

# Nassos Orthopaedic Surgery and Sports Medicine

Jonathan T. Nassos, M.D.

## PATIENT HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

List medications you are currently taking: \_\_\_\_\_

Allergies: None (circle if none) \_\_\_\_\_ Previous Surgery(ies): Y N \_\_\_\_\_

Handedness: R\_\_ L\_\_ Please list \_\_\_\_\_

### FAMILY HISTORY:

Heart Disease\_\_\_\_ Diabetes\_\_\_\_ Hypertension\_\_\_\_ Bleeding Problems\_\_\_\_ Other\_\_\_\_\_

Do you smoke? Y N If you do, how much a day?\_\_\_\_\_ How many years?\_\_\_\_\_

Do you drink alcohol? Y N If you do, how much a day?\_\_\_\_\_ For how many years?\_\_\_\_\_

Do you/have you previously used drugs? Y N Do you live alone? Y N

**Any information you provide will not be released and will only be used for the purpose of our office.**

### Please circle conditions you have and state if current condition or past history of condition :

Anemia	Cancer (Type?)	Gout	Migraine Headaches	Rheumatic
Anorexia	Cataracts	Heart disease (Type?)	Mononucleosis	Scarlet Fever
Appendicitis	Chickenpox	Hepatitis	Multiple Sclerosis	Stroke
Arthritis	Diabetes (Type?)	Hernia	Mumps	Thyroid Problem
Asthma	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Bleeding Disorders	Epilepsy	High Blood Pressure	Pneumonia	Typhoid Fever
Breast Lump	Glaucoma	Kidney Disease	Polio	Ulcers
Bronchitis		Liver Disease	Prostate Problem (Type?)	Venereal Disease
Bulimia		Measles		

### Please circle conditions you currently have or have had:

AIDS/HIV Positive                      Alcoholism                      Chemical Dependency                      Psychiatric Care

### Please circle symptoms you currently have or have had in the past 3 months:

<u>GENERAL</u>	<u>GASTROINTESTINAL</u>	<u>EYE,EAR,NOSE,THROAT</u>	<u>WOMEN ONLY</u>
Chills	Appetite poor	Bleeding gums	Abnormal pap smear
Depression	Bloating	Hoarseness	Bleeding between periods
Dizziness	Bowel changes	Nosebleeds	Breast Lump
Fainting	Constipation	Persistent cough	Hot Flashes
Fever	Diarrhea	Ringling in ears	Are you pregnant?__
Headache	Nausea		No. of children__
Loss of sleep	Rectal bleeding	<u>CARDIOVASCULAR</u>	
Loss of weight	Stomach Pain	High Blood Pressure	
Gain of weight	Vomiting	Irregular Heartbeat	<u>GENITO-URINARY</u>
Nervousness	Vomiting Blood	Low Blood Pressure	Blood in urine
Sweats		Poor Circulation	Frequent Urination
		Rapid Heartbeat	Lack of Bladder control
<u>MUSCLE/JOINT/BONE</u> (Pain, Weakness, Numbness in) Arms – Hips Back – Legs Feet – Neck Hands – Shoulders	<u>SKIN</u> Bruise easily Hives Itching Change in moles Rash Scars Sore that won't heal	Swelling of Ankles Varicose Veins Chest Pain <u>FEET</u> Pain Nail fungus Claw toe/Hammer toe	Painful Urination

**ASSIGNMENT OF BENEFITS  
& RELEASE OF INFORMATION**

**Commercial Insurance**

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to (name of patient) \_\_\_\_\_.  
I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

**Signature of patient or guardian:** \_\_\_\_\_

**Medicare/Medicaid Insurance**

Beneficiary \_\_\_\_\_ Medicare Number \_\_\_\_\_ Medigap ID Number \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Jonathan T. Nassos, MD, for any service furnished to me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine the benefits payable for related services.

**Beneficiary Signature:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Insurance Information: Who is the insurance policy subscriber?** \_\_\_\_\_

**Name of Insurance Plan/Group:** \_\_\_\_\_ **Subscriber's Social Security #:** \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Subscriber's Employer:** \_\_\_\_\_ **Effective Date of Insurance:** \_\_\_\_\_

**Secondary Insurance Information:** \_\_\_\_\_

**Name of Insurance Plan/Group:** \_\_\_\_\_

**Please know your insurance. It is your responsibility. All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance.**

**AUTHORIZATION OF BENEFITS**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, or any other health plan to: Jonathan T. Nassos, MD. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all necessary information to insurance carriers or any other services including billing and transcription, concerning my illness and treatments in order to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Name of Authorized Guardian if patient is a minor:** \_\_\_\_\_