Physician Name: Gerard T. Gabel, M.D.

PATIENT DEMOGRAPHIC INFORMATION SHEET

Last Name | First Name | Middle | Social Security No.

Date of Birth | Age | Male or Female *(Please circle one)* | Marital Status: M S W D *(Please circle one)*

Home Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Contact Preference: *(Please Check One)* Home | Work | Cell | Mail | Email Address

Referred By: | Phone #:

EMERGENCY CONTACT INFORMATION

Name | Phone No. | Alt. Phone | Relationship

PATIENT EMPLOYER INFORMATION

Employer Name | Phone | Fax

Address | City | State | Zip

GUARANTOR / POLICY HOLDER INFORMATION

Last Name | First Name | Middle | Social Security No.

Date of Birth | Patient's Relationship to Policy Holder | Home Phone | Cell Phone

Employer Name | Phone | Fax

Employer Address | City | State | Zip

INSURANCE INFORMATION

Primary Insurance	Name of Primary Insurance	ID/Policy Number	Group Number	Customer Service No.
Secondary Insurance	Name of Secondary Insurance	ID/Policy Number	Group Number	Customer Service No.
Work Comp Insurance	Name of WC Insurance	Claim #	Adjuster Name	Adjuster Phone No.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE UNDERSIGNED PHYSICIAN OF THE SURGICAL AND/OR MEDICAL BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS AUTHORIZATION DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF ALL CHARGES WITHIN 50 DAYS. **AUTHORIZATION TO RELEASE INFORMATION:** I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OF TREATMENT.

Signature: _____ **Date:** _____

GERARD T. GABEL, M.D.
HAND, SHOULDER AND ELBOW SURGEON
Department of Orthopedic Surgery
(PLEASE FILL OUT COMPLETELY INCLUDING BACK SIDE OF THIS SHEET)

DATE_____ NAME _____

AGE___ REFERRED BY _____

Employer_____ Job Title: _____

Marital Status: S M D W

ARE YOU: Right handed_____ Left handed_____ Height_____ Weight_____

Where is the Pain: NECK PAIN__
RIGHT: Shoulder____ Elbow____ Forearm ____ Wrist____ Hand____ Finger____
LEFT: Shoulder____ Elbow____ Forearm____ Wrist____ Hand____ Finger____

When did your symptoms begin? ____/____/____ What are your symptoms?
_____

If your symptoms are the result of an injury, where and on what date did the accident occur?
Where: home _____ school_____ work _____ auto_____ Date ____/____/____
What happened? _____
_____

If work related, how long have you worked at this job? _____
Any history of other job related injury?_____
Describe:_____
If job related, date last worked? _____ Present work restrictions:_____
_____
Is there an Attorney involved: Yes No
Name _____ Phone (___)_____

What treatment(s) have you had for this problem (i.e. injections, medication, surgery, therapy, splints, ect)? _____
_____

What tests have been performed? (Please include: X-ray, EMG's, CT scan, MRI, arthrogram and blood tests)_____
_____

NEXT PAGE

PATIENT HISTORY

PAST MEDICAL HISTORY

	You	Family Member		You	Family Member
Diabetes:	___	___	Lung Problems:	___	___
Heart Problems:	___	___	Transfusion:	___	___
Rheumatoid Arthritis:	___	___	Lupus:	___	___
			Tuberculosis:	___	___
Thyroid Problems:	___	___	Hiatal Hernia:	___	___
Asthma:	___	___	Psych Problems:	___	___
Blood Clots:	___	___	Irregular Heart:	___	___
Cancer:	___	___	Colitis:	___	___
Pneumonia:	___	___	Alcohol Abuse:	___	___
Bleeding Problems:	___	___	High Blood Pressure:	___	___
Sleep apena	___	___	Hepatitis:	___	___
				__A __B__C	
Kidney Problems:	___	___	HIV	___	

Last Menstrual Period: _____ Pregnant? Yes No

Do you smoke? Yes No If yes, how many pack(s) per day? _____

Do you have any hobbies that involve the use of your hand(s) or arm(s)? Yes___No___ If yes, what are they?_____

Do you have pain in any other joints? If yes, which joints? _____
_____

Please list all medication(s) to which you have had an allergic or bad reaction:
_____
_____
_____

Please list all medication(s) you are currently taking (including non-prescriptions medications):
_____
_____
_____

Please list any surgeries: _____
_____
_____

SOUTHWEST ORTHOPEDIC GROUP, LLP

Review of Notice of Privacy Practices

Acknowledgement:

I acknowledge that I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient or Personal Representative Signature **Date**

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____.

Financial Policy Statement

It is the policy of Southwest Orthopedic Group, L.L.P. to bill your insurance carrier as a courtesy to you; however, you are responsible for the entire bill. We require that arrangements for payment of your estimated share be made today. The insured/patient is responsible for any co-payments at the time service is rendered. If your insurance carrier does not remit payment within sixty (60) days, the balance will be due in full from you. If your insurance pays in excess of the balance of your account, we will refund the credit.

If any payment is made directly to you for services billed by Southwest Orthopedic Group, L.L.P., you recognize an obligation to promptly remit same to Southwest Orthopedic Group, L.L.P.

The above does not apply for those patients that are considered Workers' Compensation. However, be advised as a Compensation patient that you may be held responsible for your charges in the event that your claim is controverted.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Southwest Orthopedic Group, L.L.P., I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.
The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____

Responsible Party Print Name **Date**

_____

Responsible Party Signature

MEDICATION LIST

(PLEASE LIST ALL PRESCRIPTIONS, OVER THE COUNTER AND DIETARY SUPPLEMENTS)

DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ALLERGIES: _____

PHARMACY NAME: _____ **PHONE #:** _____ **Fax #:** _____

PHARMACY NAME: _____ **PHONE #:** _____ **Fax #:** _____

MEDICATION NAME AND STRENGTH	HOW OFTEN TAKEN	WHAT IT IS TAKEN FOR
EXAMPLE: ASPIRIN 81 MG.	*1 DAILY*	*TO THIN BLOOD*

Patient Signature: _____ Date: _____