Howard J. Gelb, MD, PA

SPORTS MEDICINE AND ORTHOPAEDIC CENTER

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

CLIVE C. WOODS, MD
Orthopaedic Surgeon
Fellowship Trained in Foot and Ankle Surgery

Please Print:

Name (First):_____ (MI) ____(Last)_____Date:_____

Address: _____City:_____State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____E-mail: _____

Driver's License #:_____ Driver's License State:_____ Occupation: _____

DOB: _____ Age: _____ Sex: _____ SSN#:_____

Employer: _____ Business Phone#:_____

Address:_____City:_____State:_____Zip:_____

WORKERS COMPENSATION INFORMATION

Insurance Carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Case# or Claim#:_____

CASE MANAGER

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

ATTORNEY

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Date of Injury: _____ Time of Injury: _____

Description of Accident/Injury:

_____

Are you still working? ☐Yes ☐No Have you had a prior or similar work injury? ☐Yes ☐No

Can you do modified work at this time? ☐Yes ☐No If yes, what type of work/activities can you perform?

_____

Are you now or have you in the past, been involved in active litigation or had a settlement and/or closure involving this injury? ☐Yes ☐No

I understand that I am responsible for making sure all my visits have been authorized. I have read all this information and understand it.

Signature:_____ Date: _____

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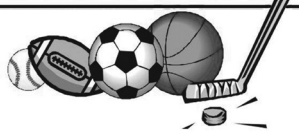

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LIABILITY PATIENT INFORMATION

Please Print:

Name (First) _____ (Last) _____Date:_____

Age: _____ Ht: _____Wt: _____ ☐Male ☐Female ☐Right Handed ☐Left Handed ☐Ambidextrous
Occupation:_____

How were you referred to our office?_____

Who is your Primary Physician _____ Phone #:_____

HISTORY OF PRESENT ILLNESS

Describe the condition that brought you to this office:_____

_____

Is your injury: ☐Work Accident ☐Auto Accident ☐Slip & Fall
Date when Accident/Injury occurred: _____Where did Accident/Injury Occur? _____
Description of Accident/Injury: _____

_____

If this is an auto accident, were you thrown from the car? ☐Yes ☐No Did you lose consciousness? ☐Yes ☐No
Contributing events or cause for symptoms: _____

Describe the severity and quality of pain: (sharp, dull, stabbing, etc.)_____

Circle rating of 1-10 for severity of symptoms with 10 being the greatest: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Frequency of symptoms: ☐Constant ☐Intermittent ☐Daily

Duration of symptoms: ☐Constant ☐Hrs ☐Mins ☐Seconds

Do symptoms include? ☐Swelling ☐Weakness ☐Numbness ☐Decreased Motion ☐Pins & Needle Sensation ☐Other____

If applicable, is the joint? ☐Popping ☐Locking ☐Clicking ☐Instability/Giving way ☐Other_____
What activities worsen your condition?

_____

When do the symptoms occur? ☐Morning ☐Afternoon ☐Evening ☐During Exercise ☐After Exercise

Have you been previously treated for this accident/injury elsewhere? _____ If yes, by whom? _____

Past Treatment of your current problem: ☐Ice treatment ☐Heat Treatment ☐Physical Therapy ☐Rest (Length of Time)____

☐Injections (How Many?)_____ ☐Medications

Related Past Surgeries for condition (Specify Procedure & Date)_____

_____

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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/RELEASEOF INFORMATION/FINANCIAL AGREEEMENT: 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 coaction, 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 □PHYSICALTHERAPIST □OTHER_____

IS YOUR INJURY: □WORK ACCIDENT □AUTO ACCIDENT □SLIP & FALL(LEGAL CASE) □SPORTS REALTED □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

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

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: _____

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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

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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: _____