



World-Class Team. Hometown Choice.

CHARLES A. GATTO, M.D.

NAME: _____

DATE: _____

MRN#: _____

AGE: _____

Please describe your problem: _____

When did this problem start?(approx): _____

Was there an injury?: _____

Have you had unexpected weight loss?: _____

Did this injury result in a lawsuit?: _____

Does the pain wake you from sleep?: _____

Is your bladder/urine function normal?: _____

How far can you walk?(city blocks): _____

Is your bowel/feces control normal? _____

PHYSICIAN ONLY:

Rad Pain- _____

N/P- _____

Weakness- _____

B/B- _____

Gait/Bal- _____

Meds- _____

PT- _____ CH/DO- _____ Accu.- _____

Brace- _____ Tens- _____

Injections: _____

Studies: _____

PE: _____

Assessment- _____

Plan: _____

WHERE IS YOUR PAIN NOW?

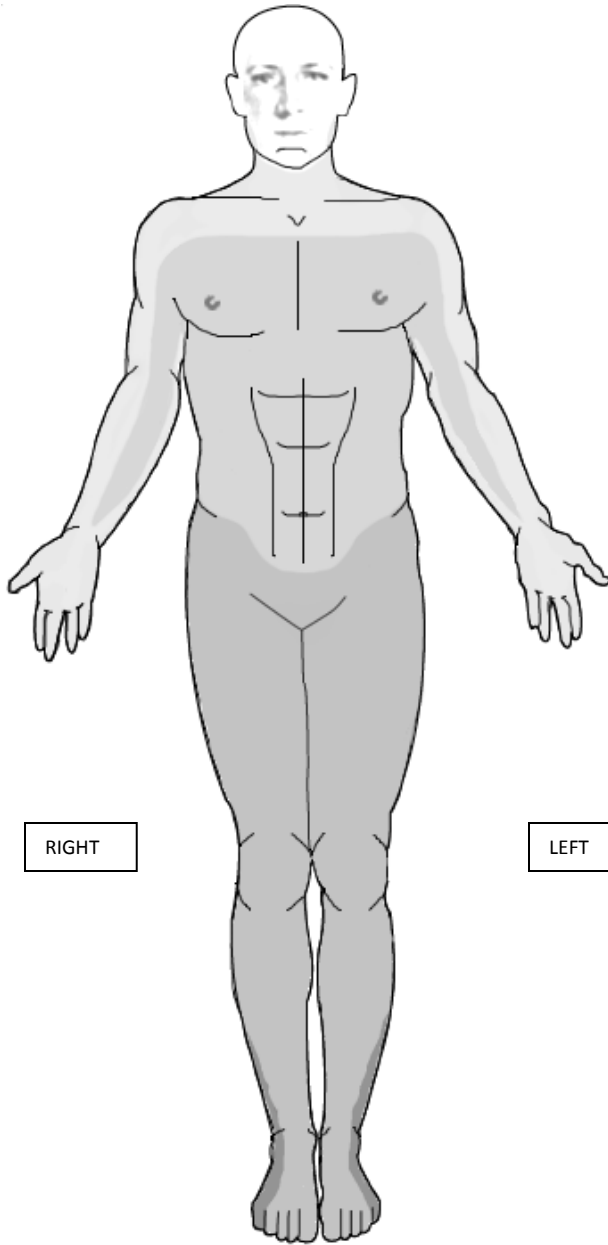
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN x x x x

