

Patient Profile

Doctor: _____

Date: _____

PATIENT INFORMATION

Name: _____

Patient ID #: _____ Sex: M F

Address: _____

Date of Birth: _____

E-mail Address: _____

Social Security #: _____

City, State, Zip: _____

Marital Status: Married Single Divorced

Phone: _____ Home Work Mobile

Referring Physician: _____

Phone: _____ Home Work Mobile

Primary Physician: _____

First Name Last Name

First Name Last Name

PATIENT EMPLOYMENT

Employed Retired Other

Did you sustain this injury at work? Y N

Are your injuries (car) accident related? Y N

Phone: _____

Employer: _____

IN CASE OF EMERGENCY CONTACT

Address: _____

How did you hear about our doctor? Doctor referral Friend or Family Internet Search Other _____

WHO IS RESPONSIBLE FOR THIS BILL Male Female
 Same as Patient

EMPLOYER

Name: _____

Employer: _____

Address: _____

Phone: _____

City, State, Zip _____

Address _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

Same as Patient Same as Guarantor Other

INSURED PARTY NAME: _____

Insurance Company: _____

RELATIONSHIP TO PATIENT: _____

Insured ID: _____

Social Security #: _____

Policy Group #: _____

Date of Birth: _____

Policy Group: _____

SECONDARY INSURANCE

Same as Patient Same as Guarantor Other

INSURED PARTY NAME: _____

Insurance Company: _____

RELATIONSHIP TO PATIENT: _____

Insured ID: _____

Social Security #: _____

Policy Group #: _____

Date of Birth: _____

Policy Group: _____

A Note About Your Insurance

With the diverse selection of insurance plans, levels of coverage, and frequent changes, it is not always possible for our office to keep abreast of all plan requirements. While we will do our best to assist and inform you of the requirements, YOU are ultimately responsible for understanding YOUR insurance policy and levels of coverage. If you have any questions or concerns regarding plan coverage and/or administrative requirements, we strongly recommend that you contact YOUR insurance company or YOUR employer to discuss these questions.

Furthermore, some plans require written authorization from your primary care physician (PCP) to see a specialist. Many of these forms cannot be issued retroactively. Therefore, YOU understand that it is YOUR responsibility to obtain a valid authorization from your PCP for each visit, and without this authorization you may NOT be seen. If you insist on being seen without YOUR insurance's proper authorization, YOU agree to waive YOUR health plan benefits. Additionally, YOU agree to be PERSONALLY and FULLY responsible for payment to *Anthony N Aram, MD, PC* for any services rendered.

Signature

Date

Patient Authorization to File Insurance Claims

I hereby authorize *Anthony N Aram, MD, PC* to apply for benefits for covered services rendered. I request payment from my insurance company and/or Medicare/Medicaid (if applicable) be made directly to *Anthony N Aram, MD, PC*.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original.

Either I or my insurance carrier may revoke this authorization at any time in writing.

Signature

Date

Financial Policy, Authorization For Treatment & Your Health Information

I authorize treatment and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. In the event legal action should be necessary to collect an unpaid balance due for medical services rendered by the providers of *Anthony N. Aram, MD, PC*, I agree to pay reasonable collection and/or attorney's fees.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon. All proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for their collection. (A copy of this assignment is as valid as the original).

Our office requires 24 hours advance notice to cancel or reschedule your appointment. Failure to comply with this will result in a failure fee of \$50.00.

I acknowledge *Anthony N Aram, MD, PC* will use my information for the purposes of treatment, payment, and health care operations.

I acknowledge that I have been given *Anthony N Aram, MD, PC's NOTICE OF PRIVACY PRACTICES*. I understand that if I have any questions or complaints I may contact the Facility Privacy Official.

Signature

Date

General Information

Name: _____ Today's Date: _____ Age: _____ Sex: Male Female
 Height: ___ ft. ___ inches Weight: _____ lbs. Occupation: _____
 Referring Physician: _____ Primary Care Physician (if different): _____

Reason for Visit – Current Condition

Briefly State the Reason for Today's Visit: _____

Is your condition a result of a(n): Auto Accident* Work Related Injury* Personal Injury* Not Sure
 Other (please explain): _____

*Please ask for and complete relevant questionnaire and agreement

Date of Injury (or Date Problem First Noticed): _____ Is this a new problem? Yes No

If **NO**, have you previously sought treatment? Yes No

If **YES**, who provided treatment: _____ City, State: _____

What did the previous treatment consist of, and what were the results? _____

Are you currently experiencing any: weakness numbness radiating pain

Do you feel your condition is getting: better worse staying the same

Please **circle** the current severity of your pain from 0 (no pain) to 10 (most extreme pain):

0 1 2 3 4 5 6 7 8 9 10

Past Medical History

Please list all previous surgeries, fractures, or serious illnesses:

Date	Type of Surgery/Fracture/Illness	Date	Type of Surgery/Fracture/Illness

Have you ever had general anesthesia? Yes No

If **YES**, did you have any problems? Yes No

If **YES**, please explain: _____

Past Medical History (Con't)

Please list ALL medications you are currently taking (prescription, over the counter, and herbal/nutritional supplements):

