ Hepatitis C
- ❑ COPD
- ❑ Atrial Fibrillation
- ❑ History of blood clots
- ❑ Other _____ _____

Are you taking Coumadin? Yes ☐ No ☐

Do you have Sleep Apnea? Yes ☐ No ☐ If yes, Do you use a C-PAP machine? ☐ Yes ☐ No

Do you use assistive devices to walk? Yes ☐ No ☐

Previous Surgeries: _____
_____
_____

Do you have allergies to medications? Yes ☐ No ☐ Please List: _____

Who is your primary doctor? _____

Do you have any additional information that would be helpful in understanding your problem? _____
_____
_____

Current Medication and Dosage	What is the Medication for?

FAMILY HISTORY

- ❑ Kidney Failure/Malfunction
- ❑ High Blood Pressure
- ❑ Rheumatoid Arthritis
- ❑ Osteoarthritis
- ❑ Joint Replacement
- ❑ Heart Attack /Bypass Surgery
- ❑ Mental Illness
- ❑ Asthma
- ❑ Diabetes
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Anemia/Bleeding Disorder
- ❑ Blood clots

St. Charles Orthopaedic Surgery Associates, Inc.
Dr. Anthony Berni - Page 2

Name: _____

Reason for Today's Visit: Right Left Both Body part: _____

Review of Systems

Have you experienced or currently experiencing any of the following symptoms?

❍ Chills	❍ Known TB exposure	❍ Vomiting	❍ Seizures
❍ Fatigue	❍ Wheezing	❍ Dysuria (painful urination)	❍ Anxiety
❍ Fever	❍ Chest Pain (non-respiratory)	❍ Frequent urination	❍ Depression
❍ Night sweats	❍ Heart Murmur	❍ Hematuria (blood in urine)	❍ Rash
❍ Weight Gain	❍ Irregular heartbeat/palpitations	❍ Urinary Incontinence	❍ Nail changes
❍ Weight Loss	❍ Abdominal Pain	❍ Difficulty walking	❍ Bleeding
❍ Chest Pain (respiratory	❍ Constipation	❍ Poor coordination	❍ Bruising
❍ Cough	❍ Diarrhea	❍ Muscle weakness	
❍ Other: _____			