

## Welcome to Groff Orthopaedics and Sports Medicine

Thank you for the opportunity to provide you with orthopaedic care! We would like to make your first appointment as smooth as possible. There are a few things to bring with you to the appointment in order to help you better.

In anticipation of your scheduled office visit, please find enclosed our

- **Patient Information Sheet:**

Please fill it out as best you can and bring it to your appointment.

If you've had any previous treatment for your problem, please bring with you:

- **Any relevant medical information for this problem**

This may take the form of any or all of the following:

- Operative notes from previous surgeries
- Office notes from previous treating doctors
- Reports and films from previous x-rays, MRIs or other studies

Please also remember to bring:

- **Your current insurance card**
- **referral** from your PCP (when applicable)
- **shorts** if being seen for hips or knees
- **a tank top** if being seen for shoulders

Should you find that you are unable to keep your appointment, please notify our office at least 24 hours in advance.

Please know that we respect your time, but due to the unpredictable nature of medical care, sometimes we run behind schedule. We thank you for your patience in advance and promise to try to make your visit efficient and worth your while!!

If you have any questions or concerns, please do not hesitate to call our office.

We look forward to meeting you in person!

Best wishes,

*Dr. Groff & Staff*

PATIENT INFORMATION

Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Home Address \_\_\_\_\_ Marital Status \_\_\_\_\_  
\_\_\_\_\_ Age \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
\_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_  
Emergency Contact Name and Phone \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_  
Family Physician \_\_\_\_\_ Employer \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_  
\_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_ Phone \_\_\_\_\_ Phone \_\_\_\_\_

If the patient is under 21 years old or mentally incompetent, please complete the following:

Guardian \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Bill to Address \_\_\_\_\_

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INSURANCE INFORMATION

Insurance Carrier \_\_\_\_\_ ID # \_\_\_\_\_  
Auto Accident Carrier \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ Claim # \_\_\_\_\_  
Worker's Comp Carrier \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_ Claim # \_\_\_\_\_

## MEDICAL HISTORY INFORMATION

Please list any operations that you have had. If possible, please give the year, the name of the procedure and surgeon, and the hospital where it was done.

YEAR	PROCEDURE	SURGEON	HOSPITAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been admitted to a hospital other than for a surgery? List the reason and year if possible.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please circle if you have had any of the following conditions.

Cancer Type: \_\_\_\_\_

Hepatitis \_\_\_\_\_

Jaundice \_\_\_\_\_

Bleeding Tendency \_\_\_\_\_

Heart Trouble \_\_\_\_\_

Heart Attack \_\_\_\_\_

Stroke \_\_\_\_\_

Current Infections \_\_\_\_\_

Low Thyroid \_\_\_\_\_

Asthma \_\_\_\_\_

High Blood Pressure \_\_\_\_\_

Blood Clot Formation \_\_\_\_\_

Psychiatric Illness \_\_\_\_\_

Stomach Ulcer \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Gout \_\_\_\_\_

Seizures \_\_\_\_\_

Hereditary Defects \_\_\_\_\_

What medications are you currently taking?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any other medical conditions that you think we should know about: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you allergic to Penicillin? Yes No      Are you allergic to Latex? Yes No

If allergic to other medications or have other allergies, please list them and the reaction you had:

\_\_\_\_\_

\_\_\_\_\_

Do you smoke? Yes No      For how many years? \_\_\_\_\_

How many packs per day? \_\_\_\_\_

On average, how many drinks do you have a week?    0    1-5    6-10    11-15    >16

# REVIEW OF MEDICAL CONDITIONS

Do you have any of these conditions? (Please circle)

## General Symptoms

Recent weight change .....Yes  
Fever .....Yes  
Fatigue .....Yes  
Headaches .....Yes

## Eyes

Eye disease or injury .....Yes  
Wear glasses/contact lenses .....Yes  
Blurred or double vision .....Yes  
Glaucoma .....Yes

## Ears/Nose/Mouth/Throat

Hearing loss or ringing .....Yes  
Earaches or drainage .....Yes  
Chronic sinus problems or rhinitis .....Yes  
Nose bleeds .....Yes  
Mouth sores .....Yes  
Bleeding gums .....Yes  
Bad breath or bad taste .....Yes  
Sore throat or voice change .....Yes  
Swollen glands in neck .....Yes

