Jeanne S. Vedder, M.D., S.C.

1400 75 Street, Suite 4
Kenosha, WI 53143
Phone: 262-657-6577
Fax: 262-657-7844
www.vedderent.com

Dear Patient:

Welcome to our practice. We thank you for trusting us with your health care. Enclosed you will find your new patient packet. Please complete these and bring them to your appointment. We also request that you bring the following:

- Completed patient registration forms
- a list of all prescription medications, over-the-counter medications, and herbal supplements you are taking,
- Your insurance card(s),
- Your driver's license or state issued identification, and
- Any co-payment required by your insurance provider.

It is important that you be on time for this appointment. It may be necessary to reschedule this appointment if you are more than ten minutes late or are missing any of the above documentation at the time of the appointment. Do not hesitate to give our office a call at (262) 657-6577 if you have any questions or if you are unable to keep this appointment. We require 24 hour notice for cancellations otherwise there will be a $75 missed appointment charge.

Please note, a parent or legal guardian must accompany any patients under age 18 to all appointments. The parent or legal guardian is required to sign patient forms and is financially responsible for services rendered.

Thank you.

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Patient Registration Form

Phone: 262-657-6577
Fax: 262-657-7844

PATIENT INFORMATION (Please Write Information About The Patient Here)

_____ ☐ Male ☐ Female
PATIENT'S NAME (Last, First, Middle Initial) SEX

_____
PATIENT'S ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____
HOME PHONE CELL PHONE

_____ _____ - _____ - _____ _____/_____/_____
AGE SOCIAL SECURITY NUMBER DATE OF BIRTH

_____ (_____)_____
FAMILY DOCTOR'S NAME FAMILY DOCTOR'S PHONE

_____ (_____)_____
EMPLOYER'S OR SCHOOL NAME EMPLOYER'S OR SCHOOL PHONE

☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed
EMPLOYMENT STATUS

☐ M ☐ S ☐ D ☐ W ☐ Full Time ☐ Part Time ☐ Not a Student
MARITAL STATUS STUDENT STATUS

INSURANCE INFORMATION (Please Write Information About The Patient's Insurance Here)

_____
PRIMARY INSURANCE COMPANY NAME

_____ _____
INSURANCE ID NUMBER GROUP OR PLAN NUMBER

_____
SECONDARY INSURANCE COMPANY NAME

_____ _____
INSURANCE ID NUMBER GROUP OR PLAN NUMBER

POLICY HOLDER INFORMATION (Complete The Policyholder Information Below If The Patient Is Not The Policyholder)

_____
PRIMARY POLICYHOLDER'S NAME (Last, First, Middle Initial)

_____/_____/_____ (_____)_____
DATE OF BIRTH CELL OR ALTERNATIVE PHONE NUMBER

_____
POLICYHOLDER'S ADDRESS CITY STATE ZIP

_____ (_____)_____
EMPLOYER'S NAME OR SCHOOL NAME PHONE

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

_____-_____-_____ RELATIONSHIP TO PATIENT
SOCIAL SECURITY NUMBER ☐ SPOUSE ☐ PARENT
☐ OTHER ☐ GUARDIAN

_____
SECONDARY POLICYHOLDER'S NAME (Last, First, Middle Initial)

_____/_____/_____ (_____)_____
DATE OF BIRTH CELL OR ALTERNATIVE PHONE NUMBER

_____
POLICYHOLDER'S ADDRESS CITY STATE ZIP

_____ (_____)_____
EMPLOYER'S NAME OR SCHOOL NAME PHONE

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

_____-_____-_____ RELATIONSHIP TO PATIENT
SOCIAL SECURITY NUMBER ☐ SPOUSE ☐ PARENT
☐ OTHER ☐ GUARDIAN

RESPONSIBLE PARTY INFORMATION Responsible Party Is: ☐ Patient ☐ Primary Policyholder ☐ Secondary Policyholder

(*Complete The Information Below About The Person Signing This Form*)

_____ ☐ MALE ☐ FEMALE
RESPONSIBLE PARTY'S NAME (Last, First, Middle Initial) SEX

_____
RESPONSIBLE PARTY ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____
PHONE CELL OR ALTERNATIVE PHONE

_____ - _____ - _____ ☐ YES ☐ NO
SOCIAL SECURITY NUMBER LEGAL REPRESENTATIVE

_____ (_____)_____
EMPLOYER'S NAME EMPLOYER'S PHONE NUMBER

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

☐ SPOUSE ☐ PARENT ☐ GUARDIAN ☐ OTHER

_____
RELATIONSHIP TO PATIENT

I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT ON ANY CLAIM. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE, AND OTHER HEALTH PLANS TO JEANNE S. VEDDER, M.D., S.C. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID OR NOT BY SAID INSURANCES. AS OF JANUARY 1, 2010, I UNDERSTAND THAT ANY BALANCES THAT ARE 60 DAYS OVERDUE WILL BE ASSESSED A BILLING CHARGE OF $5.00, TO EACH ADDITIONAL STATEMENT. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

X_____ Date_____/_____/_____
Signed (Patient, Legal Guardian, Or Parent If Under 18 Years Of Age.)

