PINNACLE
Orthopedic & Spine Specialists

700 Michigan Ave.
Buffalo, NY 14203

(716) 854.5700 tel
(716) 854.5800 fax

heal@pinnacle-orthopedics.com

Your Appointment is: _____

- Co pays due at time of visit.
- Bring Photo ID and insurance cards.
- Paperwork must be completed.
- Must bring all films, reports and test results for your injury.
- Must arrive ½ hour before appointment.
- Cannot arrive later than ½ hour after appointment.

PATIENT MEDICAL PROFILE

PATIENT NAME *(First, Middle, Last)*: _____

Marital Status: _____ Occupation: _____ Work Status _____

Primary Care Physician _____ Referring Physician _____

PRIMARY COMPLAINT *(what is your primary medical problem to be addressed at your first visit):*

_____

_____

Medical History Questionnaire:

Sex: ☐ M ☐ F Height: _____ Weight: _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ☐ Yes ☐ No If yes: _____ Packs per Day for _____ years

Alcohol ☐ Yes ☐ No
If yes -- How much _____ How often ____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Anesthesia Problems with surgery? _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

☐ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- ☐ asthma
- ☐ COPD
- ☐ emphysema
- ☐ pulmonary embolism
- ☐ pneumonia
- ☐ tuberculosis
- ☐ respiratory arrest / ventilator
- ☐ sleep apnea
- ☐ other: _____

PATIENT NAME: _____

Personal Medical History *(continued)*:

Cardiac / Heart and peripheral vascular disease

- ☐ chest pain / angina
- ☐ heart attack, myocardial infarction
- ☐ congestive heart failure
- ☐ other: _____
- ☐ high blood pressure
- ☐ heart murmur, valve disorder
- ☐ mitral valve prolapse
- ☐ irregular heartbeat, arrhythmia
- ☐ peripheral vascular disease
- ☐ deep vein thrombosis
- ☐ bleeding problems

Neurologic Disorders

- ☐ stroke or TIA
- ☐ peripheral neuropathy
- ☐ other: _____
- ☐ parkinson's
- ☐ MS
- ☐ cerebral palsy
- ☐ polio

Bone & Joint Disorders

- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ other: _____
- ☐ gout
- ☐ lupus
- ☐ osteomyelitis
- ☐ ankylosing spondylitis
- ☐ scleroderma

Gastrointestinal Disorders

- ☐ peptic ulcer or stomach ulcer
- ☐ acid reflux, GERD
- ☐ GI bleed / bleeding ulcer
- ☐ diverticulitis
- ☐ Colitis - inflammatory bowel
- ☐
- ☐ hepatitis - Type _____
- ☐ liver disease
- ☐ other: _____

Genitourinary Disorders

- ☐ urinary tract infection
- ☐ bladder problems
- ☐ kidney problems
- ☐ kidney stones
- ☐ dialysis, kidney failure
- ☐ other: _____

Metabolic & Other Disorders

- ☐ Diabetes x _____ years
- ☐ thyroid problems
- ☐ alcohol or drug dependency
- ☐ HIV Positive test
- ☐ skin disorder _____
- ☐ psoriasis
- ☐ tooth abscess, gingivitis
- ☐ AIDS
- ☐ Depression or anxiety (circle)
- ☐ sickle cell disease
- ☐ high cholesterol or lipids
- ☐ other: _____

Cancer: any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

- ☐ asthma
- ☐ COPD or Emphysema
- ☐ heart attack, myocardial infarction
- ☐ bleeding problems
- ☐ Peripheral neuropathy
- ☐ osteoarthritis
- ☐ rheumatoid arthritis
- ☐ acid reflux, GERD
- ☐ liver disease
- ☐ kidney problems
- ☐ diabetes
- ☐ thyroid problems
- ☐ Malignant hyperthermia
- ☐ tuberculosis
- ☐ other lung :_____
- ☐ congestive heart failure
- ☐ other heart :_____
- ☐ MS or Parkinson's
- ☐ Lupus, ankylosing spondylitis
- ☐ Other bone & joint: _____
- ☐ inflammatory bowel disease
- ☐ other GI :_____
- ☐ dialysis, kidney failure
- ☐ psoriasis
- ☐ sickle cell disease
- ☐ Anesthesia complications:_____
- ☐ sleep apnea
- ☐ irregular heartbeat, arrhythmia
- ☐ other neuro :_____
- ☐ gout
- ☐ hepatitis - Type _____
- ☐ other: _____
- ☐ high cholesterol or lipids
- ☐ any skin ulcer

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Pinnacle Orthopedic & Spine

Patient Name_____
(First) (Middle) (Last)
Address _____
City, State, Zip _____
Telephone _____ Soc. Sec. #_____

Private Health Insurance

PRIMARY
Insurance Co. _____
Address _____
City, State, Zip _____
Telephone _____
Subscriber Name _____ Relationship_____
Date of Birth _____ Employer_____
Patient ID# _____ Group #_____

SECONDARY
Insurance Co. _____
Address _____
City, State, Zip _____
Telephone _____
Subscriber Name _____ Relationship to pt._____
Date of Birth _____ Employer_____
Patient ID# _____ Group #_____

Workers Compensation OR No-Fault Insurance Information

WCB/NF Insurance Co. _____
Insurance Claim # _____ NYS WCB# _____
Address _____
City, State, Zip _____
Telephone _____

EMPLOYER at time of injury _____
Year began employment _____ Date last worked _____
Address _____
City, State, Zip _____
Telephone _____
Date of Injury _____

Insurance Authorization

I authorize the release of any medical information necessary to process my insurance claims. I also authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event of my failure to pay any sums due and my account is referred to a collection agency for collection, I agree to be responsible for all applicable fees. A copy of my signature below is as valid as the original. I agree that a photocopy for this form may be used in lieu of the original.

