Holy Cross Medical Group
Orthopedic Institute Patient Intake

General Medical History – Page 1 of 2

Raúl Gösthe, M.D.

Date: ______________________________

Last Name: ____ First: ____________________ Middle Initial: __________

Date of Birth: ____________ Age: _______ Height: ____ft. ____in. Weight: ________lbs. Right/Left Handed: __________

Employer: ____ Occupation: ______________________________

If retired, what was your date of retirement: ______________ Email Address: ______________________________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Family Physician: ____ Phone: ____________________

Referred By: __________________ Local Pharmacy: ____________________ Pharmacy Number: ______________

Presenting Complaint

Affected Side of the Body: Right Side ___ Left Side ___ Both Sides ___

Area of the Body Affected: Knee ___ Shoulder ___ Hip ___ Ankle ___ Foot ___ Elbow ___ Hand Spine ___

How long have you had this problem? ____#

Is this the result of an injury? No ___ Yes ___ If yes, please describe how the injury occurred: ____________________

Is this a Workman's Compensation injury? No ___ Yes ___ **Does it involve medical-legal claims?** No ___ Yes ___

Previous Treatments (IN REGARD TO YOUR KNEE PAIN)

Medications: Do you ever use any of these medications to treat your knee pain? No ___ Yes ___

Advil ___ Aleve ___ Tylenol ___ Motrin ___ Celebrex ___ Mobic ___ Ibuprofen ___ Tramadol ___

Any other medications used to treat your knee pain? ____

Injections: Have you had cortisone injection(s) into your knee before? __________ Date(s): ____________________

Have you had lubricating injection(s) into your knee before? __________ Date(s): ____________________

Bracing: __________________ **Do you ever need an assistive walking device?** No ___ Yes ___

If yes, what device(s)? Wheel Chair, Cane, Walker, Crutches

Have you done Physical Therapy or an Exercise Program for your knees? No ___ Yes ___ Date(s): ______________

What activities does your knee prevent your from doing or make difficult to do? ______________________________

Does your knee pain prevent you from performing the activities of daily living? ______________________________

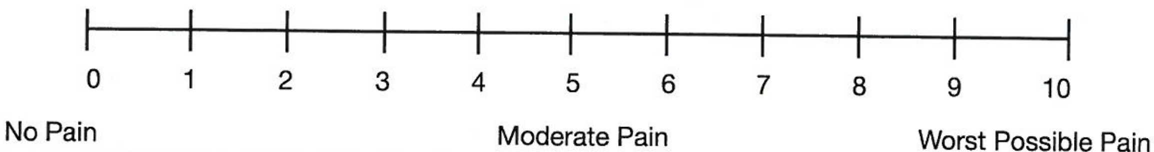
Is your knee pain changing in quality? Worse ___ Better ___ Staying the same ___

Please describe your pain: Quality: Dull ___ Throbbing ___ Sharp ___ Intermittent ___ Constant ___

Symptoms: Swelling ___ Bruising ___ Redness ___ Heat ___ Numbness ___ Weakness ___ Giving Way ___

Other Symptoms: ____

0-10 Numeric Pain Rating Scale



No Pain | Moderate Pain | Worst Possible Pain

Past Medical History: Have you had or have any of the following? (check all that apply) NONE ______

______ High Blood Prressure ______ Hepatitis ______ Asthma ______ Multiple Sclerosis
______ Mitral Valve Prolapse ______ Ulcers ______ Rash/Skin Lesion ______ Parkinsons
______ Diabetes ______ Heart Attack/MI ______ Recent Cold ______ Emphysema/Lung Disease
______ Kidney Disease ______ Blood Clots/DVT ______ Gout ______ Bronchitis
______ Cancer ______ Seizures ______ Angina ______ HIV/AIDS
______ Back/Disk Disease ______ Sickle Cell Anemia ______ Bleeding Disorder ______ TB
______ Osteoporosis ______ Atrial Fibrillation ______ Thyroid Disease ______ Past Blood Transfusions
______ Rheumatoid Arthritis ______ Psoriatic Arthritis ______ RSD ______ Fibromyalgia

Review of Symptoms: Have you had any of the following? (check all that apply) NONE ______

______ Fever/Night Sweats ______ Difficulty Breathing ______ Unexplained Weight Losss ______ Sore Throat/Ear Ache
______ Stomach Pain ______ Chest Pain ______ Bladder Problems/Infections ______ Depression
______ Numbness ______ Cramps ______ Bleeding Tendency ______ Hot Flashes