Jeanne S. Vedder, M.D., S.C.

Patient Acknowledgement & Record of Disclosures

I, _____,
Acknowledge that I have received the written notice of Privacy Practices from Jeanne S. Vedder, M.D., S.C.

☐ The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____/_____/_____

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

Alternate Telephone: _____/_____/_____

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

Written Communication

- ☐ Can mail to Home address: _____
- ☐ Can mail to work address: _____
- ☐ Can fax to this number: _____/_____/_____

I consent to have my personal health information disclosed to:

Name: _____ Phone#: _____/_____/_____ Relationship: _____

Name: _____ Phone#: _____/_____/_____ Relationship: _____

X_____ _____

Patient or Guardian Signature **Date**

_____ _____

Printed Name **Birth date**

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PATIENT QUESTIONNAIRE

Date: _____/_____/_____

Name: _____ Date of Birth _____/_____/_____

Past Medical History: Do you currently have or have ever had any of the following? Please answer all of the following questions.

☐ Yes ☐ No Chicken Pox	☐ Yes ☐ No Heart Valve Problem	☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Measles	☐ Yes ☐ No Pacemaker	☐ Yes ☐ No Seizures
☐ Yes ☐ No Mumps	☐ Yes ☐ No Asthma	☐ Yes ☐ No Stroke
☐ Yes ☐ No Rheumatic Fever	☐ Yes ☐ No Bronchitis	☐ Yes ☐ No Diabetes
☐ Yes ☐ No Tuberculosis	☐ Yes ☐ No Pneumonia	☐ Yes ☐ No Goiter
☐ Yes ☐ No Polio	☐ Yes ☐ No Emphysema	☐ Yes ☐ No Bell's palsy
☐ Yes ☐ No HIV Positive	☐ Yes ☐ No Acid Reflux	☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Deafness	☐ Yes ☐ No Ulcers	☐ Yes ☐ No Lupus
☐ Yes ☐ No Nasal Allergies	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Anemia
☐ Yes ☐ No Chronic Sinusitis	☐ Yes ☐ No Liver Disease	☐ Yes ☐ No Blood Disorder
☐ Yes ☐ No Tonsillitis	☐ Yes ☐ No Urine Infection	☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Mononucleosis	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Drug Addiction
☐ Yes ☐ No Sleep Apnea	☐ Yes ☐ No Female Problems	☐ Yes ☐ No Eating Disorder
☐ Yes ☐ No Cataracts	☐ Yes ☐ No Prostate Problem	☐ Yes ☐ No Psychiatric Problem
☐ Yes ☐ No Glaucoma	☐ Yes ☐ No Venereal Disease	☐ Yes ☐ No Cancer (Specify)
☐ Yes ☐ No Blindness	☐ Yes ☐ No Arthritis	
☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Gout	☐ Yes ☐ No Chemo Therapy
☐ Yes ☐ No High Cholesterol	☐ Yes ☐ No Spine Problems	☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Heart Disease	☐ Yes ☐ No Breast Lump	☐ Yes ☐ No Other Conditions (Specify)
☐ Yes ☐ No Heart Murmur	☐ Yes ☐ No Migraine Headache	

Past Surgical History:

□ Yes □ No Have you ever had surgery in the past? If yes, please list the **type of surgery** and the **date**:

_____

_____

_____

_____

Other Hospitalizations (Non-Surgical):

□ Yes □ No Have you been hospitalized in the past? If yes, please list the **reason** for the hospitalization and the **date**:

_____

_____

_____

□ Yes □ No Have you had any severe injuries, accidents, or head trauma? If yes, please describe: _____

_____

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Allergies:

☐ Yes ☐ No Are you allergic to any medications?
If yes, please list: ____
☐ Yes ☐ No Any other allergies? If yes, please list: ____
☐ Yes ☐ No Any allergy tests?
☐ Yes ☐ No Any allergy shots?

Medications:

☐ Yes ☐ No Do you take any aspirin or blood thinners? If yes, please list: ____________________
☐ Yes ☐ No Have you been told to use antibiotics before seeing a dentist or having medical procedures?

