

Howard J. Gelb, MD, PA

SPORTS MEDICINE AND ORTHOPAEDIC CENTER



TODAYS DATE _____ WHICH PHYSICIAN ARE YOU SEEING TODAY? _____

NAME (LAST) _____ (FIRST) _____ (MI) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

MALE FEMALE DATE OF BIRTH _____ EMAIL _____

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____ DRIVERS LICENSE STATE _____

LOCAL PHARMACY NAME _____ PHARMACY PHONE _____ OCCUPATION: _____

IN CASE OF AN EMERGENCY PLEASE CONTACT

NAME _____ RELATIONSHIP _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY INSURANCE - Please have Insurance cards ready to be copied

PRIMARY INSURANCE CARRIER _____ PHONE _____

POLICY # _____ GROUP # _____ INSURED DOB _____ INSURED SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE

SECONDARY INSURANCE CARRIER _____ PHONE _____

POLICY # _____ GROUP # _____ INSURED DOB _____ INSURED SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF THE PATIENT IS A MINOR (UNDER AGE 18) - PLEASE COMPLETE:

FATHER'S NAME _____

MOTHER'S NAME _____

EMPLOYER/POSITION _____

EMPLOYER/POSITION _____

PHONE _____

PHONE _____

AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION/FINANCIAL AGREEMENT: I give permission to administer treatment and perform tests as determined by the physician in the diagnosis and treatment of my condition. Furthermore, I authorize the release of information relating to my medical treatment to my insurance company in order to process my claim services. I request that payments for insurance benefits made on my behalf, be paid directly to Howard J. Gelb, MD PA. I assume full financial responsibility for all bills associated with this office and all tests, treatments, x-rays, etc. that are not covered by my insurance. Payment is expected at the time of service, including all applicable co-payments and deductibles. I further understand that it is my responsibility to get authorization from my Primary Care Physician or Insurance Company (if required by the insurance company) prior to services being rendered. I understand that no guarantee or assurance has been made as to the results of the procedure or treatment and that it may not cure the condition. Should this become a collection problem the patient assumes all costs of collection, including, but not limited to court costs, interest and legal fees.

Patient's or Legal Guardian's Signature: _____ Date: _____

NAME: _____

DATE: _____

PLEASE CHECK ONE:

ETHNICITY: HISPANIC/LATINO NON HISPANIC/NONLATINO OTHER

RACE: AMERICAN INDIAN ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN WHITE OTHER _____

PRIMARY LANGUAGE: ENGLISH SPANISH FRENCH ITALIAN GERMAN PORTUGUESE JAPANESE CHINESE RUSSIAN
 OTHER _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW

I WAS REFERRED TO THIS OFFICE BY (PLEASE CHECK ONE):

ANOTHER PHYSICIAN: (DR. _____) ATTORNEY PHYSICAL THERAPIST OTHER _____

IS YOUR INJURY: WORK ACCIDENT AUTO ACCIDENT SLIP & FALL (LEGAL CASE) SPORTS RELATED OTHER INJURY

***PLEASE SPECIFY RIGHT OR LEFT SIDE AND BODY PART OF CONDITION AND BRIEFLY DESCRIBE WHAT BROUGHT YOU INTO THIS OFFICE. PLEASE INCLUDE DATE OF INJURY, HOW, WHEN AND WHERE OCCURRED:**

DID YOU BRING ANY X-RAYS, MRIs, CDs, DVDs, FILMS? Yes No IF YES, PLEASE SUPPLY TO OUR STAFF.

REVIEW OF SYSTEMS

<p>CONSTITUTIONAL</p> <p><input type="checkbox"/> CHILLS <input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> WEIGHT LOSS</p> <p>INTEGUMENTARY</p> <p><input type="checkbox"/> SKIN LESIONS <input type="checkbox"/> RASH <input type="checkbox"/> REDNESS OF SKIN <input type="checkbox"/> MOLES <input type="checkbox"/> DRY OR SCALY SKIN</p> <p>EYES, EARS, NOSE, THROAT</p> <p><input type="checkbox"/> BLURRED VISION <input type="checkbox"/> CATARACTS <input type="checkbox"/> CONTACT LENS <input type="checkbox"/> GLAUCOMA <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> DRY MOUTH <input type="checkbox"/> NASAL CONGESTION <input type="checkbox"/> SORE THROAT <input type="checkbox"/> TINNITUS <input type="checkbox"/> LOOSE TEETH</p>	<p>RESPIRATORY</p> <p><input type="checkbox"/> COUGH <input type="checkbox"/> DIFFICULTY BREATHING <input type="checkbox"/> WHEEZING <input type="checkbox"/> ASTHMA <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> BREATHING TREATMENT</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> CHEST PAIN <input type="checkbox"/> CHORTNESS OF BREATH <input type="checkbox"/> DYSPNEA ON EXERTION <input type="checkbox"/> ANGINA <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> INTERMITTENT PAIN IN LEGS <input type="checkbox"/> SWELLING/EDEMA</p> <p>GASTROINTESTINAL</p> <p><input type="checkbox"/> DIARRHEA <input type="checkbox"/> BLOODY STOOL <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING <input type="checkbox"/> ULCERS <input type="checkbox"/> FOOD INTOLERANCE</p>	<p>GENITOURINARY</p> <p><input type="checkbox"/> BURNING ON URINATION <input type="checkbox"/> BLOODY URINE <input type="checkbox"/> DIFFICULTY VOIDING <input type="checkbox"/> HISTORY OF UTI</p> <p>NEUROLOGICAL</p> <p><input type="checkbox"/> NUMBNESS <input type="checkbox"/> SEIZURES <input type="checkbox"/> BALANCE PROBLEMS <input type="checkbox"/> TINGLING <input type="checkbox"/> DIZZINESS <input type="checkbox"/> DIFFICULTY WALKING <input type="checkbox"/> FREQUENT URINATION</p> <p>PSYCHIATRIC</p> <p><input type="checkbox"/> DEPRESSION <input type="checkbox"/> ANXIETY <input type="checkbox"/> INSOMNIA <input type="checkbox"/> ADDICTION <input type="checkbox"/> DRUG USE <input type="checkbox"/> HISTORY OF PSYCHIATRIC PROBLEMS</p> <p>HEMATOLOGY</p> <p><input type="checkbox"/> ABNORMAL BLEEDING <input type="checkbox"/> BLOOD CLOTS <input type="checkbox"/> AIDS <input type="checkbox"/> CANCER <input type="checkbox"/> SITE _____</p>	<p>MUSCULOSKELETAL (PLEASE SPECIFY RIGHT OR LEFT)</p> <p><input type="checkbox"/> BACK PAIN <input type="checkbox"/> DECREASED RANGE OF MOTION <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> JOINT STIFFNESS <input type="checkbox"/> SWELLING <input type="checkbox"/> NECK PAIN <input type="checkbox"/> ARM PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> SHOULDER PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> HIP PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> KNEE PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> ANKLE PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> FOOT PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> HEEL PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> WRIST PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> ELBOW PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> HAND PAIN [<input type="checkbox"/> R or <input type="checkbox"/> L] <input type="checkbox"/> LOCKING <input type="checkbox"/> GIVING WAY <input type="checkbox"/> PARTIAL GIVING WAY <input type="checkbox"/> PAIN WITH MOTION <input type="checkbox"/> TYPE _____</p> <p>ENDOCRINE</p> <p><input type="checkbox"/> THIRST <input type="checkbox"/> FREQUENT URINATION <input type="checkbox"/> NIGHT SWEATS</p>
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NAME: _____