BURNING + + + +

TINGLING - - -

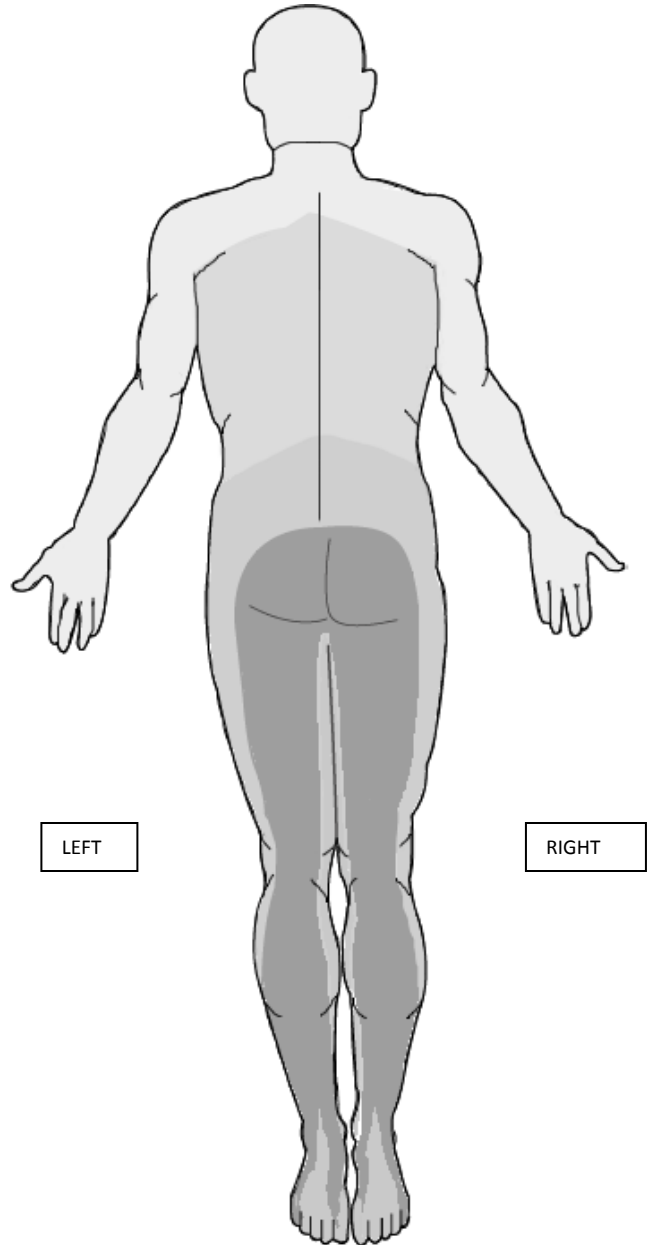
NUMBNESS o o o o



RIGHT

LEFT

FRONT



LEFT

RIGHT

BACK

My number one problem is:

___ back/neck pain

___ arm/leg pain

___ numbness/tingling

___ weakness

CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

GENERAL SYMPTOMS: (CURRENTLY OR WITH IN THE LAST YEAR)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> CHILLS/SWEATS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIVES | <input type="checkbox"/> STOMACH PAIN |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> ANXIETY | <input type="checkbox"/> RASH | <input type="checkbox"/> EXTREME THIRST |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> ITCHING | <input type="checkbox"/> NAUSEA |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> LOSS IF APPETITE | <input type="checkbox"/> SORES | <input type="checkbox"/> BLOATING/GAS |
| <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> LOSS OF WEIGHT | <input type="checkbox"/> EASY BRUISING | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> BLOOD IN URINE | | | |
| <input type="checkbox"/> PAINFUL URINATION | <u>MEN:</u> | <u>WOMEN:</u> | |
| <input type="checkbox"/> BLADDER/URINE ACCIDENTS | <input type="checkbox"/> ERECTILE DIFFICULTIES | <input type="checkbox"/> MENOPAUSE | |
| <input type="checkbox"/> BOWEL/FECAL ACCIDENTS | <input type="checkbox"/> PENILE SORES | <input type="checkbox"/> IRREGULAR MENSES | |
| | <input type="checkbox"/> PAINFUL INTERCOURSE | <input type="checkbox"/> PAINFUL INTERCOURSE | |

GENERAL CONDITIONS: (NOW OR IN THE PAST)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> ALCOHOLISM |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DRUG DEPEND. |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ASTHMA | <input type="checkbox"/> ANOREXIA/BULIMIA | <input type="checkbox"/> SERIOUS INFEC. |
| <input type="checkbox"/> RHEMATOID DZ | <input type="checkbox"/> GOUT | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> SEX. TRANS. DZ |
| <input type="checkbox"/> STROKE | <input type="checkbox"/> STOMACH ULCERS | <input type="checkbox"/> PSYCHIATRIC CARE | <input type="checkbox"/> AIDS/HIV |

PAST MEDICAL HISTORY: (PROBLEMS/CONDITIONS/DISEASES THAT YOU HAVE OR HAVE HAD IN THE PAST)

- | | |
|---|-------|
| <input type="checkbox"/> HEART PROBLEMS | _____ |
| <input type="checkbox"/> LUNG | _____ |
| <input type="checkbox"/> KIDNEY | _____ |
| <input type="checkbox"/> LIVER | _____ |
| <input type="checkbox"/> NEUROLOGIC | _____ |
| <input type="checkbox"/> RHEUMETOID | _____ |
| <input type="checkbox"/> BOWEL | _____ |
| <input type="checkbox"/> THYROID | _____ |
| <input type="checkbox"/> GENITO-URINARY | _____ |
| | _____ |

PAST SURGICAL HISTORY:

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITALIZATIONS: (BESIDES ABOVE SURGERIES)

FOR WHAT PROBLEM?	WHERE?	DATE
_____	_____	_____
_____	_____	_____

MEDICATIONS: (CURRENTLY)

NAME	DOSAGE	NAME	DOSAGE

PHARMACY NAME: _____ PHONE #: _____

ALLERGIES: (ESPECIALLY TO MEDICATION)

MEDICATION	REACTION	MEDICATION	REACTION

ARE YOU ALLERGIC TO: LATEX NICKEL NONE

SOCIAL HABITS:

DO YOU SMOKE? _____ HOW MUCH PER DAY? _____
DO YOU DRINK ALCOHOL? _____ HOW MUCH/HOW OFTEN? _____
DO YOU USE OTHER DRUGS? _____ 3RD WORLD COUNTRY TRAVEL? _____