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have any allergies? Yes No If YES, please list your allergies: _____

Do you have any of the following conditions? Liver Disease Kidney Disease Hypertension
 Diabetes Heart Disease Cancer No

Have you in the past, or are you currently taking any of the following medications? (Please Check)

<input type="checkbox"/> Aspirin (Bayer)	<input type="checkbox"/> Ibuprofen (Motrin, Advil)	<input type="checkbox"/> Naproxen (Aleve, Naprosyn)
<input type="checkbox"/> Celecoxib (Celebrex)	<input type="checkbox"/> Indomethacin (Indocin)	<input type="checkbox"/> Oxaprozin (DayPro)
<input type="checkbox"/> Diclofenac (Voltaren)	<input type="checkbox"/> Ketoprofen (Orudis/Oruvail)	<input type="checkbox"/> Refecoxib (Vioxx)
<input type="checkbox"/> Diclofenac Na/Misoprostol (Arthrotec)	<input type="checkbox"/> Ketoralac (Torodol)	<input type="checkbox"/> Sulindac (Clinoril)
<input type="checkbox"/> Etodolac (Lodine)	<input type="checkbox"/> Meloxicam (Mobic)	<input type="checkbox"/> Tolmentin (Tolectin)
<input type="checkbox"/> Fenoprofen (Nalfon)	<input type="checkbox"/> Nabumetone (Relafen)	<input type="checkbox"/> Valdecoxib (Bextra)

If you checked any of the above medications, did you have any adverse reactions? Yes No

If YES, please explain: _____

Family History

Have any of your **BLOOD RELATIVES** had (or currently have) the following (Please Check):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis	

If you checked any of the above, please explain (family members & conditions): _____

Social History

Single Married Divorced Separated Widowed

Do you have children? Yes No If YES, How Many? _____ Do you live alone? Yes No

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Social History (Con't)

Are you on a special diet? Yes No If **YES**, Please describe _____

History of substance abuse? Yes No If **YES**, Please describe _____

Do you smoke? Yes No If **YES**, ____ packs per day for ____ years

Have you quit smoking? Yes No If **YES**, when did you quit?
 This year >1 year >5 years >10 years
 Previously smoked ____ packs per day for ____ years

Do you drink alcohol? Yes No If **YES**, how often?
 Daily 1-2 x/week 1-2 x/month 1-2 x/year

Review of Systems

Please circle No (N) or Yes (Y) if you have any of the following conditions.

Constitutional			Ears, Nose, Mouth & Throat			Eyes		
Good General Health	N	Y	Hearing Loss/Ringing	N	Y	Wear Glasses/Contacts	N	Y
Recent Weight Change	N	Y	Sinus Problems	N	Y	Blurred/Double Vision	N	Y
Night Sweats, Fevers	N	Y	Nose Bleeds	N	Y	Eye Disease or Injury	N	Y
Fatigue	N	Y	Sore Throat/Voice Change	N	Y	Glaucoma	N	Y
Cardiovascular			Respiratory			Gastrointestinal		
Chest Pain	N	Y	Shortness of Breath	N	Y	Nausea/Vomiting	N	Y
Palpitations	N	Y	Cough	N	Y	Abdominal Pain	N	Y
Heart Trouble	N	Y	Wheezing/Asthma	N	Y	Rectal Bleeding	N	Y
Swelling Hands/Feet	N	Y	Coughing up Blood	N	Y	Diarrhea	N	Y
Musculoskeletal			Neurological			Inflammatory Bowel Disease	N	Y
Muscle Pain or Cramps	N	Y	Frequent Headaches	N	Y	Integumentary (Skin/Breast)		
Stiffness/Swelling Joints	N	Y	Paralysis or Tremors	N	Y	Change in Hair or Nails	N	Y
Joint Pain	N	Y	Convulsions/Seizures	N	Y	Rashes or Itching	N	Y
Trouble Walking	N	Y	Numbness/Tingling	N	Y	Breast Lump	N	Y
Endocrine			Hematologic/Lymphatic			Breast Pain or Discharge	N	Y
Excessive Thirst/Urination	N	Y	Bruise Easily	N	Y	Allergic/Immunologic		
Thyroid Disease	N	Y	Slow to Heal	N	Y	Food Allergies	N	Y
Hormone Problem	N	Y	Enlarged Glands	N	Y	Aspirin Allergies	N	Y
Genitourinary – MALE ONLY			Genitourinary – FEMALE ONLY			Antibiotic Allergies	N	Y
Blood in Urine	N	Y	Blood in Urine	N	Y	Psychiatric		
Kidney Stone	N	Y	Kidney Stone	N	Y	Hallucinations	N	Y
Sexual Problems	N	Y	Sexual Problems	N	Y	Confusion/Memory Loss	N	Y
Testicular Pain	N	Y	Menstrual Problems	N	Y	Depression	N	Y
			Could You Be Pregnant?	N	Y			

Signature

Patient (or Legal Guardian) Signature: _____ Date: _____

FOR FACILITY USE ONLY

Comments: _____

Reviewed By: _____, MD Date: _____