



Chart #: _____

PATIENT INFORMATION:

First Name: _____ Middle: _____ Last: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone (Home): () _____ (Business): () _____

Cell Phone: () _____ Beeper: () _____

Birth Date: _____ Age: ____ Sex M/F: ____ Marital Status **circle one** (S/M/W/D/Sep)

Social Security #: _____ E-Mail Address: _____

***We need to be able to reach you for last minute changes due to emergencies which may arise.**

PERSONAL INSURANCE INFORMATION:

Name of Primary Insurance: _____ Name of Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Group #: _____ ID #: _____ Group #: _____ ID #: _____

NOTE: PLEASE SUBMIT YOUR CARD(S) SO A COPY CAN BE MADE FOR OUR FILES.

Emergency Contact/Relationship: _____

Phone # (other than your home phone): () _____

How did you get Dr. Barmakian's name? _____

Your Employer: _____ Address: _____

Phone #: () _____ Occupation: _____

**PLEASE COMPLETE ONLY IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE).
ALL MINORS MUST BE ACCOMPANIED BY AN ADULT TO ALL VISITS.**

Parent/Guardian/Responsible Person: _____

Address: _____

Employer: _____ Phone #: () _____

PLEASE COMPLETE INFORMATION ON THE BACK OF THIS PAGE.

Name: _____

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IF YOUR INJURY IS WORK RELATED, PLEASE COMPLETE THIS SECTION

Employer's Name: _____

Phone #: () _____ Supervisor: _____

Worker's Comp. Insurance Carrier : _____ Phone #: () _____

Representative: _____ Claim Number: _____

Has this been reported to your employer? Yes / No When? _____ To Whom? _____

IF YOUR INJURY IS RELATED TO AN AUTO ACCIDENT, PLEASE COMPLETE THIS SECTION

Name & Address of Auto Insurance Company: _____

_____ Phone #: () _____

Policy Number: _____ Claim Number: _____

Policyholder's Name & Address: _____

Attorney's Name & Address: _____ Phone #: () _____

MEDICAL INFORMATION (PLEASE COMPLETE):

Chief Complaint: _____

Part of body affected: **(Circle one)** Left/Right: _____

How did this happen? _____

Date of Injury: _____ **OR** Date of onset of symptoms: _____

Please describe any treatment you have had for this problem: _____

Might you be pregnant now? Yes / No (Circle one) Date of Last Menstrual Period: _____

IF YOU ARE PREGNANT, OR THINK YOU MAY BE, TELL THE X-RAY TECHNOLOGIST BEFORE HAVING AN X-RAY TAKEN.

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Hazardous Substances: (Describe)
	Heavy Lifting: (Number of pounds)
	Other:

Name: _____

Chart #: _____

Personal Physician's Name: _____

Address: _____ Phone #: () _____

HEALTH HISTORY (Confidential)

CONDITIONS Check (✓) conditions you have or have had in the past.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Pneumonia | |

What Kind:

MEDICATIONS List medications you are currently taking and doses:

ALLERGIES To medications or substances and your reaction
 Check here if none (No known drug allergies)

Name of Medicine	Dose	Name of Drug	Reaction

Pharmacy Name: _____ **Pharmacy Phone #:** () _____

HEALTH HABITS Check (✓) which substances you use and describe how much.

Caffeine	Cups/day: _____	Former/Present Drug Use	Describe:
Tobacco	Packs/day: _____ # of years: _____	Alcohol	Drinks/day: Average week:

PREVIOUS SURGERIES

Year	Hospital	Type of Surgery

PLEASE COMPLETE INFORMATION ON THE BACK OF THIS PAGE.

Name: _____

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HEALTH HISTORY (Confidential)

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<div style="border: 1px solid black; padding: 5px;"> <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Shortness of breath </div>	<p>WOMEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Abnormal Pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination			<p>Date of Last Pap Smear: _____</p> <hr/> <p>Have you had a Mammogram? _____</p>

FAMILY HISTORY Fill in health information about your family. (All information is strictly confidential)

Relation	Age	List Health Problems	Age at Death	Cause of Death	Check (✓) if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					<input type="checkbox"/> Arthritis, Gout	
					<input type="checkbox"/> Asthma, Hay Fever	
Mother					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Diabetes	
Brother(s)					<input type="checkbox"/> Heart Disease, Strokes	
					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
Sister(s)					<input type="checkbox"/> Other	

MEDICATION RENEWALS WILL ONLY BE DONE BETWEEN 9 AM & 5 PM MONDAY THROUGH FRIDAY. (Please plan ahead to avoid missing necessary medication.)

