

LAMBERTI ORTHOPEDIC & HAND SURGERY, LLC
PAUL M. LAMBERTI, M.D.

MEDICAL HISTORY

NAME _____ DATE _____

BIRTH DATE ____/____/____ DOMINANT HAND Right Left

Briefly state the reason for today's visit _____

Have you had any of the following pertaining to this problem? (Please Circle) If so, give location and date

X-Rays _____ MRI _____ Bone Scan _____ Nerve Tests _____

Have any treatments been done for this problem? _____

Was an injury involved? Yes No Date of Injury: ____/____/____

Was the injury work related? Yes No How? _____

MEDICATIONS—Please list all you are currently taking (Prescription & Non-Prescription) NONE

ALLERGIES NONE KNOWN

- CODIENE PENICILLINS SULFA LATEX
EXAM DYES/SHELLFISH TAPE ERYTHROMYCIN OTHER DRUGS _____
OTHER ALLERGIES (please list) _____

SOCIAL HISTORY

DO YOU OR HAVE YOU EVER USED TOBACCO? NO YES (check all that apply) PREVIOUS SMOKER
CIGARETTES--PACKS PER DAY _____ CIGAR PIPE CHEW

DO YOU DRINK ALCOHOL? NO YES--DRINKS PER WEEK _____

DO YOU OR HAVE YOU EVER USED DRUGS? NO YES

FAMILY HISTORY—Have any of your blood relatives (parent, grandparent, brother or sister) ever had (check all that apply):

- ARTHRITIS CANCER _____ HIGH BLOOD PRESSURE MEMORY LOSS
ASTHMA DIABETES HIGH CHOLESTEROL OSTEOPOROSIS
BLEEDING PROBLEM HEART DISEASE KIDNEY DISEASE STROKE
OTHER _____ NONE KNOWN

PRESENT OR PAST MEDICAL PROBLEMS—Do you have now, or have you ever had diseases or conditions of:

- ACID REFLUX (GERD) DEPRESSION HEPATITIS A/B/C MITRAL VALVE PROLAPSE
ARTHRITIS DIABETES HIGH BLOOD PRESSURE PACEMAKER
ARTIFICIAL JOINTS EMPHYSEMA HIGH CHOLESTEROL SEIZURES
ASTHMA FRACTURE _____ HYPOTHYROID SLEEP APNEA
BLOOD CLOTS/DVT HEART ATTACK IRREGULAR HEARTBEAT STROKE
CANCER _____ HEART MURMUR MIGRAINE HEADACHES

PLEASE LIST OTHER PAST AND PRESENT MEDICAL PROBLEMS: _____

I HAVE NO MAJOR MEDICAL PROBLEMS THAT I AM AWARE OF

SURGERIES—Please check all that apply and list the YEAR in the space provided

- APPENDECTOMY _____ C-SECTION _____ HERNIA _____ TONSILLECTOMY _____
CATARACTS R L _____ GALLBADDER _____ HYSTERECTOMY _____ NONE KNOWN

PLEASE LIST ANY OTHER SURGERIES WITH THE YEAR THEY WERE PERFORMED: _____

Describe any problems with anesthesia/Novocaine in the past: _____

The above information is complete and correct.

PATIENT SIGNATURE _____ DATE _____

M.D. SIGNATURE _____ DATE _____

LAMBERTI

Orthopedic & Hand Surgery, LLC

Patient Name _____ SS# _____

Birth Date ___/___/___ Gender: Male Female Email _____

Marital Status: Single Married Divorced Widowed Significant Other

Home Address _____
Street City State Zip

Home Phone # _____ Cell Phone # _____

Employment Status: Full Time Part Time Retired Student Unemployed Disabled

Occupation _____ Mother's Maiden Name _____
For security purposes

Employer _____ Work Phone # _____

Work Address _____
Street City State Zip

Name of Family Doctor (PCP) _____ Office Phone # _____

Where did you learn about Dr. Lamberti? I am a previous patient Internet/Website Yellow Pages
 Friend/Family Doctor Referral _____ Other _____

