Nassos Orthopaedic Surgery and Sports Medicine

Jonathan T. Nassos, M.D.

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

List medications you are currently taking: _____

_____

Allergies: None (circle if none)_____ **Previous Surgery**(ies)**:** Y N_____

Handedness: R__ L__ Please list _____

FAMILY HISTORY: **_____**

Heart Disease____ Diabetes____ Hypertension____ Bleeding Problems____ Other_____

Do you smoke? Y N If you do, how much a day?_____How many years?_____

Do you drink alcohol? Y N If you do, how much a day?_____For how many years?_____

Do you/have you previously used drugs? Y N **Do you live alone?** Y N

Any information you provide will not be released and will only be used for the purpose of our office.

Please circle conditions you have and state if current condition or past history of condition :

Anemia	Cancer (Type?)	Gout	Migraine Headaches	Rheumatic
Anorexia	Cataracts	Heart disease (Type?	Mononucleosis	Scarlet Fever
Appendicitis	Chickenpox	Hepatitis	Multiple Sclerosis	Stroke
Arthritis	Diabetes (Type?)	Hernia	Mumps	Thyroid Problem
Asthma	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Bleeding Disorders	Epilepsy	High Blood Pressure	Pneumonia	Typhoid Fever
Breast Lump	Glaucoma	Kidney Disease	Polio	Ulcers
Bronchitis		Liver Disease	Prostate Problem (Type?)	Venereal Disease
Bulimia		Measles		

Please circle conditions you currently have or have had:

AIDS/HIV Positive Alcoholism Chemical Dependency Psychiatric Care

Please circle symptoms you currently have or have had <u>in the past 3 months:</u>

<u>GENERAL</u>
Chills
Depression
Dizziness
Fainting
Fever
Headache
Loss of sleep
Loss of weight
Gain of weight
Nervousness
Sweats

<u>MUSCLE/JOINT/ BONE</u> (Pain, Weakness, Numbness in)
Arms – Hips
Back – Legs
Feet – Neck
Hands – Shoulders

<u>GASTROINTESTINAL</u>
Appetite poor
Bloating
Bowel changes
Constipation
Diarrhea
Nausea
Rectal bleeding
Stomach Pain
Vomiting
Vomiting Blood

<u>SKIN</u>
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sore that won't heal

<u>EYE,EAR,NOSE,THROAT</u>
Bleeding gums
Hoarseness
Nosebleeds
Persistent cough
Ringing in ears

<u>CARDIOVASCULAR</u>
High Blood Pressure
Irregular Heartbeat
Low Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Ankles
Varicose Veins
Chest Pain

<u>FEET</u>
Pain
Nail fungus
Claw toe/Hammer toe

<u>WOMEN ONLY</u>
Abnormal pap spear
Bleeding between periods
Breast Lump
Hot Flashes
Are you pregnant?__
No. of children___

<u>GENITO-URINARY</u>
Blood in urine
Frequent Urination
Lack of Bladder control
Painful Urination

ASSIGNMENT OF BENEFITS
& RELEASE OF INFORMATION

Commercial Insurance

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to (name of patient) _____.
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Signature of patient or guardian:_____

Medicare/Medicaid Insurance

Beneficiary_____Medicare Number _____Medigap ID Number_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Jonathan T. Nassos, MD, for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

Beneficiary Signature:_____ **Date of Birth: _____/_____/_____**

Insurance Information: Who is the insurance policy subscriber? _____

Name of Insurance Plan/Group: _____ Subscriber's Social Security #: _____-_____-_____

Subscriber's Employer: _____ Effective Date of Insurance:_____

Secondary Insurance Information:_____

Name of Insurance Plan/Group: _____

Please know your insurance. It is your responsibility. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance.

AUTHORIZATION OF BENEFITS

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, or any other health plan to: Jonathan T. Nassos, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all necessary information to insurance carriers or any other services including billing and transcription, concerning my illness and treatments in order to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signature: _____ Date: _____/_____/_____

Name of Authorized Guardian if patient is a minor: _____