LIGHTHOUSE ORTHOPEDICS
GENERAL MEDICAL HISTORY

Date: ____________________

Last Name:________________________ First Name: ____________________ Middle Initial: _____

Date of Birth:______________ Age: _____ Height:_________ Weight:_________ Right / Left Handed

Employer: ____________________________________ Occupation: ____________________

Home Phone: (_____) __________ Work Phone: (_____) __________ Cell Phone: (_____) __________

Local Pharmacy:____________________________________ **Phone:** (_____) __________

Primary Care Physician:________________________________ Phone: (_____) __________

Do you wish for records to be forwarded to your Primary Care Physician? ❑ Yes ❑ No

Referred By: ❑ Primary Care Physician ❑ Family/Friends ❑ Insurance ❑ Hospital ❑ Internet ❑ Other:__________

1. **Presenting Complaint:**

   A. Affected Side of the Body: ❑ Right Side ❑ Left Side ❑ Both Sides

   B. Area of the Body Affected: ❑ Knee ❑ Shoulder ❑ Hip ❑ Ankle ❑ Foot ❑ Elbow ❑ Hand ❑ Spine
   ❑ Other: ______________________________

2. How long have you had this problem? ______________________________

3. **Is this a result of an injury?** ❑ **Yes** ❑ **No** **Date of Accident:** ____________________

   Auto Accident ____ **Worker's Comp** ____ **Slip and Fall** ____ **Where?**____________________

   Are you: ❑ **Working** **Full Duty** ____ **Light Duty** ____ ❑ **Off Work Due to Injuries**

4. Previous Treatment **(in regard to your presenting complaint)**

   Pain Medication:____

   Any Injections:____

   Bracing: ❑ Yes ❑ No Do you ever need an assistive walking device? ❑ Yes ❑ No

   Have you done Physical Therapy or an Exercise Program to treat your presenting complaint? ❑ Yes ❑ No

   How many weeks/months?____

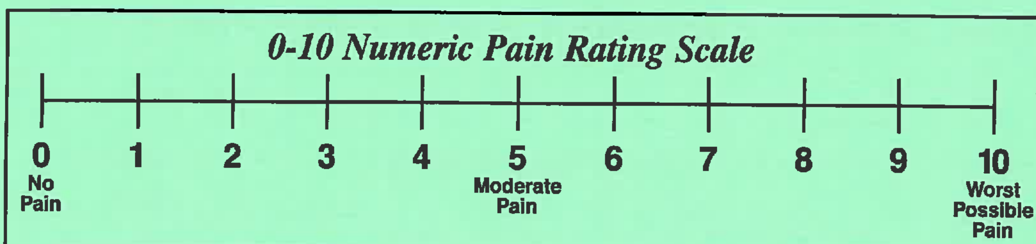
5. Is your problem getting: ❑ Worse ❑ Better ❑ Staying the Same

6. Please describe your pain:

   Quality: ❑ Dull ❑ Throbbing ❑ Sharp **Timing:** ❑ Intermittent ❑ Constant

   Severity: ❑ Mild ❑ Moderate ❑ Severe

   Associated Symptoms: ❑ Swelling ❑ Bruising ❑ Redness ❑ Heat ❑ Numbness ❑ Weakness ❑ Giving Way
   ❑ Other:____



GENERAL MEDICAL HISTORY

8. Past Medical History:

A. Have you had any of the following? (Check all that apply): ❑ NONE

❑ High Blood Pressure	❑ Hepatitis/Jaundice	❑ Asthma	❑ Thyroid Disease
❑ Mitral Valve Prolapse	❑ Ulcers	❑ Rash/Skin Lesion	❑ Bronchitis
❑ Diabetes	❑ Heart Attack/M.I.	❑ Recent Cold	❑ Emphysema/Lung Disease
❑ Kidney Disease	❑ Blood Clots	❑ High Fever	❑ Gout
❑ Cancer	❑ Seizures	❑ Angina	❑ HIV/AIDS
❑ Back/Disk Disease	❑ Sickle Cell Anemia	❑ Bleeding Disorder	❑ TB

9. Review of Symptoms:

A. Have you had any of the following? (Check all that apply): ❑ NONE

❑ Fevers/Night Sweats	❑ Difficulty Breathing	❑ Unexplained Weight Loss	❑ Sore Throat/Earache
❑ Bladder Problems/Infections	❑ Stomach Pain	❑ Chest Pain	❑ Depression
❑ Numbness: ______________	❑ Cramps	❑ Bleeding Tendency	❑ Hot Flashes

