

Winthrop Orthopaedic Associates, PC

James D. Capozzi, MD
 Ronald Lewis, MD
 Mark G. Grossman, MD
 Omid S. Barzideh, MD

Glenn A. Teplitz, MD
 John Gaffney, DO
 Nomaan Ashraf, MD
 Henry Boateng, MD

PATIENT INFORMATION

(MUST BE FILLED OUT COMPLETELY BY ALL PATIENTS)

Patient Name:			
Patient Home Address:			
City:			
State:			
Zip:			
Home Phone #:	()	Cell/ Beeper #:	()
Date of Birth:	/ /	Social Security #:	/ /
Sex:	Male Female	Marital Status:	S / M / D / W

Name of Spouse:			
Date of Birth:		Social Security #:	/ /
Emergency Contact:			
Emergency Contact #:			
Relationship:			

Patient Employer:		Spouse Employer:	
Employers Address:		Employer Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
Employer Phone #:		Employer Phone #:	

Who is your Primary Physician?	
Physician Address:	
City:	
State:	
Zip:	
Physician Phone #:	

How were you referred to the office?	Another Physician or Hospital Emergency Room
Physician Name:	Hospital:
Address:	Address:
City:	City:
State:	State:
Zip:	Zip:

Pharmacy Name			
Pharmacy Phone #		Pharmacy Fax #	
Pharmacy Address			

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INSURANCE INFORMATION

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Primary Insurance:	
Policy ID#:	
Group#	
Effective Date:	Expiration Date:
Policy Holder:	
Policy Holder's DOB:	
Policy Holder's SS#:	Policy Holder's Sex: M F
Policy Holder's Address:	
Relationship to Patient:	Self / Spouse / Parent / Guardian

Secondary Insurance:	
Policy ID#:	
Group #:	
Policy Holder:	
Policy Holder's DOB:	
Policy Holder's SS#:	Policy Holder's Sex: M F
Policy Holder's Address:	
Relationship to Patient:	Self / Spouse / Parent / Guardian

**IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE
 RECEPTIONIST FOR THE APPROPRIATE FORMS...
 THIS IS YOUR RESPONSIBILITY!**

Did injury occur at school?	
School Name:	
School Phone #:	
School Insurance Carrier Name:	
School Insurance Address:	
City:	
State:	
Zip:	
Date of Injury:	
If injury occurred during a school sport, please give name of sport: _____	

Patient Name: _____
 DOB: _____
 Date: _____

FAMILY HISTORY

Member	Alive	Deceased	Age	Health Status or cause of death
Grandmother - Mom	A	D		
Grandfather - Mom	A	D		
Grandmother - Father	A	D		
Grandfather - Father	A	D		
Father	A	D		
Mother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		

SOCIAL HISTORY

- Do you live alone? YES NO
- Do you exercise? YES NO
 - If so, what type of exercise do you do? _____
- Are you on a special diet? YES NO
 - If so, what type of diet? _____
- Is there a history of substance abuse? YES NO
 - If so, what substances did you use? _____
- Do you drink alcohol? YES NO
 - If so, state frequency: _____
- Is there a history of alcohol abuse? YES NO
- Do you currently smoke? YES NO
 - If so, how many packs per day? _____
- Have you quit smoking recently? YES NO
 - If so, when did you quit smoking: _____
 - Please list how many packs per day and years you used to smoke: _____

REVIEW OF SYSTEMS:

Are you currently having or had problems with any below. (circle and describe all yes responses):

	YES	NO	
Eyes, Ears, Nose, Throat	YES	NO	
Lungs (breathing)	YES	NO	
Digestion	YES	NO	
Bowel / Bladder Problems	YES	NO	
Diabetes	YES	NO	
High Blood Pressure	YES	NO	
Bleeding Problems	YES	NO	
Balancing	YES	NO	
Numbness / Tingling	YES	NO	
Blackouts / Fainting	YES	NO	
Epilepsy	YES	NO	
Psychological Problems	YES	NO	
AIDS	YES	NO	
Cancer	YES	NO	
Arthritis	YES	NO	
Polio	YES	NO	
TB	YES	NO	

Patient Name: _____
 Patient Signature: _____
 Reviewed by: _____

Date of Birth: _____
 Date: _____
 Date: _____

MEDICARE SECONDARY BENEFIT QUESTIONNAIRE

Patient Name: _____ Date: _____

Please indicate why Medicare is a Secondary Benefit: YES NO

Covered by Spouse Employer Group Plan? YES NO

End Stage Renal Disease Beneficiary? YES NO

Disabled Beneficiary under age 65? YES NO

Covered under Black Lung Benefits? YES NO

Benefit from Veteran's Administration? YES NO

Is Medicare a Secondary Payer to a
Workers Compensation Case? YES NO

Is Medicare a Secondary Payer to a
No Fault Case? YES NO

Is Medicare a Secondary Payer to a
Liability Case? YES NO

SIGNATURE: _____

Date: _____