{{BARCODELEFTRIGHT}}


# *New Patient Packet*

*Thank you for choosing Orozco Orthopaedics. Welcome to our practice.*

**Prior to your appointment**

- You will receive an automated text message, phone, or email 48 hours prior to your appointment to check in.
- If you are unable to keep your confirmed appointment, please call our office to reschedule your visit to suit your needs.
- Our telephone hours are 8:00am – 4:00pm Monday – Friday. Our staff will be happy to assist you by calling 609-300-7779, FAX 833-905-2603.
- Visit our website at *www.OrozcoOrtho.com* to become more familiar with our office locations, surgical site locations, and services provided.
- If you require a referral, one must be received prior to your office visit. It must be an 'insurance referral'. Please contact your primary care provider to submit request on your behalf.

**The day of your appointment**

- Please arrive on time to complete any forms, collect copays, and confirm any demographic information.
- Bring your insurance card(s) and a photo ID. If for any reason you do not have a copy of your insurance card, please contact your insurance carrier prior to your arrival and bring proof of eligibility to your appointment.
- It is your responsibility to notify us immediately if you should change your insurance carrier during your treatment as this can affect copays and authorizations.
- Cash, credit/debit card, money order or personal check up to $500 are accepted for your co-payment required by your insurance company or unmet deductible.

{{BARCODELEFTRIGHT}}

**FINANCIAL POLICY**

Orozco Orthopaedics is committed to providing you the best medical care. We believe a clear understanding of our Financial Policy is essential to our professional relationship. Additionally, your commitment to your account is just as significant as your participation with your health care.

The following information outlines financial responsibilities related to payment for professional services provided by our physicians and staff. If you have any questions or concerns, please do not hesitate to ask a member of our staff for clarification.

**FINANCIAL RESPONSIBILITY**

Orozco Orthopaedics requires a copy of any insurance information and photo identification prior to treatment. You, the patient, or guardian, are ultimately responsible for all charges associated with your care regardless of insurance coverage. If you have insurance, please remember that your insurance policy is a contract between you and your insurance company and that you have final responsibility for payment of your bill. For your convenience, our office accepts cash, check, Visa, MasterCard, American Express and money order. Payment can be made in person, over the phone, or through your Athena patient portal account.

**Self-Pay.** If you do not have health insurance, payment is expected at the time of service, unless other arrangements have been made prior to treatment. A **$275.00 payment** is required at the time of your visit for all self-pay patients. This payment will be applied to your initial visit. In the event your balance exceeds the initial payment you will be balance billed at the time of service. However, if your balance is less than the initial payment the balance will be refunded to you. In the event that surgery is necessary, we must receive a down payment in the ***amount of 50% of the estimated doctor's fees before the surgery can be scheduled then paid in full before surgery.***

**Insurance Billing**: It is your responsibility to know your benefits both in and out of network and how they will apply to your treatment by the doctor. Orozco Orthopaedics will follow the insurance contract guidelines for billing and collections. Please verify if Orozco Orthopaedics is a preferred provider with your insurance plan prior to receiving services as well as Tier status. You will be fully responsible for all charges incurred if you receive treatment without verifying Orozco Orthopaedics is a preferred provider for your insurance.

**Eligibility**: Athena Health is our Electronic Medical Records system which utilizes real-time eligibility verification with your insurance and its use is required at each visit. In addition to eligibility, the system is designed to improve transparency around costs of care. It does so by providing Orozco Orthopaedics patients estimates of patient responsibility based on information received through integration with your insurance company and the day's estimated charges. Orozco Orthopaedics will contact your insurance directly or utilize their provider portal as necessary to determine eligibility and benefits as well as estimated charges for medical services.

**PAYMENT IS DUE AT TIME OF SERVICE**

- All co-pays, deductibles and non-covered services are due at the time of services, unless you have made payment arrangements with our billing office prior to your appointment.
- Insurance required co-pays are due when you check in for your appointment. If you arrive without your co-pay, you may be asked to reschedule.
- If your co-pay is based upon a percentage, and you do not have a secondary policy, please be prepared to pay your percentage.

- Patient responsible balances are due when you check in for your appointment.
- If you have an outstanding balance you will be informed of such at check-in and will be asked for payment.
- All charges are estimates until the Explanation of Benefits EOB is confirmed.