Patient Signature_____

Pinnacle Orthopedic & Spine

Patient Policy

MINORS- You may have 1 person accompany you into the exam room. You May not leave any minor unaccompanied in the building. If you arrive with more than one minor and do not have an adult that can watch them during your exam, you will need to reschedule your appointment.

LATE- Patients arriving 30 minutes or more after the appointment time will usually be rescheduled.
If the doctor is behind his scheduled appointment by 1 hour, you will be asked if you would like to reschedule.

CO-PAY- This is due prior to your examination. You may have separate co-pay for the office visit, xray, and therapy.

HIPAA Protection

We will not divulge any information regarding your treatment, appointment dates and times etc., without your written consent. In the space provided below, kindly print clearly any person(s) to whom we may provide said information. Please note that a carbon copy of your narrative report(s) will not automatically be sent to the contacts listed below.

_____

_____

_____

_____
Patient Signature & Date

Pinnacle Orthopedic & Spine Specialists

Patients Authorization to Disclose Health Information

By completing and signing this form you authorize your healthcare provider to file medical reports with the parties you choose by checking the boxes below or naming them individually.

Failure to execute this authorization may interfere with your ability to obtain any benefits, such as social security, disability, or workers compensation benefits.

Claimant Name SS# Date of Birth

I_____, hereby authorize my treating health provider, to disclose my health information, including billing records to the following parties:

( ) NY Workers Compensation
( ) My current/former Employer
( ) Workers Compensation insurance carrier
( ) No-Fault Insurance Carrier
( ) My Current/former private health insurance
( ) The following people (state relationship):

Patient Signature Date

Pinnacle Orthopedic & Spine Specialists

Patient Treatment Waiver

Patient Name_____

Identification #_____

Provider Name_____

Date_____

Please check the appropriate box

( ) I understand that the physician I am seeing today is not my primary care physician, and therefore assume responsibility for paying the bill.

( ) I do not have a referral letter or authorized referral number. I understand that the referral letter or number is required prior to scheduling this visit in order to assure that it is a covered benefit. I have decided I want to continue with this visit today, and therefore assume responsibility for paying the bill.

( ) I understand it is my responsibility to verify that this provider participates in my healthcare plan. If the provider does not I assume responsibility for paying the bill.

Patient Signature _____

Patient printed Name_____

Pinnacle Orthopedic & Spine Specialists

Provider Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW CAREFULLY.

Uses and Disclosures: We use health information about you for treatment, to obtain payment or treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request your medical records and come to the office to pick them up, we will provide you with a CD for free. You also have a right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complain to the U.S. Department of Health and Human Services, 65 Court Street Suite 506, Buffalo NY 14202.

If you have questions or complaints, please contact:

CEO: Brent T Boeing, MBA

Address: 700 Michigan Avenue, Buffalo NY 14202

Date: _____

Patient Signature: _____

Patient Printed Name: _____

Pinnacle Orthopedic & Spine Specialists

Electronic Communication Authorization

I agree to allow Pinnacle Orthopedic & Spine Specialists to send a text message to my cell phone or an email to the email address I have provided to them in my new patient packet, regarding my healthcare appointments. This may include reminders of upcoming appointment dates and times, cancellations, rescheduling of appointments, and office closings.

Date: _____

Patient Signature: _____

Patient Printed Name: _____

Date of Birth: _____

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Motor Vehicle Accident Questionnaire

NAME:_____ TODAY'S DATE:_____

Date of Accident:_____ Time of Accident:_____

Place of Accident:_____

Diagram of Accident: (please draw a diagram of the accident)

Details:

Number of Occupants in Car____

1. Were you the: □ driver □ passenger: □ front seat
   □ back seat- driver's side
   □ back seat- passenger's side
2. Were you wearing a seat belt? □ yes □ no
   □ lap belt
   □ lap & shoulder belt
   □ head rest
   □ air bag
3. What kind of car were you in: Model_____Year_____
4. Other vehicles involved:_____
5. List your injuries:_____
6. Loss of Consciousness? □ yes □ no
7. Others injured in your car:_____
8. What is your occupation:_____
9. Did you lose time from work?: □ yes □ no dates off:_____
10. Did you return to full duties? □ yes □ no when:_____ part-time when: _____
11. Did you receive medical treatment at the scene of the accident? □ yes □ no
12. Where did you receive medical treatment?_____

Cameron B. Huckell, M.D.
Adult & Pediatric Spinal Surgery

Graham R. Huckell, M.D.
Joint Replacement & Arthroscopy General Orthopedics

A. Marc Tetro, M.D.
Hand, Shoulder & Elbow Surgery, Arthroscopy & Microsurgery

Kathleen Miller, CPA, MBA
CEO

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13. When did you receive medical treatment?_____
14. What were you told your injuries were?_____
15. Did you have x-rays taken? □ yes □ no
    where:_____when:_____
16. What treatment was prescribed?_____
17. Were you place on any medication?
    Type:_____How long:_____
18. Are you on medication now?
    Type:_____How long:_____
19. Did you have surgery? □ yes □ no
    When:_____Type:_____
20. Have you had any of the following? □ Physical Therapy
    □ Chiropractic Treatments
    □ Other:_____
21. Are you experiencing any residual discomfort? □ yes □ no
    If yes, please describe:_____
22. Have you seen any doctors for this problem? □ yes □ no
    When:_____Doctor:_____Treatment prescribed:_____
23. Is there anything you are <u>unable</u> to do that you did prior to your accident?_____
24. Is there anything you have <u>difficulty</u> doing?
    _____
25. Present disability?_____

26. Did you have pain immediately following the accident? Indicate areas:

27. Indicate you pain the next day (if different):

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