WELCOME

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1 PATIENT INFORMATION

Date: ________________

Patient: ____

Address: ____

____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthdate: ______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: ____

Occupation: ____

Employer: ____

Employer Address: ____

Employer Phone: ____

Spouse's Name: ____

Spouse's Phone: ____

Referring Physician Name: ______________________________

Ref Physician Address: ______________________________

Ref Physician Phone: ______________________________

2 INSURANCE

Who is responsible for this account? ______________________

Relationship to Patient: ______________________

Birthdate: ______________ SS #: ______________

Insurance Co. ______________________

Group #: ______________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: ______________________

Birthdate: ______________ SS #: ______________

Insurance Co.: ______________________

Group #: ______________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with ______________________ and assign directly to Richard Seldes, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

Relationship: ______________________ Date: ______________

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Richard Seldes, MD for any services furnished to me by Richard Seldes, MD. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

______________________________ ______________
Beneficiary Signature Date

3 PHONE NUMBERS

Home: ______________ Work: ______________ Ext: _______

Best time and place to reach you: ______________________

IN CASE OF EMERGENCY, CONTACT:

Name: ____________________ Relationship: ____________

Phone: Home: ______________ Work: ______________

4 FAMILY HISTORY

	Father	Present health or cause of death	**Mother**	Present health or cause of death	**Spouse**	Present health or cause of death
Alive	☐		☐		☐	
Deceased	☐		☐		☐	

	# Alive	Health	# Deceased	Cause of Death
Brothers				
Sisters				Cause of Death
Children				Ages and Cause of Death

Check illnesses which have occurred in any of your **BLOOD RELATIVES:** ☐ Diabetes ☐ Cancer ☐ Bleeding Tendency ☐ Kidney Disease ☐ Tuberculosis ☐ Heart Disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

5 MEDICAL HISTORY (All information is strictly confidential)

What is the reason for today's visit? ___________________________

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

General
Chills ☐Y ☐N
Depression/Nervousness ☐Y ☐N
Dizziness/Fainting ☐Y ☐N
Fever ☐Y ☐N
Forgetfulness ☐Y ☐N
Headache ☐Y ☐N
Loss of Sleep ☐Y ☐N
Numbness ☐Y ☐N
Sweats ☐Y ☐N

Muscle/Joint/Bone
Pain, weakness, numbness in:
Arms ☐Y ☐N
Hips ☐Y ☐N
Back ☐Y ☐N
Legs ☐Y ☐N
Feet ☐Y ☐N
Neck ☐Y ☐N
Hands ☐Y ☐N
Shoulders ☐Y ☐N

Genito-Urinary
Blood in urine ☐Y ☐N
Frequent urination ☐Y ☐N
Lack of bladder control ☐Y ☐N
Painful urination ☐Y ☐N

Gastrointestinal
Appetite poor ☐Y ☐N
Bloating ☐Y ☐N
Bowel changes ☐Y ☐N
Constipation ☐Y ☐N
Diarrhea ☐Y ☐N
Excessive thirst ☐Y ☐N
Gas ☐Y ☐N
Hemorrhoids ☐Y ☐N
Indigestion ☐Y ☐N
Nausea ☐Y ☐N
Rectal bleeding ☐Y ☐N
Stomach pain ☐Y ☐N
Vomiting ☐Y ☐N
Vomiting blood ☐Y ☐N

Cardiovascular
Chest pain ☐Y ☐N
High/low blood pressure ☐Y ☐N
Irregular/Rapid heart beat ☐Y ☐N
Poor circulation ☐Y ☐N
Swelling of ankles ☐Y ☐N
Varicose veins ☐Y ☐N
Cardiovascular disease ☐Y ☐N

Ear, Nose and Throat
Bleeding gums ☐Y ☐N
Blurred vision ☐Y ☐N
Crossed eyes ☐Y ☐N
Difficulty swallowing ☐Y ☐N
Double vision ☐Y ☐N
Earache/Ear discharge ☐Y ☐N
Hay fever ☐Y ☐N
Loss of hearing ☐Y ☐N
Nosebleeds ☐Y ☐N
Persistent cough ☐Y ☐N
Ringing in ears ☐Y ☐N
Sinus problems ☐Y ☐N
Vision – Flashes/Halos ☐Y ☐N

Skin
Bruise easily ☐Y ☐N
Hives ☐Y ☐N
Itching/Rash ☐Y ☐N
Change in moles ☐Y ☐N
Scars ☐Y ☐N
Sores that won't heal ☐Y ☐N
Other skin problems ☐Y ☐N