**PROOF OF INSURANCE**

- Please bring your insurance card with you to each appointment.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party—auto insurance, liability insurance company, workers' compensation— instead of your regular health insurance carrier.
- We will bill benefit assigned claims to your health insurance carrier for all services provided by our office. Should your insurance company reimburse you directly, we expect payment from you in full within ten (10) days of the receipt of payment.
- It is your responsibility to notify the practice of changes in your health insurance.
- It is our obligation under many insurance contracts to report patients who repeatedly refuse to pay copayments and/or deductibles at time of service.

**REFERRAL POLICY**

The patient has the responsibility to obtain a referral from the primary care physician to visit a specialist, such as our orthopaedic office. All referrals are expected to be presented prior to being seen. We will do our best to assist you through the referral process. If we are contractually obligated to obtain a referral, we will abide by the terms of your insurance. Please obtain the referral prior to your visit to avoid the possibility of being rescheduled. Most HMOs and Tricare Prime require referrals prior to treatment.

**NON-PARTICIPATING INSURANCES**

If you have insurance in which Orozco Orthopaedics does not participate or you are seeking treatment outside your network, payment is due at the time of service. Our billing department will assist you in filing a claim with your insurance company for services rendered as a courtesy.

**WORKERS' COMPENSATION**

If your treatment related to a workers' compensation injury, we would need authorization from your compensation carrier before your appointment. No payment will be due from you unless your claim has already been denied. If you neglect to inform us that you have an active worker's compensation claim, this may delay your treatment and/or may not be able to be seen at our practice without authorization from your adjuster.

**MOTOR VEHICLE**

Orozco Orthopaedics bills third party carriers as a courtesy. If you have been involved in an automobile accident and have health insurance that we participate in, you will need a signed letter of subrogation from your insurance company authorizing payment for your injuries. If you do not have health insurance, payment is expected at the time of service.

**LITIGATION**

Active liability action against someone else is not a reason to delay payment to us. Litigations may go on for several years. We will bill your health insurance if you have coverage; be sure you have signed an agreement with your health insurance so they will pay (subrogation). If you do not have health insurance coverage, we will expect payment from you for all charges incurred.

**PAST DUE AND COLLECTION ACCOUNTS**

If your account is past due or has been turned over to a collection agency, you will be subject to the full amount outstanding plus any applicable collection agency fees. Collection agency fees can range from 20-30% more than your original balance. Our billing department is more than willing to work out payment arrangements to prevent your account from being forwarded to a collection agency.

**RETURNED CHECK FEES**

All returned checks will be subject to a $25.00 NSF fee.

**NO SHOWS**

Please note that we waive No Show Fee for the first missed visit and charge $25.00 for all subsequent missed visits unless your appointment has been cancelled 24 hours prior to your scheduled appointment. Our patients' time is very important to us, and we feel that arriving on time is an integral part of the physician staying on schedule. In addition, it is frustrating to both patient and doctor when we have no appointments available, yet the physician is expecting a patient that does not show up for his/her appointment. We appreciate your understanding.

**SURGERY DEPOSITS**

Deposits are due in full prior to the scheduled procedure. Deposit amounts vary based on your share of costs and include any unpaid deductible or co-insurance. Our office will reach out to you approximately 10-14 days prior to surgery to review patient responsibility. If not able to pay in full, 3 installments payment plan will be established by signing a credit card auth to keep card on file to be billed automatically per payment plan. If Orozco Orthopaedics receives a payment from payer for a balance that the patient has paid, a refund will be sent to the patient. Hardship policy is determined on a case-by-case situation and to be discussed with Dr. Orozco prior to signing any agreement plan. Orozco Orthopaedic charges only for professional services provided by your physician and physician assistant. You will receive separate billing from the facility where your procedure is performed, the anesthesiologists, pre-admission testing, additional testing (ex. Stress test), diagnostic testing facilities, and other assistants that your surgeon may require.

**Durable Medical Equipment (DME)**: DME is provided as ordered by your physician. A limited amount of DME items will be dispensed in office depending on insurance & individual item. Your insurance will be billed in accordance to your insurance coverage guidelines; however, you will be responsible for any unmet deductible and co-insurance rates. Some insurances require the patient portion of the DME cost to be paid at the time of dispensing. If the DME product is not covered by insurance, you will be notified of the item and its cost. DME is intended for single patient use only and is not subject to returns or refunds. Patients will be required to sign proof of delivery and an Advanced Beneficiary Notic of Noncoverage (ABN) should their insurance not cover the DME.

