

Center for Orthopedic Surgery P.L.C.

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Kevin Hanlon, D.O.
Ronald Meisel, D.O.
James Kehoe, D.O.

Patient Information Sheet

Please complete the following questions in full. Thank you in advance for your cooperation.

Patient

Last Name: _____ First Name: _____ Middle Init. _____

Street

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: () _____ Social Security Number: _____ Marital Status: _____

Work Phone Number: () _____

Birthdate: _____ Age: _____ Sex: _____ Height: _____ Weight: _____ Occupation: _____

Insurance Information

Subscriber's

Last Name: _____ First Name: _____ C) (L)¹ _____

Social _____ Employer's _____

Security Number: _____ Name: _____

Employer's _____

Address _____ Telephone: () _____

I hereby authorize payment directly to Drs. Hanlon/Meisel/Kehoe of the surgical and/or medical benefits payable to me for the services as described but not to exceed the reasonable and customary charges for those services.

I authorize any holder of medical or other information about me to release such information is necessary to process these claims or related medical claims

I permit a copy of this authorization to be used in place of the original.

I understand I (am f financially responsible to the doctor for the charges not covered by this agreement.

Patient's Signature: _____ Date: _____

Patient History

Who referred you to us: _____ Why? _____

Who is your Family Physician: _____

Current Problem for this evaluation:

Body Part: _____ Right ___ Left ___ Both ___ Are you ___ Right ___ Left / handed

When did your problem begin? _____ If an injury or accident, Date: _____

Has an attorney been consulted? _____ Is your problem a result of and accident? ___ no yes ___ (auto/ Slip&Fall / Other)

Explain: How? When? Where? _____

What if any Treatment have you had so far and by whom? _____

Have you had any X-rays? No ___ Yes ___ when? _____ where? _____

Do you have *any* allergies? No ___ Yes ___, Please list: _____

List any medications you are currently taking and reason for taking (include OverTheCounter): _____

OVER

General Past Medical History

Have you had any serious illnesses ____ yes ____ no

Please List:

Review of systems Medical history;

Other *Orthopedic Problems*: None ____ Arthritis, ____ Joint swelling ____ Tendonitis ____ Sprain of ____
Other _____

Circulatory Problems., None ____ Blood Clots ____ Phlebitis ____ Stroke ____ Swelling ____ Other _____

Heart Disease: None ____ Heart Attack ____ Heart Failure ____ High Blood Pressure ____ Other _____

Respiratory Problems: None ____ Asthma ____ Wheezing ____ Short of Breath ____ Emphysema ____ Other _____

Gastrointestinal Problems: None ____ Ulcer ____ Diarrhea ____ Nausea & Vomiting ____ Weight Change ____ Hepatitis
____ Bloody Stool ____ Other _____

Genitourinary.- None ____ Infection ____ Pain on urination ____ Frequency of urination ____ Other _____

Neurological: None ____ Headaches ____ Fainting ____ Seizures ____ Stroke ____ Paralysis ____ Numbness ____ Head injury
Other _____

Emotional Problems: None ____ Nervous Breakdown ____ Depression ____ Stress ____ Sleeplessness ____ Drug/ Alcohol
Other _____

Bleeding Problems: None ____ Other _____

Endocrine Metabolic: None ____ Diabetes ____ Thyroid ____ Hypoglycemia ____ Other _____

Genetic / Inherited Disorders.- None ____ List _____

Gynecological.- (females) Last Menstrual Period: _____ Last Pap _____

Pregnancies: _____ Complications: _____ Children: _____

Past Surgeries:

Please List: _____

Life Style

Coffee/tea Caffeine: _____ Amount _____ /day

Tobacco Cigar/ Cigarettes/ Smokeless tobacco: Amount _____ / day

Alcohol / Other substances: list _____

Do you consider your overall health as: Excellent ____ Very Good ____ Good ____ Fair ____ Poor ____ Other _____

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct to the best of my ability.

Signed.- _____ Date.- ____ / ____ / ____