

**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.

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills  <input type="checkbox"/> Depression  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Fainting  <input type="checkbox"/> Fever  <input type="checkbox"/> Forgetfulness  <input type="checkbox"/> Headache  <input type="checkbox"/> Loss of sleep  <input type="checkbox"/> Loss of weight  <input type="checkbox"/> Nervousness  <input type="checkbox"/> Numbness  <input type="checkbox"/> Sweats</p> <p><b>MUSCLE/JOINT/BONE</b>                  Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms      <input type="checkbox"/> Hips  <input type="checkbox"/> Back      <input type="checkbox"/> Legs  <input type="checkbox"/> Feet      <input type="checkbox"/> Neck  <input type="checkbox"/> Hands      <input type="checkbox"/> Shoulders</p> <p><b>GENITO-URINARY</b></p> <p><input type="checkbox"/> Blood in urine  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Lack of bladder control  <input type="checkbox"/> Painful urination</p>	<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite poor  <input type="checkbox"/> Bloating  <input type="checkbox"/> Bowel changes  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Excessive hunger  <input type="checkbox"/> Excessive thirst  <input type="checkbox"/> Gas  <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> Indigestion  <input type="checkbox"/> Nausea  <input type="checkbox"/> Rectal bleeding  <input type="checkbox"/> Stomach pain  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Vomiting blood</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Irregular heart beat  <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> Poor circulation  <input type="checkbox"/> Rapid heart beat  <input type="checkbox"/> Swelling of ankles  <input type="checkbox"/> Varicose veins</p>	<p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding gums  <input type="checkbox"/> Blurred vision  <input type="checkbox"/> Crossed eyes  <input type="checkbox"/> Difficulty swallowing  <input type="checkbox"/> Double vision  <input type="checkbox"/> Earache  <input type="checkbox"/> Ear discharge  <input type="checkbox"/> Hay fever  <input type="checkbox"/> Hoarseness  <input type="checkbox"/> Loss of hearing  <input type="checkbox"/> Nosebleeds  <input type="checkbox"/> Persistent cough  <input type="checkbox"/> Ringing in ears  <input type="checkbox"/> Sinus problems  <input type="checkbox"/> Vision - Flashes  <input type="checkbox"/> Vision - Halos</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily  <input type="checkbox"/> Hives  <input type="checkbox"/> Itching  <input type="checkbox"/> Change in moles  <input type="checkbox"/> Rash  <input type="checkbox"/> Scars  <input type="checkbox"/> Sore that won't heal</p>	<p><b>MEN only</b></p> <p><input type="checkbox"/> Breast lump  <input type="checkbox"/> Erection difficulties  <input type="checkbox"/> Lump in testicles  <input type="checkbox"/> Penis discharge  <input type="checkbox"/> Sore on penis  <input type="checkbox"/> Other</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal Pap Smear  <input type="checkbox"/> Bleeding between periods  <input type="checkbox"/> Breast lump  <input type="checkbox"/> Extreme menstrual pain  <input type="checkbox"/> Hot flashes  <input type="checkbox"/> Nipple discharge  <input type="checkbox"/> Painful intercourse  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Other</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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**CONDITIONS** Check (✓) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS  <input type="checkbox"/> Alcoholism  <input type="checkbox"/> Anemia  <input type="checkbox"/> Anorexia  <input type="checkbox"/> Appendicitis  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bleeding Disorders  <input type="checkbox"/> Breast Lump  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> Bulimia  <input type="checkbox"/> Cancer  <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency  <input type="checkbox"/> Chicken Pox  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Emphysema  <input type="checkbox"/> Epilepsy  <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Goiter  <input type="checkbox"/> Gonorrhea  <input type="checkbox"/> Gout  <input type="checkbox"/> Heart Disease  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Hernia  <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol  <input type="checkbox"/> HIV Positive  <input type="checkbox"/> Kidney Disease  <input type="checkbox"/> Liver Disease  <input type="checkbox"/> Measles  <input type="checkbox"/> Migraine Headaches  <input type="checkbox"/> Miscarriage  <input type="checkbox"/> Mononucleosis  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Mumps  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem  <input type="checkbox"/> Psychiatric Care  <input type="checkbox"/> Rheumatic Fever  <input type="checkbox"/> Scarlet Fever  <input type="checkbox"/> Stroke  <input type="checkbox"/> Suicide Attempt  <input type="checkbox"/> Thyroid Problems  <input type="checkbox"/> Tonsillitis  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Typhoid Fever  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Vaginal Infections  <input type="checkbox"/> Venereal Disease</p>
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<b>MEDICATIONS</b> List medications you are currently taking.	<b>ALLERGIES</b> 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	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS			PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS		
Check (✓) which substances you use and describe how much you use.		
		Caffeine
		Tobacco
		Street Drugs
		Other

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate dates. \_\_\_\_\_

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

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