**Medical Records**: All Medical Record requests are subject to a clinical preparation fee of $10.00. Reports from outside diagnostic facilities can be provided by our office, however, imaging must be obtained by the performing entity. The actual cost of shipping and handling will be added if applicable.

{{BARCODELEFTRIGHT}}

**Forms**: At this time Orozco Orthopaedics does not charge for forms completion. However we reserve the right to change this policy at any time.

**Referrals for Physician & Ancillary Services**: When being referred to an outside organization as part of your care (i.e. Physical Therapy, MRI, DME Providers, Physicians, etc.), Orozco Orthopaedics does not verify if these organizations are preferred providers with your insurance plan. Please verify this directly with your insurance company prior to obtaining services.

If you choose to seek care at a non-preferred/non-participating provider for ancillary services, you may be responsible for higher copayments and costs in excess of your insurance company's allowable amounts, up to the non-preferred provider's total billed charges. Patients accept the financial responsibility for any additional cost for service when obtaining services from a non-preferred/non-participating provider regardless of being referred by Orozco Orthopaedics. For assistance locating a preferred provider for ancillary services, you may contact your insurance company directly.

**Returned Checks**: A $25.00 fee will be charged for any returned checks. We will be unable to accept your check for any services thereafter.

**Outside Collections and Payment Plans**: If unable to make payment in full, contact the billing department immediately to make payment arrangements. If the account is referred for collections, you will be responsible for the balance of your account plus a collection agency charge of 25% of the balance and reasonable attorney's fees. If your account becomes delinquent or is referred for collections, your provider and/or any collection agent of your provider has authorization to obtain your credit report to assist them in the collection of your bill.

**DIAGNOSTIC TESTING RESULTS**

You may be sent to have diagnostic testing preformed (MRI, CT-scan, bone scan, lab work). It is the patient's responsibility to return to the office to receive the results of any diagnostic testing. Testing is completed at an outside facility. It is the patient's responsibility to obtain the results of all tests in addition to ensuring all outside results are sent to the Physician's office prior to the follow up appointment. Orozco Orthopaedics has access to AtlantiCare, Atlantic Medical Imaging, LabCorp, and Quest Diagnostics. All other testing sites should fax reports to 833-905-2603.

**DME ACKNOWLEDGEMENT OF DRIVING IMPAIRMENT**

While under the care of your Physician, you may be fitted into Durable Medical Equipment (DME). While the DME is to be utilized to protect or support your condition, by wearing the DME, it may impair your ability to operate automotive vehicles. If you are not able to operate a vehicle safely due to the use of your DME, please arrange for proper transportation and use the proper precautions. If you have any questions regarding this matter, please ask your Physician.

**VISCOSUPPLEMENTATION**

During your treatment, hyaluronic acid or Viscosupplementation injections may be suggested. We will determine your benefit coverage, determine if prior authorization is required and if your insurance has a preferred brand of medication. In the event it is determined that your deductible applies, you are responsible for such costs if you wish to proceed with these injections. If you are changing your insurance, please do not schedule a series of injections during the transition period as this will affect payment, authorization, brand, and coverage of this treatment. Changing your insurance during a series may result in a delay in serves or the inability to complete the series.

{{BARCODELEFTRIGHT}}

**NOTICE OF PRIVACY PRACTICES**

Your agreement only acknowledges that we have made available for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

HIPAA POLICY NOTICE OF PRIVACY PRACTICES This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, Orozco Orthopaedics, LLC has prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. 1999 New Road, Suite B, Linwood, NJ 08221 Phone (609) 300-7779 FAX (833) 905-2603 517 Route 72 W, Suite E, Manahawkin, NJ 08050 www.OrozcoOrtho.com

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you.

We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative location. The right to obtain a paper copy of this notice from us upon request. The right to inspect and copy your protected information. The right to amend your health information. The right to obtain a paper copy of this notice from us upon request. This notice is effective as of April 1, 2020, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve

the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain.