MINOR PATIENT Parent or Guardian's Name _____

SS# & Birth Date of Parent or Guardian _____

INSURANCE INFORMATION ***PLEASE PRESENT INSURANCE CARD FOR US TO SCAN TO OUR FILES**

IS THIS A WORKER'S COMPENSATION CLAIM? Y or N

PRIMARY Insurance Company _____

Do you have a co-pay? Yes No If yes, please give amount of co-pay \$ _____

Name of Insured _____ Relationship to Patient _____

Employer of Insured _____

SS# of Insured _____ Birth Date of Insured ___/___/___

SECONDARY Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Employer of Insured _____

SS# of Insured _____ Birth Date of Insured ___/___/___

Acceptance of financial responsibility: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another person at fault. Authorization to treat and to release medical information: I hereby authorize medical treatment and the release of medical information requested by my insurance company. Authorization to pay: I hereby authorize payment directly to Lamberti Orthopedic & Hand Surgery, LLC.

Signature of Patient, Parent or Guardian _____ Date ___/___/___

**Notice of Privacy Practices
ACKNOWLEDGEMENT OF RECEIPT**

Patient Name: _____

The above named patient acknowledges receipt of Lamberti Orthopedic & Hand Surgery, LLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.

The above named patient understands that the practice reserves the right to change the privacy practices that are described in the Notice. The patient also understands that a copy of any Revised Notice will be provided or made available to the patient.

Signature: _____ **Date:** _____

Relationship to Patient: _____

FOR OFFICE USE ONLY:

Date acknowledgement received: _____

Reason acknowledgement was not obtained:

Disposition: File in patient's medical record.
Last Updated: 9/1/07

LAMBERTI ORTHOPEDIC & HAND SURGERY, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

LAMBERTI ORTHOPEDIC & HAND SURGERY, LLC (LOHS) is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of legal duties and privacy practices with respect to protected health information. LOHS is required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by the administration personnel reviewing the quality of the care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- **Appointment Reminders.** We may contact you to provide appointment reminders.
- **Treatment Information.** We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Fund Raising.** We may contact you to raise funds for LOHS.
- **Disclosure to Department of Health and Human Services.** We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.
- **Facility Directory.** Unless you object, we may disclose your medical information to family members, other relatives or close personal friends when the medical information is directly relevant to that person's involvement with your care.
- **Notification.** Unless you object, we may use or disclose you medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.
- **Disaster Relief.** We may disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.
- **Abuse or Neglect.** We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.
- **Legal Proceedings.** We may disclose your medical information in the course of certain judicial or administrative proceedings.
- **Law Enforcement.** We may disclose your medical information for law enforcement purposes or other specialized governmental functions.
- **Coroners, Medical Examiners and Funeral Directors.** We may disclose your medical information to a coroner, medical examiner or a funeral director.
- **Organ Donation.** If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
- **Research.** We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.
- **Worker's Compensation.** We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.
- **Business Associates.** We may disclose your health information to a business associate with whom we contract to provide services on your behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.
- **Public Safety.** We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

LAMBERTI ORTHOPEDIC & HAND SURGERY LLC
2425 W 22nd Street
Suite 212
Oakbrook, IL 60523
ATTN: Privacy Officer

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by LOHS during the last six years (or following April 14, 2003), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way.

To complain to us, please contact:

LAMBERTI ORTHOPEDIC & HAND SURGERY LLC
2425 W 22nd Street
Oakbrook, IL 60523
ATTN: Privacy Officer

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

LAMBERTI ORTHOPEDIC & HAND SURGERY LLC
2425 W 22nd Street
Suite 212
Oakbrook, IL 60523
ATTN: Privacy Officer

THIS NOTICE IS EFFECTIVE AS OF September 1, 2007.

REVISION OF NOTICE OF PRIVACY PRACTICES:

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at LOHS and will make paper copies of the revised Notice of Privacy Practices available on request.