MOHAWK VALLEY ORTHOPEDICS, P.C.

PATIENT NAME:_____ DATE:_____

Date of Birth:_____ Height:_____ Weight:_____ Gender:_____

Primary Care Physician:_____ Cardiologist:_____

Reason for Appointment:_____

ILLNESSES: ☐ High Blood Pressure ☐ Heart Problems ☐ Diabetes

Current medical problems you have: _____

_____

Medications you are currently taking: _____

_____

_____

Medication Allergies: _____

Operations: _____

_____

_____

Marital Status: _____ Do you smoke? _____ Have you ever smoked?_____

Date of last Bone Density (Dexascan) test: _____ Do you drink alcohol? _____

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

_____

MOHAWK VALLEY ORTHOPEDICS, P.C. CHART COVER SHEET
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PATIENT NAME:_____ **DATE:**_____

Address:_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Emergency Contact Name:_____ **Daytime Phone Number:**_____

Employer's Name & Address:

_____

_____

Parents' Names (If Child):_____

Spouse's Name:_____ **Spouse's Date of Birth:**_____

Spouse's/Parents' Occupation & Employer:

_____

_____

REGULAR INSURANCE INFORMATION

PRIMARY INSURANCE:_____

ID #_____ **Group #**_____ **Co-Pay Amount**_____
Name of Insurance Holder:_____ **Insurance Holder's Date of Birth:**_____
Insurance Holder's Social Security Number:_____ **Insurance Referral Needed?**_____

SECONDARY INSURANCE:_____
ID #_____ **Group #**_____ **Co-Pay Amount**_____
Name of Insurance Holder:_____ **Insurance Holder's Date of Birth:**_____
Insurance Holder's Social Security Number:_____ **Insurance Referral Needed?**_____

TERTIARY INSURANCE:_____
ID #_____ **Group #**_____ **Co-Pay Amount**_____
Name of Insurance Holder:_____ **Insurance Holder's Date of Birth:**_____
Insurance Holder's Social Security Number:_____ **Insurance Referral Needed?**_____

WORK INJURY

WORK INJURY?_____ **Date of Injury:**_____ **Working Now?**_____

Employer's Name & Address:_____

Employer's Work Comp Carrier Name & Address:

_____

_____

AUTOMOBILE ACCIDENT

AUTOMOBILE ACCIDENT?_____ **Date of Injury:**_____ **Working Now?**_____

No-Fault Insurance Carrier's Name & Address:_____

_____

5/23/13 jv

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
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ 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
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ 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.

_____

_____

_____

_____

_____

Pharmacy Name Phone

ALLERGIES List allergies or reactions to drugs.

All information is strictly confidential

Family History

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	

Medications

Allergies

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

If yes, please give approximate dates. _____

Habits

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Work

	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.
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.

5/22/18 jv

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, understand that as part of my healthcare, Mohawk Valley Orthopedics, P.C. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means to facilitate communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided
- A tool for healthcare operations of Mohawk Valley Orthopedics, P.C. such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of Mohawk Valley Orthopedics, P.C.'s treatment, payment, or healthcare operations it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand and have been offered and/or provided with a *NOTICE OF PRIVACY PRACTICES* that provides a more complete description of how Mohawk Valley Orthopedics, P.C. may use and disclose my protected healthcare information. I further understand that Mohawk Valley Orthopedics, P.C. reserves the right to change its *NOTICE OF PRIVACY PRACTICES*. Should Mohawk Valley Orthopedics, P.C. change its *NOTICE OF PRIVACY PRACTICES*, an amended copy will be sent to the address I have provided.

I agree that Mohawk Valley Orthopedics, P.C. may do the following unless I specifically give direction prohibiting such activity:

Send visit reminders and test results to the address I have provided.
Send routine correspondence, such as billing statements, to the address I have provided.
Leave messages on an answering machine, voice mail, or e-mail associated with the telephone numbers or e-mail address I have provided to either confirm appointments or to request that I call the Practice on medical or billing matters.

_____
Patient Signature or Signature of Personal Representative

_____
Date

FOR OFFICE USE ONLY
[ ] Receipt received by _____
[ ] Patient refused to sign receipt _____
(Signature of Practice Representative)

5/21/13 jv