We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

**Please contact the following for more information:**

The U.S. Department of Health & Human Services Office of Civil Rights

200 Independence Avenue,

S.W. Washington, D.C. 20201

(202) 619-0257 Toll Free: 1-877-696-6775

{{BARCODELEFTRIGHT}}

**OROZCO ORTHOPAEDIC OPIOID PAIN MANAGEMENT AGREEMENT**

During your treatment, your provider may prescribe a controlled substance, which is a type of medication that is regulated by State and/or Federal Government. By accepting the prescription, you are agreeing to follow the Orthopaedic Opioid Pain Management Agreement. The purpose of this Agreement is to prevent misunderstandings about certain medications and to help you and your provider comply with the laws regarding controlled pharmaceuticals.

**If you are under the care of a pain management provider, it is your responsibility to inform them you are to undergo surgery and may require adjustments to your pain management regimen and may require higher doses than our team can safely prescribe.**

I, the patient, understand that I have the following responsibilities:

- I am aware that there is a risk of addiction to opioid/narcotic pain medications.
- I will take the medications only at the dose, frequency, and route as prescribed for the shortest duration needed to control my postoperative pain.
- I understand that while I am under the care of Orozco Orthopaedics and as part of the coordination of my care, I will disclose and discuss all Opioid prescription medications that I am taking from other physicians.
- I will protect my opioid/narcotic pain prescriptions and medications. I will keep them out of the reach of children and pets and will place them in a secure location to prevent theft.
- I understand that lost and/or destroyed medications will not be replaced.
- I understand that Orozco Orthopaedics does not order controlled medication for long-term chronic pain management.
- I will not share, sell, or trade my opioid/narcotic pain medications with anyone. I understand this is a violation of federal and state law.
- I will not drive or operate heavy machinery while under the influence of medications that may impair my judgement. I will make arrangement for alternative transportation.
- I will dispose of all unused medications in accordance with FDA regulations.
- I understand that Orozco Orthopaedics complies with the state of New Jersey guidelines for prescribing controlled substances including reviewing the NJPMP prior to prescribing narcotics.

{{BARCODELEFTRIGHT}}


**Signature Page**

By initialing & signing below, you are acknowledging that you have received, read, and agree to Orozco Orthopaedics Policies.

| Initial Each Line | |
|---|---|
| | **Financial Policy (attached)**<br>I have read the Financial Policy. I understand and agree to this Financial Policy. |
| _____ | **Notice of Privacy Practice (attached)**<br>I hereby acknowledge the receipt of the Notice of Privacy Practices. |
| _____ | I have read and understand the Viscosupplementation acknowledgement |
| _____ | I have read and understand the Opioid Prescription Agreement |
| _____ | I have read and understand the Diagnostic Testing Results and DME acknowledgement Policy |
| _____ | I have reviewed my patient FACESHEET. I confirm it is complete and accurate. |
| _____ | I hereby assign my insurance benefits to be paid directly to the healthcare provider |
| _____ | I authorize Orozco Orthopaedics to release medical information required to process my claim |
| _____ | I consent to Text Messaging (SMS rates may apply) |
| _____ | I consent to Leaving a voicemail |
| _____ | I consent to treatment by Orozco Orthopaedics, I have the right to refuse any treatment or procedure |
| | I authorize Orozco Orthopaedics to obtain/have access to my medication history |
| _____ | I authorize Orozco Orthopaedics to submit Personal Health Information at my request needed to process my disability forms. |
| _____ | |

