Michael I. Goldberger, M.D./Robert T. Goldman, M.D./Claudia L. Ginsberg, M.D.
Paul M. Lombardi, M.D./ Wayne A. Colizza, M.D. /Mark J. McBride, M.D./David M. Epstein, M.D.

______________________________ Patient Name	____ Age	____/____/____ Date of Birth	____/____/____ Today's Date
____ Phone Number			New Patient to the Practice Established Patient to the Practice

Primary Physician: ______________________________ Phone #: _________________________

Cardiologist: __________________________________ Phone #: _________________________

Pharmacy Name: _______________________________ Phone #: _________________________

What is the reason for today's visit? Left ( ) Right ( ) ____

How did this problem occur? ____

When/where did this happen? ____

Have you had X-rays taken for this problem? Yes No If yes, indicate date/place:________________________

Have you had physical therapy for this problem? Yes No If yes, for how long: ____________________________

Have you tried any medications for this problem? Yes No If yes, list names:_________________________________

____

Past Medical History:

Do you have (or have you had) any of the following medical problems? **OR CHECK ❑ NONE**

- ❑ High Blood Pressure
- ❑ Heart Disease (Heart Attack /Stent Placement)
- ❑ Stroke/TIA
- ❑ Arrhythmias/CHF
- ❑ High Cholesterol
- ❑ Migraine Headaches
- ❑ Diabetes
- ❑ Underactive Thyroid
- ❑ Overactive Thyroid
- ❑ Osteoporosis
- ❑ Asthma
- ❑ Seizures
- ❑ Alcoholism/Substance Abuse
- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Breast Cancer
- ❑ Prostate Cancer
- ❑ Ulcers/Stomach Bleeding
- ❑ Kidney Failure/One Kidney
- ❑ Prior History of Sleep Apnea

OTHER Medical History____

Height: ____ft. ____in. Weight: ______lbs.

Have you ever had **a blood clot** or **deep venous thrombosis**? Yes No If yes, please explain:__________

____

Past Surgical History:

Have you had any type of surgery? Yes No If yes, please list: ______________________________________

____

____

Medication Allergies:

Please **list any medication** to which you have an allergy and **explain your reaction**: _______________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Are You Allergic To: ❑ LATEX ❑ NICKEL ❑ NONE

Medications:

Do you regularly take any medications? Yes No If yes, please list: ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Social History:

Occupation: ________________________________ or Current School Name: ____________________________

Do you smoke? No Yes, _____cig/day for _____years

Do you drink alcohol? No Yes, _____drinks/day OR _____drinks/wk OR _____occasional use

Family History:

List any medical problems that run in your family: ____

____

Review: Please check if you currently have any of the following: **OR CHECK ❑ NONE**

☐ Unexpected weight loss?	Yes	No	☐ Diarrhea?	Yes	No
☐ Unexpected weight gain?	Yes	No	☐ Nausea/Vomiting?	Yes	No
☐ Visual changes?	Yes	No	☐ Constipation?	Yes	No
☐ Fevers?	Yes	No	☐ Pain with urination?	Yes	No
☐ Headaches?	Yes	No	☐ Frequent urination?	Yes	No
☐ Cold sores?	Yes	No	☐ Incontinence?	Yes	No
☐ Coughing?	Yes	No	☐ Rashes?	Yes	No
☐ Wheezing?	Yes	No	☐ Breast pain?	Yes	No
☐ Shortness of breath?	Yes	No	☐ Nipple discharge?	Yes	No
☐ Phlebitis?	Yes	No	☐ Lumps in breast?	Yes	No
☐ Chest pains?	Yes	No	☐ Blood sugar problems?	Yes	No
☐ Palpitations?	Yes	No	☐ Thyroid problems?	Yes	No
☐ Leg Swelling?	Yes	No	☐ Severe night sweats?	Yes	No
☐ Mood Changes?	Yes	No	☐ Snoring/Irregular Breathing?	Yes	No
☐ Depression?	Yes	No	☐ Non-Restorative Sleep/Daytime Sleepiness?	Yes	No
☐ Anxiety?	Yes	No			

X____ ____________________________

Patient Signature **Date**

X____ ____________________________

MD Signature **Date**

To be completed by the physician

Date reviewed: ____________ Any Changes? _ Yes _ No _________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No _________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No _________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No _________________________________
MD Signature

Date reviewed: ____________ Any Changes? _ Yes _ No _________________________________
MD Signature

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 ____
Name Address City State Zip Code
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 NECESSAY FOR COMPLETION OF CLAIMS. I UNDERSTAND THAT ULTIMATELY I AM FINANCIALLY RESPONSIBE FOR ALL CHARGES.

Signature ____ **Date** _________________________

TRI-COUNTY
ORTHOPEDICS

World-Class Team. Hometown Choice.

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

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