❑ Other (Explain): ____

10. List all allergies: ____

____

11. List medications currently being taken and provide dosage and number of times per day taken:

A. ____

B. ____

C. ____

D. ____

12. List any surgery or hospitalization that you have had:

A. ____ Date: ____________

B. ____ Date: ____________

C. ____ Date: ____________

D. ____ Date: ____________

13. Social History:

A. Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

B. Family History – Children: ❑ Yes ❑ No If YES, how many?: ❑ Male: _____ ❑ Female: _____

❑ Brothers: _____ ❑ Sisters: _____

C. Do you use any of the following? (Check all that apply):

1. Tobacco: ❑ Yes ❑ No How much per day?: ______________________________
2. Alcohol: ❑ Yes ❑ No How much per day?: ______________________________
3. Controlled Narcotics: ❑ Yes ❑ No What and how much?: ______________________________
4. Other Drugs: ❑ Yes ❑ No What and how much?: ______________________________

14. Family Medical History: (Check all that apply): ❑ NONE

❑ Arthritis ❑ Cancer ❑ Osteoporosis ❑ Problems with Anesthesia ❑ Diabetes ❑ Obesity

❑ Other: ____

Patient Signature: ____ Date: ____________

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Reviewed by: ____ Date: ____________

Reviewed by: ____ Date: ____________

PATIENT INFORMATION RECORD

Allergies: ______________ Age: ______________

Patient's Legal Name: ______________ (First / M.I. / Last) Today's Date: ______________

Address: ______________ (Street / City / State / Zip)

Phone #'s – Daytime: ______________ Evening: ______________ Emergency: ______________ Cell: ______________

Where do you prefer to receive calls?: ❑ Home Number ❑ Work Number ❑ Cell Number ❑ In Writing

❑ OK leave message with detailed info ❑ Leave message with call-back number only

Patient's Date of Birth: ______________ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Partner Religion: ________ Primary Language: ________

Ethnicity: ______________ Race: ______________

Social Security No.: ________ – ______ – ________ Referred By: ______________

Responsible Party: ______________ (First / M.I. / Last) Telephone: (___)- ________

Address: ______________ (Street / City / State / Zip)

Responsible Party Social Security No.: ________ – ______ – ________ Date of Birth: ______________

Employer: ______________ Telephone: (___)- ________

Address: ______________ (Street / City / State / Zip)

Next of Kin: ______________ Relationship: ________ Telephone: Res:(___)-________ Work:(___)- ________

I. INSURANCE INFORMATION:

Is Your Insurance a: ❑ PPO ❑ HMO ❑ Medicare ❑ Medicaid ❑ Other: ______________

II. IS PATIENT'S CONDITION RELATED TO:

Employment (Current or Previous): ❑ Yes ❑ No Auto Accident: ❑ Yes ❑ No Other Accident: ❑ Yes ❑ No

PRIMARY

INSURANCE COMPANY NAME: ______________

Address: ______________ (Street / City / State / Zip)

Group Number: ______________ Medicare/Policy Number: ______________

Name of Insured: ______________ Insured's Date of Birth: ______________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): ______________

SECONDARY

INSURANCE COMPANY NAME: ______________

Address: ______________ (Street / City / State / Zip)

Group Number: ______________ Medicare/Policy Number: ______________

Name of Insured: ______________ Insured's Date of Birth: ______________

Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Student over 18

Other (Please describe): ______________

*** * * * FOR OFFICE USE ONLY * * * ***

Identification Presented: ❑ Passport ❑ Driver's License ❑ State I.D. ❑ Insurance Card

→ TURN OVER AND COMPLETE

MEDICARE AND MEDICAID SIGNATURE AUTHORIZATION

Medicare and Medicaid patient certification - patient certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII and/or TITLE XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services. I request that this authorization apply to all claims, present and future. I understand that I am responsible for my health insurance deductible and coinsurance.

Date: ______________________________

Print Patient's/Beneficiary's Name: ______________________________

Patient's/Beneficiary's Signature: ______________________________

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COMMERCIAL INSURANCE, MANAGED CARE MEMBERS AND SECONDARY PAYOR AUTHORIZATION

I authorize the release of any medical information necessary to process my insurance claim(s). I request that the payment authorized be made on my behalf. I assign the benefits payable for physician services to the HOLY CROSS MEDICAL GROUP / HOLY CROSS HOSPITAL. I request that this authorization apply to all insurance claims, present and future. I understand that I am responsible for payment of any balance not paid by my insurance company.