Men Only
Erection difficulties ☐Y ☐N
Lump in testicles ☐Y ☐N
Penis discharge ☐Y ☐N
Sore on penis ☐Y ☐N

Other ___________________

Women Only
Abnormal Pap Smear ☐Y ☐N
Bleeding between periods ☐Y ☐N
Breast lump ☐Y ☐N
Extreme menstrual pain ☐Y ☐N
Hot flashes ☐Y ☐N
Nipple discharge ☐Y ☐N
Painful intercourse ☐Y ☐N
Vaginal discharge ☐Y ☐N
Other ☐Y ☐N

Date of last menstrual period __________
Date of last Pap Smear __________
Have you had a mammogram? __________
Are you pregnant? __________
Number of children __________

Check (✓) symptoms you have or have had in the past:

AIDS ☐Y ☐N
Appendicitis ☐Y ☐N
Arthritis ☐Y ☐N
Asthma ☐Y ☐N
Bleeding Disorders ☐Y ☐N
Breast Lump ☐Y ☐N
Cancer ☐Y ☐N
Cataracts ☐Y ☐N
Chemical Dependency ☐Y ☐N

Chicken pox ☐Y ☐N
Diabetes ☐Y ☐N
Emphysema ☐Y ☐N
Epilepsy ☐Y ☐N
Glaucoma ☐Y ☐N
Heart Disease ☐Y ☐N
Hepatitis ☐Y ☐N
Herpes ☐Y ☐N
High Cholesterol ☐Y ☐N

HIV positive ☐Y ☐N
Kidney Disease ☐Y ☐N
Liver Disease ☐Y ☐N
Measles ☐Y ☐N
Migraine Headaches ☐Y ☐N
Multiple Sclerosis ☐Y ☐N
Mumps ☐Y ☐N
Pacemaker ☐Y ☐N
Pneumonia ☐Y ☐N

Polio ☐Y ☐N
Prostate Problem ☐Y ☐N
Rheumatic Fever ☐Y ☐N
Scarlet Fever ☐Y ☐N
Stroke ☐Y ☐N
Thyroid Problems ☐Y ☐N
Tuberculosis ☐Y ☐N
Ulcers ☐Y ☐N
Venereal Disease ☐Y ☐N

Have you ever been under the care of a psychiatrist or neurologist? ☐Yes ☐No

Describe serious illnesses or operations ___________________________

Primary Physician Name ___________________________

PCP'S Address ___________________________

PCP'S Phone ___________________________

6 MEDICATIONS/ALLERGIES

List medications you are currently taking ___________________________

____

Pharmacy Name ____________________ Phone ______________

List allergies to medications or substances ___________________________

____

7 HEALTH HABITS

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

☐ Caffeine ______________
☐ Drugs ______________
☐ Tobacco ______________
☐ Other ______________

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

☐ Stress
☐ Heavy Lifting
☐ Hazardous Substances
☐ Other ______________

Your Occupation ___________________________

8 SIGNATURES

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

Signature ______________________________ Date ____________

Reviewed by ______________________________ Date ____________

PATIENT'S NAME: ______________________________

Sex: Male / Female Height: ____________ **Weight:** ____________ **Age:** ________

What Injury? ______________________________ **LEFT RIGHT BILATERAL**

Were you injured at work auto accident sports ____________ **gym other**____________

When? ____________________ **Patient's signature:**____________________

Office Use Only

Past Medical History ______________________________

Past Surgical History ______________________________

Family History ______________________________
Father : alive deceased Mother : alive deceased

Social History Smoke ________ ___**Alcohol** ________ **Active**________

Allergies: ______________________________

Meds: ______________________________

Review of Systems:

Neurological: ____________________

Musculoskeletal:____________________

Eyes:____________________

Ears/Nose/Throat:____________________

Cardiovascular:____________________

Respiratory:____________________

Gastrointestinal:____________________

Genitourinary:____________________

Skin:____________________

Psychiatric:____________________

Endocrine:____________________

Hema/Lymphatic____________________

Allergic/Immunologic____________________

Family History

Diabetes

Arthritis

Cancer

Heart Disease

H. Blood Pressure

Kidney Disease

Stroke

TB

Nervous Disease

Allergy

Bleeding Tendency

Liver disease

Other:

PX: Voltaren ; P.T. ; Brace:____________________ **Foot Orthotics ; Glucosamine ; Synvisic Injections ;**