

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 _____ _____	

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.	What medications are you currently taking?
Cancer Type: _____	Asthma _____
Hepatitis _____	High Blood Pressure _____
Jaundice _____	Blood Clot Formation _____
Bleeding Tendency _____	Psychiatric Illness _____
Heart Trouble _____	Stomach Ulcer _____
Heart Attack _____	Tuberculosis _____
Stroke _____	Gout _____
Current Infections _____	Seizures _____
Low Thyroid _____	Hereditary Defects _____

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 changeYes
FeverYes
FatigueYes
HeadachesYes

Eyes

Eye disease or injuryYes
Wear glasses/contact lensesYes
Blurred or double visionYes
GlaucomaYes

Ears/Nose/Mouth/Throat

Hearing loss or ringingYes
Earaches or drainageYes
Chronic sinus problems or rhinitisYes
Nose bleedsYes
Mouth soresYes
Bleeding gumsYes
Bad breath or bad tasteYes
Sore throat or voice changeYes
Swollen glands in neckYes

Cardiovascular and Heart

Heart troubleYes
Chest pain or angina pectorisYes
PalpitationYes
Shortness of breath with walking
or lying flatYes
Swelling of feet, ankles or handsYes

Respiratory and Breathing

Chronic or frequent coughsYes
Spitting up bloodYes
Shortness of breathYes
Asthma or wheezingYes

Gastrointestinal

Loss of appetiteYes
Change in bowel movementsYes
Nausea or vomitingYes
Frequent diarrheaYes
Painful bowel movements or
constipationYes
Rectal bleeding or blood in stoolYes
Abdominal pain or heartburnYes
Peptic ulcer (stomach or duodenal)Yes

Genitourinary

Frequent urinationYes
Burning or painful urinationYes
Blood in urineYes
Change in force of strain
when urinatingYes
Incontinence or dribblingYes
Kidney stonesYes

Musculoskeletal

Joint painYes
Joint stiffness or swellingYes
Weakness of muscle or jointsYes
Muscle pain or crampsYes
Back painYes
Cold extremitiesYes
Difficulty walkingYes

Skin and Breast

Rash or itchingYes
Change in skin colorYes
Change in hair or nailsYes
Varicose veinsYes
Breast painYes
Breast lumpYes
Breast dischargeYes

Neurological

Frequent or recurring headachesYes
Light-headedness or dizzinessYes
Convulsions or seizuresYes
Numbness and tingling sensationsYes
TremorsYes
ParalysisYes
StrokeYes
Head InjuryYes

Psychiatric

Memory loss or confusionsYes
NervousnessYes
DepressionYes
InsomniaYes

Endocrine

Glandular or hormone problemYes
Thyroid diseaseYes
DiabetesYes
Excessive thirst or urinationYes
Heat or cold intoleranceYes
Skin becoming dryerYes
Change in hat or glove sizeYes

Hematologic/Lymphatic

Slow to heal after cutsYes
Bleeding or bruising tendencyYes
AnemiaYes
PhlebitisYes
Past transfusionsYes
Enlarged glandsYes

Allergic

History of skin reaction or other adverse reaction to:
Penicillin or other antibioticsYes
Morphine, Demerol, other narcoticsYes
Novocaine or other anestheticsYes
Aspirin or other pain remediesYes
Tetanus antitoxin or other serumsYes
Iodine, methylate or other antisepticsYes
Known food allergies _____

Family Medical History

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

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 _____