**Signature of Patient or Responsible Party** _____

**Printed Name** _____

**Date** _____

{{BARCODELEFTRIGHT}}

**Please review and update the information below to the best of your ability. **

## Patient Registration

| CURRENT PATIENT INFORMATION -- PLEASE PRINT | Guarantor Information (to whom statements are sent) |
|---|---|
| Last Name: **{{PATIENTLASTNAME}}** | Name: **{{GUARANTORFIRSTNAME}} {{GUARANTORMIDDLEINITIAL}} {{GUARANTORLASTNAME}}** |
| First Name: **{{PATIENTFIRSTNAME}}** | Address: **{{GUARANTORADDRESS}}** |
| Middle Name: **{{PATIENTMIDDLEINITIAL}}** | **{{GUARANTORCITY}}, {{GUARANTORSTATE}} {{GUARANTORZIP}}** |
| Address: **{{PATIENTADDRESS1}}** | Relationship to patient: _____ |
| City: **{{PATIENTCITY}}** State: **{{PATIENTSTATE}}** | Date of Birth: **{{GUARANTORDOB}}** |
| Zip: **{{PATIENTZIP}}** | Social Security No.: **{{GUARANTORSSN}}** |
| Home Phone: **{{PATIENTHOMEPHONE}}** | Phone: (  ) _____ - _____ |
| Work Phone: **{{PATIENTWORKPHONE}}** | Emergency Contact Information |
| Mobile Phone:**{{PATIENTMOBILEPHONE}}** | Name: **{{PATIENTCONTACTNAME}}** |
| Sex: **{{PATIENTSEX}}** | Relationship: **{{PATIENTCONTACTRELATIONSHIP}}** |
| Date of Birth: **{{PATIENTDOB}}** | Phone: **{{PATIENTCONTACTPHONE}}** |
| Social Security No.:**{{PATIENTSSN}}** | Mobile Phone:(  ) _____ - _____ |
| Patient email: **{{PATIENTEMAIL}}** | |
| Required by government mandate [although you may refuse]: | Employer information |
| Language: **{{PATIENTLANGUAGE}}** | Employer: **{{PATIENTEMPLOYERNAME}}** |
| Race: **{{PATIENTRACE}}** | Address: **{{PATIENTEMPLOYERADDRESS}} {{PATIENTEMPLOYERCITY}} {{PATIENTEMPLOYERSTATE}} {{PATIENTEMPLOYERZIP}}** |
| Ethnicity: **{{PATIENTETHNICITY}}** | Phone: **{{PATIENTEMPLOYERPHONE}}** |
| Marital Status: **{{PATIENTMARITALSTATUS}}** | |
| Other | Pharmacy Information: |
| Patient Referred by: | Name: |
| Primary Care Provider: | Crossroads: |
| Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email | Phone: |
| Primary Insurance Information | Secondary Insurance Information |
| Insurance Plan Name: **{{PATIENTINSURANCE1NAME}}** | Insurance Plan Name: **{{PATIENTINSURANCE2NAME}}** |
| Last Name:**{{PATIENTINSURANCE1POLICYHOLDERLASTNAME}}** | Last Name: **{{PATIENTINSURANCE2POLICYHOLDERLASTNAME}}** |
| First Name: **{{PATIENTINSURANCE1POLICYHOLDERFIRSTNAME}}** | First Name.: **{{PATIENTINSURANCE2POLICYHOLDERFIRSTNAME}}** |
| Middle Name: **{{PATIENTINSURANCE1POLICYHOLDERMI}}** | Middle Name:**{{PATIENTINSURANCE2POLICYHOLDERMI}}** |
| Address: **{{PATIENTINSURANCE1POLICYHOLDERADDRESS}}** | Address: {{PATIENTINSURANCE2POLICYHOLDERADDRESS}} |
| City: **{{PATIENTINSURANCE1POLICYHOLDERCITY}}** State: **{{PATIENTINSURANCE1POLICYHOLDERSTATE}}** Zip: **{{PATIENTINSURANCE1POLICYHOLDERZIP}}** | City: **{{PATIENTINSURANCE2POLICYHOLDERCITY}}** State: **{{PATIENTINSURANCE2POLICYHOLDERSTATE}}** Zip: **{{PATIENTINSURANCE2POLICYHOLDERZIP}}** |
| Date of Birth: **{{PATIENTINSURANCE1POLICYHOLDERDOB}}** Sex (please circle): **M** or **F** | Date of Birth: **{{PATIENTINSURANCE2POLICYHOLDERDOB}}** Sex (please circle): **M** or **F** |
| Employer Name: **{{PATIENTINSURANCE1EMPLOYERNAME}}** | Employer Name: **{{PATIENTINSURANCE1EMPLOYERNAME}}** |
| Patient's relationship to policy holder:**{{PATIENTINSURANCERELATIONSHIPTOINSURED1}}** | Patient's relationship to policy holder:**{{PATIENTINSURANCERELATIONSHIPTOINSURED2}}** |