Name: _____

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I certify that the information I have provided is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

PAYMENT AGREEMENT

IT IS THE POLICY OF THE ORTHOPAEDIC HAND & UPPER EXTREMITY CENTER, A PROFESSIONAL ASSOCIATION, THAT CHARGES FOR SERVICES RENDERED BY OUR PHYSICIANS AND STAFF BE PAID AT THE TIME OF SERVICE, UNLESS OTHER FORMAL ARRANGEMENTS HAVE BEEN MADE WITH OUR BUSINESS OFFICE.

AS A COURTESY TO YOU, ELECTRONIC OR HARDCOPY INSURANCE CLAIMS WILL BE FILED BY THE ORTHOPAEDIC HAND & UPPER EXTREMITY CENTER, A PROFESSIONAL ASSOCIATION. HOWEVER, IT WILL BE YOUR RESPONSIBILITY TO PROVIDE OUR OFFICE WITH THE NECESSARY INFORMATION AND SIGNED AUTHORIZATION FOR US TO FILE. THIS INFORMATION AND AUTHORIZATION MUST BE PROVIDED TO OUR OFFICE AT YOUR FIRST VISIT, ACCOMPANIED BY THE PAPERS NEEDED TO FILE A HARDCOPY CLAIM.

ARRANGEMENT FOR MONTHLY PAYMENTS MAY BE MADE WITH OUR BUSINESS OFFICE FOR ANY PATIENT ACCOUNT BALANCE IN EXCESS OF \$200. A MINIMUM PAYMENT IS REQUIRED EACH MONTH TO KEEP AN ACCOUNT ACTIVE. YOU ARE RESPONSIBLE FOR MAKING THE MONTHLY PAYMENT BY THE 5TH WORKING DAY OF EACH MONTH WHETHER OR NOT A STATEMENT HAS BEEN SENT TO YOU. ANY PATIENT ACCOUNT WHICH BECOMES DELINQUENT (MONTHLY PAYMENT NOT MADE WITHIN 30 DAYS OF THE LAST PAYMENT), WILL BEGIN TO BE PROCESSED IN THE OFFICE COLLECTION DEPARTMENT, AND THE COMPLETE BALANCE WILL BECOME DUE IMMEDIATELY.

I AGREE TO THE ABOVE FINANCIAL AGREEMENT FOR ANY SERVICES PROVIDED TO ME BY THE ORTHOPAEDIC HAND & UPPER EXTREMITY CENTER, A PROFESSIONAL ASSOCIATION.

Date: _____ Responsible Party Signature: _____

PRIVACY STATEMENT

We value you as a patient and take your personal privacy seriously. We contractually require any person or organization providing products or services to patients on our behalf to protect the confidentiality of all patient information. We do not share patient information with anyone unless you expressly authorize us to do so.

We afford prospective and former patients the same protections as existing patients with respect to the use of personal information.

PLEASE COMPLETE INFORMATION ON THE BACK OF THIS PAGE.

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AUTHORIZATIONS
Please sign where

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to The Orthopaedic Hand & Upper Extremity Center, A Professional Association for any services furnished to me. I understand I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

MEDICARE LIFETIME SIGNATURE ON FILE:

I request the payment of authorized Medicare benefits to be made on my behalf to The Orthopaedic Hand & Upper Extremity Center, A Professional Association, for any services furnished to me by the physician. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits.

Signed: _____ Date: _____

MEDICAL RECORDS RELEASE:

I authorize release of my medical records to The Orthopaedic Hand & Upper Extremity Center, A Professional Association, and permit a copy of this authorization to be used as the original. I authorize The Orthopaedic Hand & Upper Extremity Center, A Professional Association, to release information or photocopies of the course of my treatment with the understanding that this will be used for the purpose of insurance, legal, research or education.

Signed: _____ Date: _____

MEDICAL SERVICES AUTHORIZATION:

I authorize you to give me reasonable and proper medical care by today's standards.

Signed: _____ Date: _____

CONSENT:

I consent to photographs that may be taken for medical, educational or insurance purposes provided that my name is neither revealed nor listed in any medical publication.

Signed: _____ Date: _____

ALL DISABILITY FORMS WILL BE COMPLETED AND MAILED WITHIN 7 - 10 DAYS FROM THE TIME YOU SUBMIT THEM TO US FOR COMPLETION OF THE MEDICAL PORTION.

PLEASE DO NOT EXPECT THE DOCTOR TO COMPLETE THESE FORMS DURING YOUR VISIT.