

GEORGE J. ZAMBETTI, Jr., M.D.
 ORTHOPAEDIC ASSOCIATES OF New York, PC
 343 WEST 58TH STREET ♦♦ New York, NY
 10019 ♦♦ Tel (212) 506-0236 ♦♦ Fax (212) 265-0491
 Website: *ZambettiMD.com*

Date: _____

Your Email _____

PATIENT INFORMATION

Patient name: _____ Dr. Mr. Ms. Mrs.
 Home address: _____ Home phone: _____
 City, State, Zip: _____ Cell Phone: _____
 Date of birth: _____ Age: _____ SS#: _____
 Occupation: _____ Bus. Phone: _____
 Employer's Name: Or (School) _____
 Employer's address: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____

REFERRAL SOURCE

Patient referred by: Physician Friend Insurance
Send office notes to referring M.D. Yes or No
 Referring Name: _____ Phone: _____
 Address: _____

PRIMARY INSURANCE

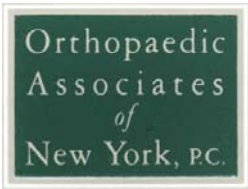
Policyholder is: Patient Spouse Parent Managed Care? Yes No
 Policyholder name: _____ SS # _____ DOB _____
 Insurance company: _____ Phone: _____
 Insurance address: _____
 Certificate number: _____ Group: _____ Plan: _____

SECONDARY INSURANCE

Policyholder is: (Patient) (Spouse) (Parent)
 Policyholder name: _____ SS # _____ DOB: _____
 Insurance company: _____ Phone: _____
 Certificate number: _____ Group: _____ Plan: _____

WORKERS' COMPENSATION INFORMATION

Carrier Name: _____ Phone: _____
 Carrier Address: _____ Contact Person: _____
 WCB Case # _____ Carrier Case # _____
 Date of Accident: _____ Place: _____
 Comments/Details: _____



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PATIENT MEDICAL HISTORY

Please note the reason for today's visit: _____

Please provide any additional medical information relevant to your current problem: _____

Date of Injury/Problem began: _____ Side of body affected: Right Left Both
 I am Right handed I am Left handed

Medications: _____

Allergies: _____

Please circle any of the following conditions you have now, or have had in the past:

- | | | | |
|-----------------------------|-------------------------|------------------------|------------------------|
| Rheumatoid Arthritis | Bleeding | Problem Gout | Cancer |
| Tuberculosis | Kidney Disease | Stomach Ulcer | Thyroid Disease |
| High Blood Pressure | Goiter | Bladder Disease | Heart Disease |
| Diabetes | High Cholesterol | HIV | |

List prior surgeries of any kind including dates and complications: _____

Please describe, with dates, any serious injuries: _____

PATIENT AUTHORIZATIONS

Claims Authorization - I hereby authorize any treating physician to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon my dependents, and our heirs, executor's administrators and me.

Assignment of Benefits - Private and Federal (Medicare) - I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to this office (**OANY**) for any services furnished by my physician(s) to me. 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 payable for related services. I understand that any services deemed "Non Covered" by my carrier are my sole financial responsibility, as outlined in my coverage manual, Prompt and complete payment of said services is also my sole responsibility.

Credit Card Authorization – I authorize, when requested by me over the phone, use of my credit card for outstanding charges

Litigation Disclaimer - It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X ray in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

Date: _____ **Signature:** _____ **Print Name:** _____