CIARLONE ORTHOPEDICS

JOINT REPLACEMENT • TRAUMA • SPORTS MEDICINE

PATIENT INFORMATION

Patient Last Name	First Name	Middle
Female Male	/ /	- -
Sex (circle above)	**Date of Birth**	**Social Security**

Address	Apt Number	City	State	Zip

Home Phone	Cell Phone	Work Phone

Email Address	Primary Language	Race	Ethnicity

Employer	Employer's Address	Phone

Spouse's Name	Phone Number

INSURANCE

Primary Insurance: _____
Policy Holder Name: _____
Employer: _____
Date of Birth: _____
Relationship to patient: _____

Secondary Insurance: _____
Policy Holder Name: _____
Employer: _____
Date of Birth: _____
Relationship to patient: _____

_____ _____

Signature of Patient or Responsible Party **Date**

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HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you cannot remember specific details, please approximate. This information will be kept strictly confidential.

Reason for today's visits: _____

Is the current injury the result of a(n): Car Accident _____ Work Accident ____ Other _____

Date of injury: _____ Please describe: _____

Person to notify in case of an emergency:

Name: _____ Relationship: _____ Phone: _____

MEDICATIONS

Please list ALL medications you are taking:

	DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ALLERGIES

List anything you are allergic to (medications, food, bee stings, etc.) and how it affects you.
Please check the box if applicable: **Latex allergy?** [ ] Yes [ ] No **Metal allergy?** [ ] Yes [ ] No

	ALLERGY	REACTION
1.		
2.		
3.		

Primary Physician: _____ Address: _____

Referring Physician: _____ Address: _____

FAVORITE PHARMACY

Pharmacy Name: _____ Pharmacy Phone Number_____

Pharmacy Address: _____

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots (or DVT)
- ☐ COPD
- ☐ Cancer
- ☐ Claustrophobic
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes – Insulin
- ☐ Diabetes – Non-Insulin
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Fibromyalgia
- ☐ General Anesthesia adverse reaction
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism (over active)
- ☐ Hypothyroidism (under active)
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pollo
- ☐ Pulmonary Embolism
- ☐ Reflux or Ulcers
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke—Cerebrovascular accident
- ☐ Tuberculosis
- ☐ Other: Please List

Have you ever had general anesthesia? [ ] Yes [ ] No
Have you or a member of your family had problems with anesthesia? [ ] Yes [ ] No
Describe: _____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	DOCTOR/HOSPITAL
1.			
2.			
3.			
4.			

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Grandfather (maternal)	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Grandmother (paternal)	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Grandfather (paternal)	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Father (paternal)	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Mother	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Brother/Sister	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____
Brother/Sister	Y/N	_____	Alcoholism__ Arthritis__ Depression__Cancer__Diabetes__ Genetic Disease__ Hypertension__Osteoporosis__Stroke__Other_____

SOCIAL HISTORY

Education
Less than 8th grade__ High School__
2 Year College__ Post Graduate__

Marital Status
Married__ Single__ Divorced__ Separated__
Widowed__ Domestic Partner__

Occupation_____

Drugs: Do you currently use recreational street drugs? [ ] Yes [ ] No
If yes, please list: _____
Tobacco: Do you use tobacco? [ ] Yes [ ] No If not currently, did you ever use tobacco? [ ] Yes [ ] No
Alcohol: Do you drink alcohol? [ ] Yes [ ] No
If so, how often? Occasionally___ Less than 3 times per week___ More than 3 times per week___
Caffeine: None___ Occasional ___ Moderate___ Heavy___ # of cups per days? ____

REVIEW OF SYMPTOMS

Please check all that apply:

Allergic/Immunology:
- ☐ Frequent Sneezing
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Cardiovascular:
- ☐ Arm Pain on exertion
- ☐ Chest Pain on Exertion
- ☐ Chest Heaviness/Pressure of Exertion
- ☐ Irregular Heart Beats
- ☐ Known Heart Murmur
- ☐ Light-headed on Standing
- ☐ Shortness of breath when lying down
- ☐ Shortness of breath when walking
- ☐ Swelling (edema)

Constitutional:
- ☐ Exercise intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain (___lbs)
- ☐ Weight Loss (___lbs)

Eyes:
- ☐ Dry Eyes
- ☐ Irritation
- ☐ Vision Change

Ears/Nose/Mouth/Throat:
- ☐ Bleeding Gums
- ☐ Difficulty Hearing
- ☐ Dizziness
- ☐ Dry Mouth
- ☐ Ear Pain
- ☐ Frequent Ear Infection
- ☐ Frequent Nosebleeds
- ☐ Hoarseness
- ☐ Mouth Breathing
- ☐ Mouth Ulcers
- ☐ Nose/Sinus Problems
- ☐ Ringing in Ears

Endocrine:
- ☐ Fatigue
- ☐ Increased Thirst/Hunger/Urination
- ☐ Hair Loss
- ☐ Increased hair growth
- ☐ Cold Intolerance

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Black or Tarry Stool
- ☐ Blood in stool
- ☐ Change in appetite
- ☐ Frequent indigestion
- ☐ Hemorrhoids
- ☐ Trouble Swallowing
- ☐ Vomiting
- ☐ Vomiting, Blood
- ☐ Frequent diarrhea

Genitourinary:
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Incomplete emptying
- ☐ Increased urinary frequency
- ☐ Urinary loss of control