Please list all **Medications, [prescription and over the counter medications]**, the dosage {**Strength (mg)**], how often you take the medication (daily, three times a day, etc.) [**How Often**], and when they were started [**Since When**]

Medication (name)	Strength (mg) (dose)	How Often	Since when (month/year)
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/
		☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ other ________	/

☐ Yes ☐ No Do you or your family have a history of problems with anesthesia, bleeding, or clotting?
If yes, please explain: ____

Family History:

Fill in the information about your immediate family. **Check (√) if, your blood relatives had any of the following:**

Relation	Age	State of Health	Cause of Death	√	Disease	Relationship to you
Father				☐	Anesthesia Problems	
Mother				☐	Arthritis	
Brothers				☐	Asthma	
				☐	Bleeding Tendencies	
				☐	Cancer	
				☐	Chemical Dependency	
Sisters				☐	Diabetes	
				☐	Hay Fever	
				☐	Heart Disease	
				☐	Strokes	
Children				☐	High Blood Pressure	
				☐	Inherited Diseases	
				☐	Kidney Disease	
				☐	Death before age 55	
					Other (Specify)	

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Social History and Health Risk Assessment: Please answer all of the following questions

Marital Status? _____
Number of Children? _____

☐Yes ☐No **Are you pregnant, or do you believe that it is possible you are pregnant?**

☐Yes ☐No Have you had a physical in the last year?
If yes, when: _____
Which physician performed your physical?
_____

Employment:
What is your job? _____
How long have you had this job?
☐Yes ☐No Do you experience any job exposure to hazardous material (e.g. asbestos)?
If yes, what? _____

Tobacco:
☐Yes ☐No **Are you exposed to 2nd hand Smoke?**

Do you smoke or chew tobacco?
☐No I never smoked
☐No I Quit _____years ago
At that time I was smoking _____ packs per day for _____ years
☐Yes I smoke _____ packs per day for _____ years
☐Yes I smoke cigars or a pipe for _____ years
☐Yes I chew tobacco for _____ years

Alcohol:
Do you drink alcohol?
☐No I never drank alcohol
☐No I quit _____ years ago
At that time I was drinking _____ drinks daily
☐Yes Daily _____ drinks per day for _____years
☐Yes Weekends _____ drinks per day for ____years
☐Yes Less Often

Recreational Drugs:
□ Yes □ No Do you, or have you , used recreational drugs in the past?

□ Yes □ No Are you at risk for HIV/AIDS?
(Sexual orientation, drug use, previous blood transfusion)

Immunization:
□ Yes □ No Immunization up to date? (Children only)

Date of most recent Tetanus Shot _____/_____/_____

Date of most recent Flu Shot _____/_____/_____

Exercise:
□ Yes □ No **Do you exercise?**
If yes, describe type and frequency: _____
_____

Nutrition Screening:
Height _____Weight _____

I have gained _____ pounds over the past _____ weeks
I have lost _____ pounds over the past _____ weeks
□ Yes □ No I intentionally lost or gained the above weight

□ Yes □ No Do you drink caffeinated beverages?
If yes, specify _____
□ Yes □ No Do you follow any specific diet?
If yes, specify _____

Pets:
□ Yes □ No Do you have pets in your home?
If yes, specify _____
_____

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Review of Systems: Do you currently have any of the following? Please answer all of the following questions.

Ears, Nose Throat, Mouth

☐Yes ☐No Ear Pain
☐Yes ☐No Ear Pressure
☐Yes ☐No Ear Drainage L R Both
☐Yes ☐No Hearing Loss L R Both
☐Yes ☐No Ringing L R Both
☐Yes ☐No Vertigo
☐Yes ☐No Family History of Hearing Loss
☐Yes ☐No Loud Noise Exposure in Life
☐Yes ☐No TMJ or Jaw Pain
☐Yes ☐No Hearing Aid (s) L R Both
☐Yes ☐No Facial Numbness
☐Yes ☐No Facial Weakness
☐Yes ☐No Nosebleeds
☐Yes ☐No Trouble Breathing through Nose
☐Yes ☐No Runny Nose
☐Yes ☐No Nose Drips into Throat
☐Yes ☐No Sneezing or Itching
☐Yes ☐No Altered smell or Taste
☐Yes ☐No Headaches in Face
☐Yes ☐No Frequent Need to Clear Throat
☐Yes ☐No Feeling like You Are Choking
☐Yes ☐No Chronic Cough
☐Yes ☐No Hoarseness
☐Yes ☐No Trouble Swallowing
☐Yes ☐No Sensation of Lump in Throat
☐Yes ☐No Sour or Acid Taste
☐Yes ☐No Recurrent Sore Throats
☐Yes ☐No Mouth Sores
☐Yes ☐No Neck Swelling
☐Yes ☐No Reflux
☐Yes ☐No Difficulty Swallowing or Choking
☐Yes ☐No Snoring
☐Yes ☐No Stop Breathing While Sleeping