DATE: _____

HISTORY MEDICAL (CHECK ALL THAT APPLY):

- ASTHMA ARTHRITIS ANEMIA ANXIETY BLOOD CLOTTING TENDENCY
- CATARACTS COPD DEPRESSION DIABETES I / II DRUG DEPENDENCY
- EPILEPSY EMPHYSEMA GOUT HEADACHE HEART DISEASE
- HIGH BLOOD PRESSURE KIDNEY DISEASE LIVER DISEASE PEPTIC ULCER PSORIASIS
- VISION LOSS CANCER TYPE _____ HEPATITIS TYPE _____ OTHER _____

ALLERGIES TO MEDICATIONS (CHECK ALL THAT APPLY):

- ASPIRIN CODEINE IODINE NOVACAINE PENICILLIN TAPE OR ADHESIVES
- SULFA OTHER _____ NICKEL OR OTHER METALS NO KNOWN ALLERGIES

ARE YOU: RIGHT HANDED LEFT HANDED AMBIDREXTROUS

SMOKING HISTORY: NEVER PREVIOUSLY,BUT QUIT CURRENT SMOKER: PACKS PER DAY _____

ALCOHOL USE: NONE RARE SOCIALLY OCCASIONALLY OTHER _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING DOSAGE:: _____ ,
_____, _____ , _____ , _____ , _____ , _____

PAST SURGERY

- APPENDECTOMY ARTHROSCOPY BACK SURGERY BREAST SURGERY
- CARPAL TUNNEL GALLBLADDER HEART BYPASS HEART VALVE REPLACEMENT
- HERNIA REPAIR HYSTERECTOMY JOINT REPLACEMENT NECK SURGERY
- PACEMAKER PROSTATE SURGERY TONSILECTOMY OTHER _____

HEIGHT ____ FT ____ IN **WEIGHT** _____ LBS **SHOE SIZE** _____

LIST PARTICIPATING SPORTING ACTIVITIES: _____

FAMILY HISTORY

FATHER: ALIVE? YES NO AGE: _____ MEDICAL CONDITIONS: _____

MOTHER: ALIVE? YES NO AGE: _____ MEDICAL CONDITIONS: _____

SIBLINGS: ALIVE? YES NO AGE: _____ MEDICAL CONDITIONS: _____

Howard J. Gelb, MD, PA

HOWARD J. GELB, M.D., F.A.A.O.S.

Board Certified Orthopaedic Surgeon
Fellowship Trained in Sports Medicine
Sub-specialty Certified in Sports Medicine

SPORTS MEDICINE AND ORTHOPAEDIC CENTER



CLIVE C. WOODS, MD

Orthopaedic Surgeon
Fellowship Trained in Foot and Ankle Surgery

Please check all appropriate boxes:

I, _____ give permission to Howard J. Gelb, MD, Clive C. Woods, MD,
(Patient's name)

or his staff to leave any test results or exam results:

- Leave message on answering machine or fax at home
- Leave message with spouse or family member
- Leave message with _____ (name of person)
- Leave message on voice mail at work
- Leave message with only myself by phone or fax

I, _____ give permission for my medical records to be faxed or
(Patient's name)

mailed upon request to:

- My Primary physician
- Any other physician or facility that will be involved with my care
- Dr. Howard Gelb
- My insurance carrier

I, _____ give permission to Dr. Gelb or Dr. Woods to discuss my medical
(Patient's name)

condition with:

- My spouse
- My children
- My parents
- Other _____

I hereby authorize the release of any medical records necessary for Dr. Gelb or Dr. Woods to render medical services by signing a lifetime signature below:

Signature

Date



PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment payment of health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information, (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restriction and revoke consent in writing after you have reviewed our privacy notice.

Printed Name: _____

Signature: _____

Date: _____