Date: ______________________________

Print Patient's/Insured's Name (Parent's Signature if child): ______________________________

Signature of Insured: ______________________________

Patient's/Insured's Signature: ______________________________

PATIENT ACKNOWLEDGEMENT

I have been given a copy of the Holy Cross Hospital, Inc. Notice of Privacy Practices, version effective July 15, 2004.

Signature of Patient or Representative: ______________________________ Date: ____________

Print Name of Patient or Representative: ____

Relationship of Representative to Patient: ____

Test Results may be left on my answering machine: ❑ YES ❑ NO

When calling my phone, results can also be left with – **Name:**________________________________

IN EMERGENCY SITUATIONS ONLY:

PLEASE CHECK ONE BOX:

❑ DO NOT RELEASE ANY OF MY MEDICAL INFORMATION TO A FAMILY MEMBER OR FRIEND

❑ PLEASE RELEASE MY MEDICAL INFORMATION IF NEEDED TO:

____

Relationship: ______________________________ Phone: __________________

* *

FOR HOLY CROSS HOSPITAL, INC. USE ONLY

If acknowledgement of receipt of the Notice of Privacy Practices is not obtained from the Patient or the Patient's Representative, please explain your efforts to obtain their acknowledgement and the reason you could not obtain it: ____

____

____

ADVANCE MEDICAL DIRECTIVE

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time, even in hopeless situations. For many, this is a great concern and question, how can you be sure this does not happen to you? If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive/Living Will. An Advance Directive is a witnessed statement, usually written and made in advance of a future event, that states a person's wishes about what life-sustaining treatments would be wanted if he/she became incapacitated and unable to express his/her wishes. There is no legal requirement to complete an Advance Directive. However, if you have not made an Advance Directive or Designated Healthcare Surrogate, healthcare decisions may be made for you by a court appointed guardian, your spouse, adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person would be called a proxy.

DO YOU HAVE A LIVING WILL?

* ☐ YES ☐ NO

WOULD YOU LIKE TO HAVE A LIVING WILL?

* ☐ YES ☐ NO

Patient's Name: ______________________________

Patient's Signature: ______________________________

Date: ____________________

*** If you have a Living Will or Advance Directive, or plan to have one in the future, it is your responsibility to provide this office with a copy so that we may abide by your directives.**

Holy Cross Medical Group

Date: ______________ Patient Name__________________________ DOB________________

Holy Cross Hospital is now collecting information from patients during their office visit as part of the Meaningful Use healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the new program. If you would please take a moment to answer the following questions then hand this paper back to the front desk.

We thank you in advance for your time.

Standards for Maintaining, Collecting, and Presenting
Federal Data on Race and Ethnicity

This classification provides a minimum standard for maintaining, collecting and presenting data on race and ethnicity for all Federal reporting purposes. The categories in this classification are social political constructs and should not be interpreted as being scientific or anthropological in nature. They are not to be used as determinants of eligibility for participation in any Federal program. The standards have been developed to provide a common language for uniformity and comparability in the collection and use of data on race and ethnicity by Federal agencies. (http://www.whitehouse.gov/omb/inforeg statpolicy/#dr).

1. Which of the following do you consider yourself?

___Hispanic or Latino ___Not Hispanic or Non-Latino ___Decline ___Unknown ___Other

2. Which category best describes your race?

___Black, African American ___American Indian, Alaska Native ___Asian

___Native Hawaiian, Other Pacific Islander ___Pacific Islander ___White

___Chinese ___Filipino ___Hispanic ___Japanese ___Other ___Declined ___Unknown

3. Which language do you prefer to use to communicate?

___English ___French ___Creole ___Spanish ___Russian

______Portuguese ______Other

4. What communication method would you prefer the office to use when conveying medical information?

Home Phone____-____-_______ Cell Phone_____-_____-_______

Work Phone_____-____-_______ ______Postal Service (mailing) ______PO Box

5. How did you hear about us?

______Health Screening ______ Insurance Company ______Ad/TV/Internet

______Word of mouth ______another patient ______Physician referral

Date: ________________ Patient Name: ____________________________

DOB: ________________

Holy Cross Hospital is collecting information from patients during their office visit to assist with the Patient Access Web Portal healthcare initiatives put in place by the Federal Government. Listed below is the information that we are gathering to comply with the programs measures. If you would please take a moment to answer the following questions then hand this paper back to the front desk. We thank you in advance for your time.

1. Current Email Address: ____________________________

2. Cellular Phone Number: ____________________________