

2 of 3: Your medical history

Past problems

Please describe your past orthopaedic problems

Current medications

Please list any medications you are currently taking, including dosage and frequency (include oral contraceptives)

Past surgery

Please list any major surgical procedures you've had

1.	Date
2.	Date
3.	Date
4.	Date
5.	Date
6.	Date

Have you ever had any complications from anesthesia? Yes No

Allergies

Are you allergic to any medication / drug? Yes No

If yes, please specify

Illnesses

Please check any that you have been diagnosed with:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder problems	<input type="checkbox"/> Emotional problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Immunological disorder	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Thyroid	

Describe any checked:

Symptoms

Please check any that you have or ever had:

<input type="checkbox"/> Anesthesia problems	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Swelling of hands
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Fever / Chills	<input type="checkbox"/> Shortness of breath	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Headaches	<input type="checkbox"/> Swelling of ankles / feet	

Family history

Has anybody in your family ever suffered from any of the following:

<input type="checkbox"/> Cardiac history	<input type="checkbox"/> Joint problems	<input type="checkbox"/> Major anesthesia problems
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Other considerations

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily usage	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Daily usage
Do you use street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type	Daily usage	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No

3 of 3: Your insurance details

Primary insurance information

Insurance name		
Your contract or ID number		
Attention		
Address		
City	State	Zip
Phone		

Secondary insurance information

Insurance name		
Your contract or ID number		
Attention		
Address		
City	State	Zip
Phone		

Primary subscriber information

Last	First	Initial
Address		
City	State	Zip
Social Security		
DOB	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Employer	Phone	

Secondary subscriber information

Last	First	Initial
Address		
City	State	Zip
Social Security		
DOB	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Employer	Phone	

If work injury

Employer at time of injury	Phone		
Address	City	State	Zip
Employer's workers compensation carrier	Phone		
Address	City	State	Zip
Date of injury	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of disability	
Carrier Case Number	WCB number		

If motor vehicle injury

Insurance name	Policy number	Claim number	
Address	City	State	Zip

If school / sport injury

School name			
Address	City	State	Zip

Statement to release information and authorize payment of benefits. **SIGN BELOW**

Commercial insurance I hereby consent to Greater Rochester Orthopaedics, PC using and/or disclosing my protected health information ("PHI") for my care, payment for my care and the Practice's health care operations, and for such other uses that are permitted or required under federal or state law without my consent or authorization. Specifically, I authorize release of information necessary to file a claim with my insurance company and assign payment of benefits to the physician indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event of my failure to pay any sums due and

my account is referred to an attorney for collection, I agree to be responsible for reasonable attorney's fees. A copy of my signature below is as valid as the original.

Medicare I further certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.

Signature:

Date: