ROCHESTER COMMUNITY ORTHOPAEDICS, LLP

David A. Carrier, MD / Rola H. Rashid, MD / Matthew C. Bessette, MD / Steven J. Posnick, MD

Patient Information

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: _____ Gender Identity: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Home Phone Number: _____

E-mail Address: _____

Contact Preferences: Cell Phone Home Phone Mail Portal Work Phone

Employer: _____ Occupation: _____

Work Phone Number: _____

Preferred Language: _____ Ethnicity: ☐ White ☐ African American ☐ Hispanic ☐ Asian ☐ Native American ☐ Other ☐ Decline

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Who is your Primary Care Physician: _____

Address: _____

Do you have a cardiologist (name): _____

Address: _____

What Pharmacy do you use: _____

Address: _____

How were you referred to this office: _____

Health Insurance Information

PRIMARY Insurance Company: _____
Contract No: _____
Subscriber Name: _____ Relation to Patient: _____
Subscriber Date of Birth: _____
Subscriber Address: _____

SECONDARY Insurance Company: _____
Contract No: _____
Subscriber Name: _____ Relation to Patient: _____
Subscriber Date of Birth: _____
Subscriber Address: _____

Would you like a printed copy of our HIPAA policy? Yes No

Authorizations:

I understand that I will be held responsible for payment for services not covered by my insurance.

I consent to the use or disclosure of my protected health information (PHI) by Rochester Community Orthopaedics, LLP for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Rochester Community Orthopaedics, LLP, and for such other uses that are permitted or required under federal or state law. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidence by my signature on this document.

Medicare: The information given by me in applying for payment under Title XVIII of the Social Security Administration Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carriers, any information required to process my Medicare claims for payment purposes.

_____ _____
Signature **Date**

Relationship to Patient: _____
(If other than patient)

Please fill out this section if the patient is less than 18 years of age:

Father's Name:
_____

DOB: _____

Address:
_____

City: _____ State: _____ Zip: _____

Phone Number: _____

Mother's Name:
_____

DOB: _____

Address:
_____

City: _____ State: _____ Zip: _____

Phone Number: _____

Medical History

Patient Name: _____

Height: _____ Weight: _____ DOB: _____

Primary Care Physician: _____

List All Medications You Take:

_____

_____

_____

_____

_____

List Medical Problems You Have or Had:

_____

_____

_____

_____

List Allergies to Medications:

_____

_____

List Surgeries You Have Had:

_____

_____

_____

Are you taking any Blood Thinners?
(Aspirin, Warfarin, Coumadin, Eliquis, Xarelto, Plavix) YES NO

Can you take Anti-Inflammatory Drugs (Ibuprofen, Aleve, Aspirin)? YES NO

Do you have a latex allergy? YES NO

List Any Medical Problems in Your Family:

_____

_____

What Hobbies Do You Have? _____

Do You Play Any Sports/ or Exercise Regularly? _____

Are you currently experiencing or have you experienced any of the following:

Yes	No		Yes	No	
☐	☐	Heart Disease	☐	☐	Stomach Ulcers
		Cardiologist: _____	☐	☐	Acid Reflux
		Address: _____	☐	☐	Renal/Kidney Disease
☐	☐	Blood Clots	☐	☐	Fibromyalgia
☐	☐	Bleeding Problems	☐	☐	Gout
☐	☐	Diabetes	☐	☐	Hepatitis/Liver Disease
☐	☐	High Blood Pressure	☐	☐	AIDS
☐	☐	Stroke	☐	☐	Osteoporosis
☐	☐	Sciatica	☐	☐	Cancer
☐	☐	Weight Loss	☐	☐	Drink Alcohol
☐	☐	Weight Gain	☐	☐	Use Recreational Drugs
☐	☐	Depression	☐	☐	Tobacco Use
☐	☐	Sleep Apnea			Packs per Day _____
☐	☐	COPD			

Signature: _____ **Date:** _____

CURRENT MEDICAL PROBLEM

Body Part: _____ **LEFT** **RIGHT**

Please give us a description of the problem that brings you here for diagnosis and treatment:

_____

_____

_____

Yes	No	
☐	☐	Is this problem related to a specific injury? Date of injury: _____
☐	☐	Is this problem related to a work injury? _____
		Employer at time of injury? _____
☐	☐	Is this problem related to a motor vehicle accident? Date of Accident? _____
☐	☐	Have you missed work because of this problem? _____
		When was the last day you worked? _____
☐	☐	Have you seen another doctor for this problem?
		Who and when: _____
☐	☐	Have you had any x-rays, MRI, or CT scan done for this problem?
		When and where: _____

(TO BE FILLED OUT BY PHYSICIAN)

Patient Age R/L Handed

- Location
- Duration d / w / m / y
- Injury
- Quality ache / sharp / dull
- Severity 1.....5.....10
- Timing day / night / work
- Context progressing / improving / no change
- Previous
- Modifying Factors

  PT / HEP Meds
  Injection
  Brace
- Associated Sx