FAMILY HISTORY:

ARE YOU MARRIED? _____
HOW MANY CHILDREN DO YOU HAVE? _____ AGES: _____
DO ANY FAMILY MEMBERS HAVE OR HAVE HAD ANY SIGNIFICANT MEDICAL PROBLEMS? _____

OCCUPATIONAL HISTORY:

DO YOU CURRENTLY WORK? _____ OCCUPATION: _____
WHO REFERRED YOU TO OUR OFFICE? _____
WHO IS YOUR GENERAL PHYSICIAN? _____
TOWN: _____

*** **WOMEN:** IF YOU MAY BE PREGNANT BE SURE TO TELL THE DOCTOR OR THE TECHNITION PRIOR TO ANY X-RAYS. ***

I CERTIFY THAT THE ABOVE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT'S SIGNATURE: _____ PHYSICIAN'S SIGNATURE: _____



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Social Security # _____ Sex: M F Status: S M W D Spouse Name: _____
Legal Name _____ Date of Birth ___/___/___ Age _____
Address _____ City _____ State _____ Zip _____
Phone _____ Cell _____ Work _____
Email _____
Family Physician _____

Doctor treating you today: McBride Goldman Colizza Goldberger Lombardi Gatto Willis
Montgomery Ginsberg Polesin Tsairis Longworth

Referred by _____

Emergency Contact Name: _____ Phone#: _____

Relation: _____

INJURY/ACCIDENT RELATED TO: () WORK () SCHOOL () MOTOR VEHICLE () OTHER
Date of Injury/Accident ___/___/___ Claim Number _____

PRIMARY INSURANCE INFORMATION

Policyholder's Legal Name _____ Date of Birth ___/___/___
Social Security # _____ Home Phone _____ Work Phone _____
Home Address _____
Employer _____ Occupation _____
Employer's Address _____
Street/PO Box _____ City _____ State _____ Zip Code _____
Insurance Co _____ Effective Date ___/___/___
Group Number _____ ID # _____
Insured's Relationship to Patient _____ Co-Pay Amount _____

SECONDARY INSURANCE INFORMATION

Policyholder's Legal Name _____ Date of Birth ___/___/___
Social Security # _____ Home Phone _____ Work Phone _____
Home Address _____
Employer _____ Occupation _____
Employer's Address _____
Street/PO Box _____ City _____ State _____ Zip Code _____
Insurance Co _____ Effective Date ___/___/___
Group Number _____ ID # _____
Insured's Relationship to Patient _____ Co-Pay Amount _____

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO TRI-COUNTY ORTHOPAEDICS & SPORTS MEDICINE, P.A. AND AUTHORIZE THE FILING OF INSURANCE AND RELEASE INFORMATION NECESSARY FOR COMPLETION OF CLAIMS. I UNDERSTAND THAT ULTIMATELY I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

Signature _____ Date _____

X-RAY REQUEST POLICY

- **It is the policy of this practice that upon request, we will provide you with a copy of your x-rays on a CD disc.**

- **If you need the actual films from your exam, it is always \$15.00 for the entire set. If requesting an older set of films that were not done digitally they are free, but must be returned when you are finished with them. These films which were done in our office are stored for 7 years. After this time period they will be destroyed.**

- **Please be reminded that we need 72 hours to process your request.**

- **Be aware that films not taken in this office are the responsibility of the patient. Please take them with you. They are your property. If left in our facility, they will only be stored for 3 years. After this time period they will be destroyed.**

- **If you are a Worker's Comp patient, please contact your case manager to get authorization for any films to be rendered to you.**

- **If a request for x-rays is submitted. Pick up must be within 30 days otherwise a new request must be submitted.**

Please sign below acknowledging that you have read this policy.

Thank you.

Patient Name

Date



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CONSENT to the USE AND DISCLOSURE OF HEALTH INFORMATION
For the TREATMENT, PAYMENT or HEALTHCARE OPERATIONS

I _____ understand that as part of my treatment, Tri-County Orthopedics
(Patient Name)

originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment.
• A means of communication among any other health professionals who might contribute to my care, i.e.: via facsimile, telephone, etc.
• A source of information for applying diagnosis and surgical information to my account to process for payment.
• A means by which a third-party payer can verify that services billed and accurate and actual.
• As a tool for routine healthcare operations, such as assessing quality, and reviewing the competence of healthcare officials.
• A means by which an insurance appeal at any stage, may be filed.
• I assign all benefits for my medical services to Tri-County Orthopedics.

I understand Tri-County Orthopedics will take care to ensure that any and all information pertaining to me and my treatment at this facility will be handled with an emphasis on maintaining my privacy at all times. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations, and that this facility is not required to agree to these restrictions in the event of an emergency. I understand that I may revoke this consent in writing at any time, but not to the extent the organization has already acted in.

- I authorize Tri-County Orthopedics to release my medical records to the following friend or family member:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Print Name of Patient or Legal Guardian

Signature

Date