



World-Class Team. Hometown Choice.

KENNETH MONTGOMERY, M.D.

Name _____ Date of Birth _____ Age _____

Occupation _____ Were you referred here by another physician? Y N

Contact Phone Number _____ If yes, please name _____

ORTHOPEDIC HISTORY

Height _____ Weight _____ Right Handed Left Handed

What is the reason for today's visit (Please Check) Right Left

Neck Shoulder Elbow Wrist Hand Back Hip Knee Ankle/Foot

Duration of Symptoms: _____

Is your present complaint due to an accident? Yes No

If so, please describe: _____

If Unable to work, please give dates: From _____ to _____

Rate your pain from (1- 10, 10 being the most severe): _____

Please describe the nature of pain (circle all that apply): constant intermittent dull sharp burning radiating

Does the pain radiate to any other location? _____

Associated symptoms (circle all that apply):

Clicking Swelling Locking Buckling Stiffness Weakness Difficulty using stairs Numbness/Tingling

Does the pain wake you at night? Yes No

What makes it better? _____

What makes it worse? _____

Have you taken any medications for this problem? _____

Previous treatments/surgeries for this problem? _____

Have you consulted any other physicians for this problem? If yes, who? _____

WHERE IS YOUR PAIN NOW?

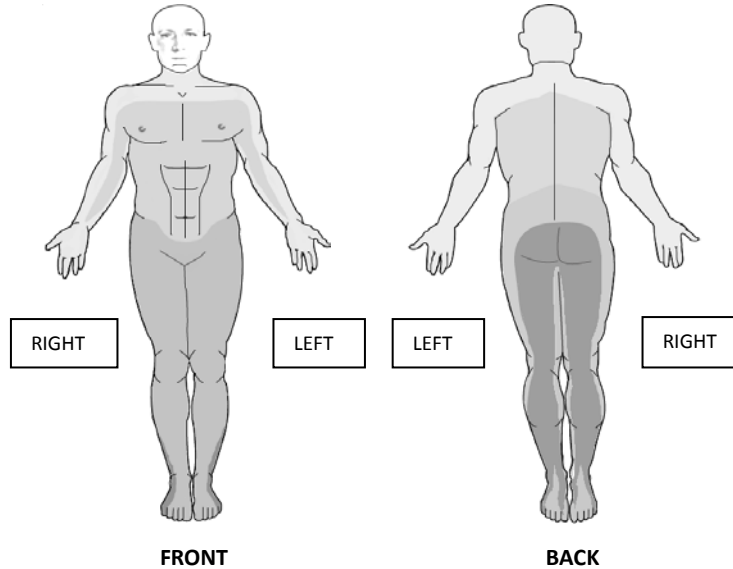
Using the appropriate symbols, mark all of the areas on your body where you feel the sensations described below

PAIN xxxx

BURNING +++++

TINGLING ----

NUMBNESS oooo



Past Medical History: (Please circle any conditions that you have had in the past or have currently)

- | | | |
|---------------------|---------------------------|------------------------------|
| Anemia | Gout | Lung Disease |
| Anxiety | Heart Disease (Type_____) | Arthritis (Type_____) |
| Asthma | Hepatitis | Seizure/Epilepsy |
| Bleeding Disorders | High Blood Pressure | Stroke |
| Cancer (Type _____) | High Cholesterol | Thyroid Disease |
| Depression | HIV/AIDS | Ulcer |
| Diabetes | Kidney Disease | Sexually Transmitted Disease |
| Lyme Disease | Liver Disease | Vision Problem |

Other Medical Problems: _____

Is there any chance that you are pregnant? Yes No

Past Surgical History: (Please List: Surgery & Date of Surgery)

Family Medical History: (Please list any medical conditions seen in the family)

Mother: _____

Father: _____

Siblings: _____

Medications: (Please List)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____
- 9. _____
- 10. _____

Allergies **Y** **N**

- Penicillin
- Sulfa
- Latex
- Other _____
- _____

Pharmacy Name: _____ **Phone #:** _____

Social History

Do you smoke? Yes No
If Yes, how many packs per day? _____ For how many years? _____

Do you drink alcohol? Yes No
If Yes, how often? (Please circle) rarely socially 1 drink/day 2-3 drinks/day 4 or more

Please rate your physical activity level:

- Inactive: Normal activities of daily living
- Light: Some walking, gardening, occasional weekend recreational exercise
- Moderate: Regular (up to 3x per week) moderate exercise, weekend athletics
- Vigorous: Regular (3-5x per week) vigorous exercise and/or athletics weekly
- Intense: Competitive daily vigorous sports training

Review of Symptoms (Have you experienced any of the following symptoms over the past 6 months)

- Unexpected Weight Gain/Loss
- Fatigue/Weakness
- Fever/Chills
- Skin Rash
- Nose/Throat Problems
- Hearing Problems
- Frequent Headaches
- Fainting Spells
- Coordination Problems
- Change in appetite
- Recent respiratory infection
- Chest Pain
- Swollen legs or feet
- Easy Bruising / Bleeding disorders
- Change in Urinary Habits



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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