## Cardiovascular and Heart

Heart trouble .....Yes  
Chest pain or angina pectoris .....Yes  
Palpitation .....Yes  
Shortness of breath with walking  
or lying flat .....Yes  
Swelling of feet, ankles or hands .....Yes

## Respiratory and Breathing

Chronic or frequent coughs .....Yes  
Spitting up blood .....Yes  
Shortness of breath .....Yes  
Asthma or wheezing .....Yes

## Gastrointestinal

Loss of appetite .....Yes  
Change in bowel movements .....Yes  
Nausea or vomiting .....Yes  
Frequent diarrhea .....Yes  
Painful bowel movements or  
constipation .....Yes  
Rectal bleeding or blood in stool .....Yes  
Abdominal pain or heartburn .....Yes  
Peptic ulcer (stomach or duodenal) .....Yes

## Genitourinary

Frequent urination .....Yes  
Burning or painful urination .....Yes  
Blood in urine .....Yes  
Change in force of strain  
when urinating .....Yes  
Incontinence or dribbling .....Yes  
Kidney stones .....Yes

## Musculoskeletal

Joint pain .....Yes  
Joint stiffness or swelling .....Yes  
Weakness of muscle or joints .....Yes  
Muscle pain or cramps .....Yes  
Back pain .....Yes  
Cold extremities .....Yes  
Difficulty walking .....Yes

## Skin and Breast

Rash or itching .....Yes  
Change in skin color .....Yes  
Change in hair or nails .....Yes  
Varicose veins .....Yes  
Breast pain .....Yes  
Breast lump .....Yes  
Breast discharge .....Yes

## Neurological

Frequent or recurring headaches .....Yes  
Light-headedness or dizziness .....Yes  
Convulsions or seizures .....Yes  
Numbness and tingling sensations .....Yes  
Tremors .....Yes  
Paralysis .....Yes  
Stroke .....Yes  
Head Injury .....Yes

## Psychiatric

Memory loss or confusions .....Yes  
Nervousness .....Yes  
Depression .....Yes  
Insomnia .....Yes

## Endocrine

Glandular or hormone problem .....Yes  
Thyroid disease .....Yes  
Diabetes .....Yes  
Excessive thirst or urination .....Yes  
Heat or cold intolerance .....Yes  
Skin becoming dryer .....Yes  
Change in hat or glove size .....Yes

## Hematologic/Lymphatic

Slow to heal after cuts .....Yes  
Bleeding or bruising tendency .....Yes  
Anemia .....Yes  
Phlebitis .....Yes  
Past transfusions .....Yes  
Enlarged glands .....Yes

## Allergic

History of skin reaction or other adverse reaction to:  
Penicillin or other antibiotics .....Yes  
Morphine, Demerol, other narcotics .....Yes  
Novocaine or other anesthetics .....Yes  
Aspirin or other pain remedies .....Yes  
Tetanus antitoxin or other serums .....Yes  
Iodine, methylate or other antiseptics .....Yes  
Known food allergies \_\_\_\_\_

Family Medical History

	Age	Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

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PLEASE READ AND SIGN THE INSURANCE AUTHORIZATION

**Commercial Insurance: required for all commercial carriers excluding Workman's Compensation and Auto Carriers:**

I authorize Groff Orthopaedics and Sports Medicine, to release to my insurance company any medical information necessary to process my medical claim. I hereby authorize payment to Groff Orthopaedics and Sports Medicine, of any benefit due me under my insurance plan. I understand that I am responsible for non-covered charges. This authorization or copy of it shall be valid for 12 months.

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

**Medicare Authorization:**

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information or other information to provide to the Medicare Program and/or any of my insurance carriers any information needed for this or a related claim. I request payment be made directly to the provider.

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

**Workers Compensation/Auto Insurance Authorization:**

I authorize Groff Orthopaedics and Sports Medicine, to release to my worker's compensation/ auto insurance company any medical information necessary to process my medical claim. If, for any reason, payment is denied, I authorize Groff Orthopaedics and Sports Medicine, to bill my primary health insurance and/or myself for non-covered charges.

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