Constitutional

☐Yes ☐No Fever/Chills
☐Yes ☐No Night Sweats
☐Yes ☐No Excessive Fatigue

Eyes

☐Yes ☐No Glasses or contacts
☐Yes ☐No Recent Change in Vision
L R

Cardiovascular

☐Yes ☐No Chest Pain
☐Yes ☐No Irregular Heart Beat

Respiratory

☐Yes ☐No Wheezing
☐Yes ☐No Shortness of Breath
☐Yes ☐No Blood in Phlegm

Gastrointestinal

☐Yes ☐No Nausea / Vomiting
☐Yes ☐No Abdominal Pain
☐Yes ☐No Indigestion

Genitourinary

☐Yes ☐No Difficulty or Pain Urinating
☐Yes ☐No Blood in Urine
☐Yes ☐No Bed Wetting

Integumentary

☐Yes ☐No Rashes or Itching
☐Yes ☐No Skin Spots or Growth
☐Yes ☐No Breast pain, Tenderness, Swelling or discharge

Anything not checked above is negative-confirmed with patient

Musculoskeletal

☐Yes ☐No Arm or Leg Weakness
☐Yes ☐No Back Pain
☐Yes ☐No Joint Swelling

Neurological

☐Yes ☐No Fainting spells
☐Yes ☐No Difficulty Speaking
☐Yes ☐No Forgetfulness
☐Yes ☐No Numbness or Weakness

Psychiatric

☐Yes ☐No Anxiety
☐Yes ☐No Depression
☐Yes ☐No Other (specify)

_____

Endocrine

☐Yes ☐No Change in Appetite
☐Yes ☐No Excess Thirst
☐Yes ☐No Heat or Cold Intolerance
☐Yes ☐No Hormone Problems

Hematologic/Lymphatic

☐Yes ☐No Bleeding or Bruise Easily
☐Yes ☐No Swollen Lymph Nodes

Allergic/Immunologic

☐Yes ☐No Dry Eyes
☐Yes ☐No Dry Mouth

Other

Describe Any Other Health Concerns

_____
_____
_____
_____
_____
_____

The above information is accurate to the best of my knowledge. **I have reviewed the above information with the patient.**

X_____ ____/____/____ _____ ____/____/____
Patient Signature *Date* *Physician Signature* *Date*

X_____ ____/____/____ _____ ____/____/____
Patient Signature *Date* *Physician Signature* *Date*

X_____ ____/____/____ _____ ____/____/____
Patient Signature *Date* *Physician Signature* *Date*

X_____ ____/____/____ _____ ____/____/____
Patient Signature *Date* *Physician Signature* *Date*

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FINANCIAL POLICY

CANCELATIONS: If you cannot keep an appointment, please give 24-hour notice. **There is a $75.00 fee when a patient misses or cancels an appointment without 24-hour notice.**

SELF-PAY: Self-pay patients are required to pay at the time of service. Payments made in full at the time of service qualify for a 10% discount.

INSURANCE: Your insurance is a contract between you, your employer and the insurance company. We are not part of that contract. As a courtesy, we will bill contracted insurance providers if given accurate insurance information at the time of the visit. If your insurance provider fails to pay, for any reason, you are responsible for the balance. We will transfer responsibility of payment of the claim to you if your insurance provider does not submit payment within 45 days. Please be sure to communicate with your insurance provider about any open claims. If you are without insurance coverage at any time or there are any changes regarding your insurance provider, please notify us immediately.

CO-PAYMENTS**:** Co-pay payment is due in full at the time of service. Please be ready to pay when you check in for your appointment.

DEDUCTIBLE: Payment for services subject to insurance deductibles may be required at the time of service.

STATEMENTS: Billing statements are issued about 30 days following an appointment. Statement balances are due in full 14 days after the date on the statement. Please be sure to communicate with your insurance provider about any unpaid claims.

ACCOUNT BALANCE: If your payment balance is more than $300.00, you may contact our billing department to set up payment arrangements. Payment arrangements may extend no more than 90 days beyond the date of service. Balances more than 90 days past due may be subject to collection action. Collection action may result in your discharge from Jeanne S. Vedder, M.D., S.C.

PAYMENTS: We accept cash, checks, MasterCard and Visa as forms of payment. There is a $50.00 bank fee for any checks returned for any reason.

MINORS: A parent or legal guardian must accompany patients under age 18 and will be held responsible for all payments due as a result of services rendered.

I have read and understand the above Financial Policy and agree to the conditions listed.

X

Signature of Patient or Parent/Legal Guardian if less than 18 years of age Date

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I authorize payment of Medicare or other health insurance benefits be made on my behalf for any services rendered by Jeanne S. Vedder, M.D., S.C. I authorize the release of necessary medical information to the Health Care Financing Administration and its agents or my health insurance provider to determine these benefits or benefits for related services.

I understand that I may revoke this consent at any time.

PRINT Name of Patient Date

X

Signature of Patient or Parent/Legal Guardian if less than 18 years of age

Please PRINT name of authorized representative and relationship to patient