Trinity Medical WNY, PC

Patient Demographic Information

Date of Appointment: _____ Patient Legal Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Ht.: _____ Wt.: _____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Race: _____ Primary Language: _____ Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Lives with: ☐ Alone ☐ Spouse ☐ Other (specify): _____

Are you currently working: ☐ Yes ☐ No Full time: ☐ Yes ☐ No Occupation: _____

If not employed, why: ☐ Retired ☐ Disabled, date: _____ ☐ Other (specify): _____ Length of Employment: _____

Employer: _____ Address: _____ Phone: _____

Parent/Guarantor Name: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Address: _____ Phone: _____

Referring Physician: _____ Address: _____ Phone: _____

Primary Care Physician: _____ Address: _____ Phone: _____

Date of last visit with Primary Care Physician: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Primary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Secondary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Is there another insurance primary to Medicare: ☐ No ☐ Yes If yes, reason: _____

Do you have active Medicaid insurance: ☐ Yes ☐ No Is today's visit related to an automobile or wok injury: ☐ Yes ☐ No

Complete only if related to automobile or work injury: ☐ Work Injury ☐ Automobile Accident Date of Accident: _____

Insurance Carrier Name: _____ Address: _____ Phone: _____

Carrier Claim Number: _____ Adjuster's Name: _____ Ext. (if applicable): _____

If visit is related to a work injury or automobile accident please complete the No Fault/Worker's Compensation Questionnaire and also the Worker's Compensation A-9 form or the No Faults Assignment of Benefits form.

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Why are you seeing the provider today:

Shoulder: ☐ Right ☐ Left Elbow: ☐ Right ☐ Left Wrist: ☐ Right ☐ Left Hand: ☐ Right ☐ Left

Hip: ☐ Right ☐ Left Knee: ☐ Right ☐ Left Ankle: ☐ Right ☐ Left Foot: ☐ Right ☐ Left

Other (please specify): _____

Injury is related to: ☐ Work injury; date _____ ☐ Automobile accident; date _____ ☐ Sports injury; date _____

☐ Other (please specify): _____ Onset was: ☐ Sudden ☐ Gradual Duration: _____

In your own words, please describe your chief complaint: _____

_____

What, if anything, alleviates your condition: _____

Have you:

☐ Yes ☐ No Had any diagnostic studies, other than routine X-Rays taken? Yes, where: _____

☐ Yes ☐ No Seen any other doctors for this condition? Yes, who, Specialty: _____

☐ Yes ☐ No Had any formal physical therapy for this condition? Yes, where: _____

☐ Yes ☐ No Had any previous surgery for this condition? Yes, name of procedure, when: _____

☐ Yes ☐ No Missed work for this condition? Yes, dates: _____

Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Pollen ☐ Iodine ☐ Nickel ☐ Cobalt ☐ Chromate

Other (specify): _____ Reaction: _____

Medications: Please list all current medications, including over the counter medications, such as vitamins. Attach additional sheets if necessary.

Drug	Strength	Dose (how often)

Surgeries: Please list all prior inpatient or outpatient procedures. Attach additional sheets if necessary. ☐ None

Anesthesia complications: ☐ No ☐ Yes Explain: _____

Surgery	Date	Surgery	Date

Are you currently using any assistive devices for ambulation? ☐ No ☐ Yes Explain: _____

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please check conditions you currently have, or have had in the past:

☐ AIDS	☐ Eating Disorder: _____	☐ Miscarriage	☐ Respiratory Disease
☐ Anemia	☐ Gout	☐ Mononucleosis	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Hepatitis A, B, or C (circle one)	☐ Multiple Sclerosis	☐ Sleep Apnea
☐ Asthma	☐ Hernia	☐ Mumps	☐ Scarlett Fever
☐ Bleeding Disorder	☐ HIV Positive	☐ Osteoporosis	☐ Thyroid Disease
☐ Cancer: _____	☐ Kidney Disease	☐ Pacemaker/Defibrillator	☐ Tuberculosis
☐ Cardiovascular Disease	☐ Liver Disease	☐ Psychiatric Condition	☐ Typhoid Fever
☐ Chemical Dependency	☐ Measles	☐ Pneumonia	☐ Ulcers
☐ Chicken Pox	☐ Migraine headache	☐ Polio	☐ Venereal Disease
☐ Diabetes (Insulin Dependent)	☐ Other (please specify) _____		
☐ Diabetes (Non-Insulin Dependent)	_____		

Please check any symptoms you are currently experiencing:

Constitutional	Cardiovascular	Gastrointestinal	Skin	Neurologic
☐ Chills	☐ Blood clots	☐ Abdominal pain	☐ Bruising	☐ Confusion
☐ Fainting	☐ Edema	☐ Change in appetite	☐ Lesions	☐ Depression
☐ Impaired growth	☐ Coldness in extremities	☐ Constipation	☐ Ulcers	☐ Vertigo
☐ Change in height	☐ Faintness/dizziness	☐ Diarrhea	☐ Warts	☐ Numbness
☐ Change in weight	☐ Chest pain	☐ Excessive vomiting	☐ Brittle nails	☐ Tingling
☐ Shakiness	☐ Other: _____	☐ Other: _____	☐ Thickened nails	☐ Other: _____
☐ Other: _____			☐ Other: _____	

Musculoskeletal				
☐ Fibromyalgia	☐ Difficulty ambulating	☐ Instability	☐ Muscle cramps	☐ Muscle weakness
☐ Joint pain	☐ Muscle stiffness	☐ Leg swelling	☐ Movement limitations	☐ Tremors

☐ Other: _____

Personal Habits:

Do you currently smoke: ☐ No ☐ Yes Former smoker: ☐ No ☐ Yes Type and amount: _____

Do you currently use alcohol: ☐ No ☐ Yes Type and amount: _____

Do you currently use drugs: ☐ No ☐ Yes Type and amount: _____

Do you currently follow any special diet: ☐ No ☐ Yes Explain: _____

Do you currently exercise: ☐ No ☐ Yes Type and frequency: _____

List highest grade completed or degree received: _____

Physician signature _____ Date: _____

Trinity Medical WNY, PC

Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History: List all major medical illness for each member.

Mother: _____

Father: _____

Grandparents: _____

Siblings: _____

Children: _____

The information on this form is accurate to the best of my knowledge. I understand this Practice does not participate in the New York State Medicaid program, and, failure to disclose my coverage with the Medicaid program, prior to receiving services, may result in a balance being owed by me. I understand it is my responsibility to notify the office of any changes in the information contained on this form. I hereby give my consent to Trinity Medical, WNY to use and disclose protected health information about me to carry out treatment, payment, and health care operations. I authorize payment of medical benefits to the named physician/practice for services rendered. I understand that I am responsible for any additional fees incurred as a result of placing my account with an outside collection agency.

x _____ Date: _____

Signature of Patient or Parent/Legal Guardian (if patient under 18 years of age)

x _____

Printed Name of person signing form if different from patient

Physician signature _____ Date: _____