Hematologic/Lymphatic:
- ☐ Easy Bruising/Bleeding
- ☐ Swollen Glands

Integumentary (Skin):
- ☐ Changes in moles
- ☐ Dry skin
- ☐ Eczema
- ☐ Growth/Lesions
- ☐ Itching
- ☐ Jaundice (Yellow skin/eyes)
- ☐ Rash

Musculoskeletal:
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐ Muscle Weakness
- ☐ Swelling in extremities

Neurological:
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Memory Loss
- ☐ Migraines
- ☐ Numbness
- ☐ Restless legs
- ☐ Seizures
- ☐ Weakness
- ☐ Loss of consciousness

Psychiatric:
- ☐ Alcohol overuse
- ☐ Anxiety/Stress
- ☐ Depression
- ☐ Do not feel safe in relationship
- ☐ Sleep disturbances
- ☐ Restless sleep
- ☐ Mania

Respiratory:
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Wheezing

_____ _____

Patient, Parent, Guardian, or Caregiver Signature **Date**

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PATIENT AUTHORIZATON FOR PERSONAL REPRESENTATIVE

This request will authorize the practice to disclose my protected health information to the following individual(s) who is (are) authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my delegated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protocol health information. He/she may also consent or authorize the use of disclosure of my protected health information:

Name of Personal Representative		**Date**	
Street Address	**City**	**State**	**Zip**
Name of Personal Representative		**Date**	
Street Address	**City**	**State**	**Zip**

- Description of information to be disclosed: I authorize the practice to disclose all my protected health information to me designated personal representative.
- Expirations of termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization at any time by submitting a written request.

Re-disclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the privacy rule and will no longer be the responsibility of the practice.

Signature of Patient/Personal Representative

Printed Name of Patient/Personal Representative

Date

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Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned Patient or Legally Authorized Representative (Agent or Guardian) of the patient acknowledges that he or she has been offered a copy of Ciarlone Orthopedics Notice of Privacy Practices on the date indicated below.

Signature: _____ **Date**: _____

Printed Name: _____ **Relationship to Patient**: _____

For office use only:

____ Patient/Representative Refused to Sign-Notice of Privacy Practices Provided

____ Other: _____

Signature: _____ Date: _____

Print Name: _____

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Patient Financial Responsibility Policy

Ciarlone Orthopedics appreciates the confidence you have shown in choosing us to provide for your orthopedic needs. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask if you have any questions regarding your financial responsibility.

Our receptionist may ask to see your insurance card at every visit and will scan your card into our system as needed to keep our information current and to facilitate accurate insurance billing.

Individual's Financial Responsibility:

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non- covered services.
- Co- payments are due at the time of service.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all the services provided in full.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

Referrals:

If your insurance plan requires a referral from your primary care physician, **it is the patient's responsibility** to obtain your referral prior to your appointment and to have it with you at the time of your appointment. If you don't have the referral, **YOU MAY BE REQUIRED TO RESCHEDULE.**

Automobile Accident/ Worker's Comp Cases:

Patients shall be financially responsible for medical services related to automobile/worker's comp. It is the responsibility of the patient to notify Ciarlone Orthopedics of the date of injury, Claim number, insurance company address, phone number and contact person. If your motor vehicle claim exhaust, or your worker's comp claim is denied, it will be the patients responsibility to submit to Ciarlone Orthopedics any other insurance plans that you may have, or the charges will be considered patients responsibility. If your insurance plan is a non-participating plan with Ciarlone Orthopedics, and your mobile vehicle exhausts or worker's comp denies, you will be responsible for any unpaid charges.

Financial Responsibility of Patient:

I understand that if I do not make payment for services rendered, Ciarlone Orthopedics will take necessary and appropriate action to collect any money due for me to Ciarlone Orthopedics, but not limited to the use of collection agencies, or attorneys. I will be responsible for any and all fees associated with these collection efforts. We accept CASH, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS and checks. I hereby authorize Ciarlone Orthopedics to release all medial information to insurance carries concerning my illness and treatment and I hereby assign payment to Ciarlone Orthopedics for services rendered to myself/ my dependent. I understand I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY MY INSURANCE.

_____ _____

Signature of patient, Power of Attorney, or Guardian if minor **Date**

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At Ciarlone Orthopedics, we feel the doctor/ patient relationship is built on mutual trust, respect and our concern for your health care. As such, we strive to be respectful of the time for your scheduled appointments, and ask that you give us the same courtesy. Missed appointments and "No-Shows" are disruptive and more importantly create a slot that could have been used by another patient in need. We understand that unforeseen circumstances occur and you will be unable to keep your scheduled appointment.

CMS, Centers for Medicare & Medicaid Services, have published a notice providing new guidance on billing Medicare patients for missed appointments. Under the current guidelines, Medicare allows a no-show fee as long as the practice:

- Has a written policy on missed appointments that is provided to all patients.
- Ensures that the missed appointment policy applies equally to all patients.
- Establishes that the billing staff is aware that Medicare beneficiaries should be billed directly for missed appointments.
- Ensures that charges for missed appointments are reflective of a missed business opportunity and not the cost of the service itself.

If you are unable to keep your scheduled appointment, we require a 24-hour notice (one full business day) so that we may accommodate the needs of other patients. If an appointment is cancelled or rescheduled after 24 hours of the reserved appointment time, Ciarlone Orthopedics will charge the patient a cancellation fee of $50.00. As a last resort, patients who miss more than 3 appointments will be terminated from the practice.

Andrew Ciarlone, DO
Ciarlone Orthopedics

_____ _____

Patient Signature **Date**