Mohawk Valley Orthopedics, PC

Patient Name: ______________________________ Date: ________________________

Date of Birth: ________________ Height: __________ Weight: _________ Gender: ______________

Address:____

____

Home Phone: ____________________________ Cell Phone: ______________________________________

SS#:____-____-_____ (needed for insurance purposes) E-Mail: _______________________________________

Marital Status: _____________

Employer's Name & Address:

____

____

Parent's Names (if child): ____

Spouse's Name______________________________ Spouse's Date of Birth: ____________________

Spouse's/Parent's Employer:

____

____

Primary Care Physician: __________________________ **Cardiologist:**

____

Any current medical problems you have (such as high blood pressure, heart problems or diabetes):

____

____

Current Medications: **Pharmacy:**

____

____

____

Medication Allergies:

____

____

Operations:

____

____

Date of last bone density scan: ____________

Do you smoke? _____________ Have you ever? _________________Do you drink alcohol: ____________

Do you have any other problems such as bleeding or kidney trouble?

____

____

Emergency Contact____ **Phone Number:**____________________

Insurance Information

Patient Name: ______________________________ **Primary Insurance:** ____________________________

ID#:_________________________ Group #___________________ Co-Pay Amount________________

Name of Insurance Holder: ______________________________ Insurance Holder's Date of Birth: ______________

Insurance Holder's SS#: ____________________ Insurance Referral Needed? ____________________

Secondary Insurance: ____________________________

ID#:_________________________ Group #___________________Co-Pay Amount ________________

Name of Insurance Holder: ______________________________ Insurance Holder's Date of Birth: ______________

Insurance Holder's SS#: ____________________ Insurance Referral Needed? ____________________

Tertiary Insurance: ____________________________

ID#:_________________________ Group #___________________Co-Pay Amount ________________

Name of Insurance Holder: ______________________________ Insurance Holder's Date of Birth: ______________

Insurance Holder's SS#: ____________________ Insurance Referral Needed? ____________________

Work Injury

Is this a work injury? ____________ Date of Injury: _____________ Working Now? ________________

Claim Number (if available): ______________________________ Is the case still open? ____________

Employer's Name & Address:

____

____

Employer's Work Comp Carrier Name & Address:

____

____

Automobile Accident

Is this an automobile accident? ________Date of Injury: ________________ Claim #: ________________________

No fault Insurance Carrier's Name & Address:

____

____

HEALTH HISTORY

Confidential

Patient Name ______________________________ Today's Date ______________

Age ______ Birthdate ______________ Date of last physical examination ______________

What is your reason for visit? ______________________________

SYMPTOMS Check (✔) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ______________

Date of last Pap Smear ______________

Have you had a mammogram? ______________

Are you pregnant? ______________

Number of children ______________

CONDITIONS Check (✔) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pneumonia
- ☐ Pacemaker
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications or substances
Pharmacy Name Phone	

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following:

✓	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates.________________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

✓	Substance	Amount
	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

✓	Exposure
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

________________________________ ________________

Signature of Patient, Parent, Guardian, or Personal Representative — Date

________________________________ ________________

Please print name of Patient, Parent, Guardian, or Personal Representative — Relationship to Patient

________________________________ ________________

Reviewed By — Date

INSURANCE AUTHORIZATIONS SHEET

MOHAWK VALLEY ORTHOPEDICS, P.C.
Russell Cecil, MD, Ph.D.   Gerald J Ortiz, MD   Jian Shen, MD, Ph.D. Joseph Popper, MD
5010 State Highway 30, Suite 205, Amsterdam, N.Y. 12010/ (518) 842-2663 Fax (518) 842-4861
434 S. Kingsboro Ave, Suite 102, Johnstown, NY 12095 / (518)773-4242 Fax (518) 842-4861

SIGNATURE ON FILE

- ✓ I authorize use of this form for all my insurance submissions.
- ✓ I authorize release of information to all my Insurance Companies/Payers.
- ✓ I understand I am responsible for my co-pays and bill if insurance does not pay.
- ✓ I authorize my doctor to act as my agent in helping me obtain payment from my insurance company.
- ✓ I authorize payment direct to my doctor.
- ✓ I permit a copy of this authorization to be used in place of the original.

Name:____

Signature:____**Date:**______________________

ONE TIME AUTHORIZATION TO AUTHORIZE PAYMENT OF MEDICARE BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Name:____**Medicare #**____________________

Signature:____**Date:**______________________

MEDIGAP ASSIGNMENT OF BENEFITS

Name of Beneficiary: ____

Medicare Insurance #:______________________________

Medigap Insurer: ______________________________________Medigap Policy #: _______________

I request that payment of authorized Medigap benefits be made either to me or on my behalf to *Mohawk Valley Orthopedics, P.C.* (Russell N.A. Cecil, M.D., Ph.D.; Gerald J. Ortiz, M.D.; Jian Shen, M.D., Ph.D. and/or providers in their employ) for any services furnished to me by them. I authorize any holder of medical information about me release to:

____any information needed
To determine these benefits payable for related services.

4/18/18 mbm