Other (Explain): ______________________________

Do you have any metal allergies or sensitivities? ______________________________

List of Allergies: ______________________________

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

____

____

____

List any surgery or hospitalization that you have had:

______________________________ Date: ______________
______________________________ Date: ______________
______________________________ Date: ______________
______________________________ Date: ______________

Social History:

Marital Status: Single ______ Married ______ Divorced ______ Saparated ______ Widowed ______ Domestic Partner ______
Family History: Children: Yes ______ No ______ IF YES, how many? Male ______ Female ______

Do you use any of the following?

Tobacco Never a Smoker ______ Past Smoker ______ Current Smoker ______ If so, how much daily? ______
Alcohol Yes ______ No ______ How much per day? ______________
Controlled Narcotics Yes ______ No ______ What and how often? ______________
Other Drugs Yes ______ No ______ What and how often? ______________

Family Medical History: (check all that apply) NONE ______

Arthritis ______ Cancer ______ Osteoporosis ______ Problems with Anesthesia ______ Diabetes ______ Obesity ______
Other: ______________________________

Patient Signature: ______________________________ Date: ______________

<u>OFFICE USE ONLY</u>

Reviewed By: ______________________________ Date: ____________ Time: ____________
Reviewed By: ______________________________ Date: ____________ Time: ____________

PATIENT INFORMATION RECORD

Allergies:_______________ **Age:**_______________

Patient's Legal Name: ______________________________ Today's Date: ______________
First M.I. Last

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: ______________________

Email Address:____

Responsible Party: ______________________________ Telephone: (___)- ___________
First M.I. Last

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. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.v

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. I authorize the Hospital and all of its employees, independent contractors, business associates, agents and/or affiliates of same (collectively "Hospital") to contact me through the use of any dialing equipment or an artificial voice or prerecorded voice, at any telephone number associated with my account including wireless telephone numbers, provided by me or found by means of skip tracing methods or otherwise even if I am charged for the call. I expressly consent to such automated calls and with such consent, I specifically waive any objection or claim I may have against the Hospital, for making such calls, including any claim under the Telephone Consumer Protection Act and any similar law and regulations as amended. This consent may not be orally revoked or modified but may be withdrawn at any time in writing.

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 September 23, 2013.

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: ______________________________

____

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Holy Cross Medical Group

24 Hour cancellation & "No Show" Fee Notice

Recognizing that everyone's time is valuable and the appointment time is limited, we ask that you provide a 24 hour notice if you are unable to keep your appointment. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, the Physicians of Holy Cross Medical Group reserve the right to charge a fee of $ 25.00 for each missed (No Show) appointment, which is, absent for compelling reason, and is not cancelled within a 24 hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "No Shows" in any 12 month period may result in termination from our practice.

Thank you for anticipated cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy

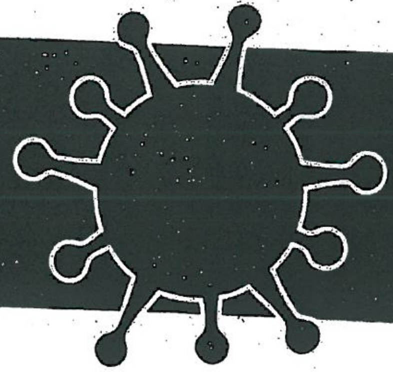
____
Patient Name Date of Birth

____
Printed – Guardian or Parent Name Date

____
Signature Date

CORONAVIRUS DISEASE 2019
(COVID-19)

Patient intake form for all ambulatory sites



Patient must complete and sign this form prior to coming back for their appointment:

Today's Date:____________

Name: ____________________ **Date of Birth:**____________

- Have you been exposed to anyone who has been diagnosed with the Coronavirus within the last 14 days?
  YES or **NO**
- Are you currently awaiting your results for a Coronavirus test?
  YES or **NO**
- Have you tested positive with the Coronavirus within the last 14 days?
  YES or **NO**

Do you have:

- Fever? **YES** or **NO**
- Cough? **YES** or **NO**
- Shortness of breath? **YES** or **NO**
- Any flu like symptoms? **YES** or **NO**

Patient Signature: ______________________________

Updated 2020-07-13