



# ADVANTAGE ORTHOPAEDICS, PC

William O. Thompson, MD

695 Dutchess Turnpike  
Poughkeepsie, NY 12603  
(845) 473-2100  
(845) 473-2910 Fax

525 East 71<sup>st</sup> ST  
New York, NY 10021  
(212) 606-1733  
(845) 473-2910 Fax

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of accident/injury: \_\_\_\_\_

Why are you seeing the doctor today?-

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past Medical History: (Medical conditions):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries/Hospitalizations	Year	Complications

Have you ever had general anesthesia?  No  Yes

Have any problems with anesthesia?  No  Yes

Describe: \_\_\_\_\_

Family History: (any heart, lung, cancer, diabetes, rheumatoid or orthopaedic conditions in the family at a young age)

\_\_\_\_\_  
\_\_\_\_\_

Social History:

Work in the home    Employed (occupation)    Student    Daycare    Retired  
 Single    Married    Divorced    Separated    Widowed

Children?  No  Yes # \_\_\_\_\_

Do you live alone?  No  Yes

Exercise?  Daily    Weekly    Monthly    Rarely    Never

What type of exercise?  No  Yes

History of substance abuse?  No  Yes

Smoke currently?  No  Yes \_\_\_\_\_ Packs per day for \_\_\_\_\_ years.

Quit smoking?  This year    >1 year    >5 years    >10 years

Previously smoked \_\_\_\_\_ packs per day for \_\_\_\_\_ years.

Drink alcohol?  Daily    1-2 x/week    1-2 x/month    1-2 x/year    None



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Current problem is the result of a(n): Check all that apply:

Car Accident    Work Accident    Accident    Other

Medication	Dose	Reason For Medication	Side Effects

ALLERGIES: \_\_\_\_\_

Are all immunizations up to date?  Yes  No, If no, which immunizations are due?

### REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

Circle      Please describe all Yes responses

- Eyes                       No  Yes \_\_\_\_\_
- Ears, Nose, Throat     No  Yes \_\_\_\_\_
- Lungs, Breathing       No  Yes \_\_\_\_\_
- Digestion                 No  Yes \_\_\_\_\_
- Bowel movement       No  Yes \_\_\_\_\_
- Bladder problem       No  Yes \_\_\_\_\_
- Diabetes                  No  Yes \_\_\_\_\_
- High blood pressure    No  Yes \_\_\_\_\_
- Bleeding problems     No  Yes \_\_\_\_\_
- Balance problems       No  Yes \_\_\_\_\_
- Numbness/tingling     No  Yes \_\_\_\_\_
- Blackout/fainting       No  Yes \_\_\_\_\_
- Psychological problems  No  Yes \_\_\_\_\_
- AIDS                       No  Yes \_\_\_\_\_
- Cancer                     No  Yes \_\_\_\_\_
- Arthritis                  No  Yes \_\_\_\_\_
- Polio                       No  Yes \_\_\_\_\_
- TB                          No  Yes \_\_\_\_\_
- Epilepsy                  No  Yes \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ MD Date: \_\_\_\_\_



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NAME: \_\_\_\_\_ AGE OF PATIENT: \_\_\_\_\_ DATE: \_\_\_\_\_

DATE OF BIRTH OF PATIENT: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

REFERRED BY: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE# \_\_\_\_\_

PHYSICIAN'S ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OFFICE OF WILLIAM O. THOMPSON, M.D.

## RELEASE OF MEDICAL INFORMATION TO OTHER PHYSICIANS:

Often times it may be necessary for your doctor to share medical information with other physicians (i.e. your family doctor or primary care physician) who may be currently involved in your treatment. This allows the doctor to cross reference important medical information to provide you the best care possible. Your doctor can only share your medical records with other physicians when you release him/her to do so. By completing your signature below, you understand all of the above and allow this office to share medical information necessary for your treatment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



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Please List Current Medical Insurance Information:

Insured's Name \_\_\_\_\_

Primary Ins: \_\_\_\_\_ ID #: \_\_\_\_\_

Address of Company \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ ID #: \_\_\_\_\_

Address of company: \_\_\_\_\_

Compensation  No Fault  Date of Accident: \_\_\_\_\_

Comp or Auto Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax#: \_\_\_\_\_ Personal contact at Ins. Co: \_\_\_\_\_

## FINANCIAL POLICY:

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT IF FOR ANY REASON MY INSURANCE COMPANY DENIES PAYMENT, I AM FULLY RESPONSIBLE FOR ANY SERVICES RENDERED. I CERTIFY THAT THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY STATUS OR IN THE PROVIDED INFORMATION. I ALSO AUTHORIZE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY, SHOULD IT BE NECESSARY, IN ORDER TO PROCESS ANY OF MY MEDICAL CLAIMS.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_