**To the best of my knowledge the above information is complete and accurate.**

**Signature** _____ **Date** _____

{{BARCODELEFTRIGHT}}

Patient Health History Form

PLEASE PRINT ALL INFROMATION

| | |
|---|---|
| NAME: DOB: | |
| What is your approximate weight? _____ Lbs. | Height?_____ ft _____in |
| Referred here by: (circle one) self family friend doctor attorney internet search insurance company other | |
| Name of Person / Physician making referral: | |
| List Current Treating Physicians including PCP: | |
| Describe the reason for your visit: | |
| Body Part to be examined: Right Left Both | |
| How did your symptoms/injury begin? (Describe in detail) | |
| Approximate date symptoms began or date of injury: New or Old injury (circle one) | |
| On a scale of 1-10 (10 being most severe) circle the # that best describes your pain: 1 2 3 4 5 6 7 8 9 10 | |
| Resulting from: (circle which applies) Work Related Involving Litigation Auto | |
| Are Symptoms: constant intermittent worsening improving unchanged | |
| Circle all that apply pain stiffness swelling instability weakness numbness/tingling | |
| What makes symptoms worse? | |
| What makes symptoms better? | |
| What previous formal treatment have you had for this problem? (Medications, therapy, surgery, injections) | |
| PAST SURGICAL HISTORY<br>Previous Type of Operation and Year<br>1.<br>2. | 3.<br>4.<br>5. |
| Any previous fractures? YES NO WHERE? | |
| **DO YOU HAVE ANY DRUG ALLERGIES? ** (circle one) YES NO<br>If yes, name the drug and describe the reaction, please be specific. (Example: rash, nausea, etc) | |
| CURRENT MEDS: (List any medications you are taking currently. Include items such as aspirin, vitamins, etc.<br>NAME OF DRUG REASON FOR USE DOSING INSTRUCTIONS (strength & frequency) | |
| 1.<br>2.<br>3.<br>4.<br>5. | 6.<br>7.<br>8.<br>9.<br>10. |

{{BARCODELEFTRIGHT}}

| MEDICAL HISTORY/ REVIEW OF SYSTEMS | | | |
|---|---|---|---|
| Please check if you have a history of any of the following. **CHECK ONLY THOSE THAT APPLY** | | | |
| | **GENERAL** | | **CARDIOVASULAR** |
| | Are you currently pregnant? | | Pacemaker/ Defibrillator |
| | Diabetes – type I type II | | Heart Attack/ Myocardial Infarction |
| | Stroke Palpitations | | High Blood Pressure/ Hypertension |
| | Kidney Disease | | Coronary Artery Disease |
| | Ulcers | | Swelling of Lower Extremities |
| | Asthma or lung disease | | **HEMATOLOGIC** |
| | Cancer: Type? | | Anemia |
| | Fatigue | | Blood Clots |
| | Weakness | | Bleeding Tendency |
| | Sleep Apnea | | Easily Bruised |
| | Skin problems/disorders | | Circulatory Problems |
| | Rheumatic Fever | | Currently on Blood Thinners Type: |
| | Tuberculosis | | **MUSCULOSKELETAL** |
| | Recent weight gain/loss: (circle one) how much: | | Joint Pain |
| | **BLOODBORNE PATHOGENS** | | Osteoporosis / Osteopenia |
| | Phlebitis | | Bone/ Joint Infection |
| | HIV / AIDS | | Gout |
| | Hepatitis | | Rheumatoid Arthritis |
| | Hepatitis | | **PSYCHOLOGICAL** |
| | **NEUROLOGICAL** | | Depression |
| | Headaches | | Anxiety Disorder |
| | Dizziness | | **Other Illness not listed:** |
| | Fainting | | |
| | Memory Loss | | |
| | Loss of Consciousness Depression | | |
| | Muscle Spasms Anxiety Disorder | | |
| | Numbness or Tingling of Hands | | |
| | Blindness or Trouble Seeing | | |
| | Deafness or Trouble Hearing | | |
| | Seizures | | |
| **FAMILY HISTORY** | | | |
| | Diabetes | | Anesthesia Complications |
| | Heart Disease | | Cancer |
| **SOCIAL HISTORY** | | | |
| Occupation: Retired: yes no | | | |
| Martial Status: M S D W Race: Ethnicity: | | | |
| Smoker: Current: Yes No How much? Former: Yes No Quit Date: | | | |
| Do you drink Alcohol Yes No If so how many drinks per week? History of abuse? Yes No | | | |
| Any history of Drug Abuse? Yes No What Drug? Treatment? | | | |

I acknowledge that these answers are accurate and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

{{BARCODELEFTRIGHT}}