ORTHOPAEDIC MEDICINE AND SURGERY
HEALTH QUESTIONNAIRE

PLEASE PRINT _____ Today's Date _____

Patient Name _____ SS# _____ Sex. M. F.

Age:____ Height:____ Weight: _____ Marital Status: M S Sep W D Occupation: _____

Reason for Visit Today (Please describe detail of your injury or problem) _____

_____

_____

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the past six months.

Weight gain-more than 10 Lbs.	NO	YES	**GASTROINTESTINAL SYSTEM:**	NO	YES
Weight loss-more than 10 Lbs	NO	YES	Persistent, recurring belly pain	NO	YES
Appetite change	NO	YES	Uncontrolled loss of stool	NO	YES
Marked fatigue	NO	YES	Heartburn/indigestion	NO	YES
Unexplained night fever	NO	YES	Pain with bowel movement	NO	YES
Night sweats	NO	YES	Diarrhea	NO	YES
Difficulty sleeping	NO	YES	Blood in stool	No	YES
Psychological difficulties	NO	YES	Constipation	NO	YES
BREASTS:			Yellow jaundice	NO	YES
Pain	NO	YES	**UROLOGICAL SYSTEM:**		
Skin change	NO	YES	Difficulty with urination	NO	YES
Lump	NO	YES	Pain/burning on urination	NO	YES
Discharge	NO	YES	Uncontrolled loss of urine	NO	YES
RESPIRATORY SYSTEM:			Urinary tract infection	NO	YES
Chest pain	NO	YES	**SKELETAL SYSTEM:**		
Recurring cough	NO	YES	Joint pain	NO	YES
Sneezing	NO	YES	Joint stiffness	NO	YES
Shortness of breath	NO	YES	Joint redness	NO	YES
CARDIOVASCULAR SYSTEM:			Joint swelling	NO	YES
Chest pain/tightness/pressure	NO	YES	**NERVOUS SYSTEM:**		
Palpitations	NO	YES	Tremors	NO	YES
Lightheadedness/fainting	NO	YES	Headaches	NO	YES
			Numbness	NO	YES
			Dizziness/vertigo	NO	YES

PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions?

Arthritis (other than back)	NO	YES	HIV/AIDS	NO	YES
Asthma/lung disease	NO	YES	Kidney stones	NO	YES
Blood clots	NO	YES	Kidney failure	NO	YES
Cancer	NO	YES	Liver disease	NO	YES
Colitis	NO	YES	Migraine	NO	YES
Depression	NO	YES	Psoriasis	NO	YES
Diabetes	NO	YES	Shingles	NO	YES
Epilepsy	NO	YES	Stomach ulcers	NO	YES
Gall bladder disease	NO	YES	Stroke	NO	YES
Glaucoma	NO	YES	Tuberculosis	NO	YES
Gout	NO	YES	Venereal disease	NO	YES
Heart disease	NO	YES			

Other (please describe) _____

Allergies Shellfish NO YES X-ray contrast dye NO YES

Medications NO YES (If yes list below) Local Anesthetic NO YES

CURRENT MEDICATIONS Name | Dose | Frequency | Reason

HEALTH HABITS/DIETARY SUPPLEMENTS — Explain

Vitamins NO YES
Calcium NO YES
Estrogen NO YES
Tobacco NO YES What type/amount/day_____ Have you ever used/smoked? NO YES If so, date you quit? _____
Alcohol NO YES _____ Amount/day History of drug or alcohol abuse? NO YES _____
Coffee/Tea NO YES _____ Cups/day
Exercise NO YES Amount/type _____

HOSPITALIZATIONS/OPERATIONS Reason | Date

FAMILY HISTORY — List Relative(s)

Diabetes NO YES
Cancer NO YES
Heart Disease NO YES
Hypertension NO YES
Other NO YES Specify: _____

Any other information of which the doctor should be aware _____

PHYSICIAN USE ONLY: Reviewed by _____ Date _____

Kevin A. Mansmann M.D.
Orthopaedic Sports and Arthritis Surgery P.C.
250 West Lancaster Avenue • Suite 310
Paoli, PA 19301
610-644-6040 • Fax: 610-644-7202

PATIENT REGISTRATION

Patient: (Mr., Mrs., Ms., Dr.,) Last Name _____ First Name _____ M.I. _____
Street_____Apt._____ City_____State_____Zip _____
Home Tel #_____ Cell #_____ Business Tel #_____ Ext._____
Social Security #_____ Sex: M F Date of Birth_____ Age_____
Occupation_____ Family Physician_____ Tel #_____
How were you referred to the practice?_____ Reason for Appt. _____
Date of Injury_____Were you seen in the hospital E.R.? _____ Where?_____
How was injury sustained?_____ Were x-rays taken? _____
Employer_____ Tel #_____
Employers's Address _____

INSURANCE INFORMATION

Primary Insurance Co. _____	Secondary Insurance Co. _____
Ins. Co. Address_____	Ins. Co. Address _____
Phone #_____	Phone # _____
Group #_____ID #_____	Group #_____ ID #_____
Subscriber_____	Subscriber_____
Subscriber's DOB _____SS #_____	Subscriber's DOB_____SS#_____
Relationship to Ins: Self / Spouse / Child / Other	Relationship to Ins: Self / Spouse / Child / Other
Is Referral needed?_____	Is Referral needed?_____

FOR WORKMEN'S COMPENSATION OR AUTO CLAIMS - COMPLETE THE FOLLOWING

Is this related to employment? Yes No	Is this related to "MVA"? Yes No
Date of Injury_____Claim #_____	Date of Injury _____ Claim #_____
Ins Co. Name:_____	Ins Co. Name:_____
Ins Co. Address: _____	Ins Co. Address: _____
Ins. Co. Phone #_____	Ins Co. Phone # _____
Contact Person _____	Contact Person _____

EMERGENCY INFORMATION

For all patients: In an emergency, list the names and phone numbers of two people we can contact:

_____	_____	_____	_____
(Name)	(Phone #)	(Name)	(Phone #)

I hereby authorize release of my protected health insurance information necessary only for processing of my claims and authorize payment by my insurance carrier directly to:

Kevin A. Mansmann M.D.
250 W. Lancaster Avenue
Suite 310
Paoli, PA 19301

Signed_____
Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

USES AND DISCLOSURES---PLEASE READ THIS IN ITS ENTIREITY AND CAREFULLY

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating you health, diagnosing medical conditions, and providing treatment. For example, results of lab tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources or coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information, health, and auto and workers compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to0day activities and management of this practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to public health agencies, without your permission, to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

OTHER USES/DISCLOSURES REQUIRING YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that has occurred prior to the date you notify us.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send your information on the treatment and management of your medical condition that you may find of interest. We may also send your information describing other health related goods and service that we believe may interest or be of benefit to you.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections of your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

THE DUTIES OF THIS MEDICAL PRACTICE: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION: as permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing.

COMPLAINTS: If you would like to submit a comment about our privacy practices, or suspect violations, you may do so by letter, outlining your concerns. Please address correspondence to this medical practice at our current address.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF ORTHOPAEDIC, SPORTS AND ARTHRITIS SURGERY'S PRIVACY NOTICE.

SIGNATURE: _____

Arbitration Agreement

a. Any controversy, dispute or disagreement arising out of or relating to my medical treatment shall be settled by arbitration, which shall be conducted in Chester County, Pennsylvania in accordance with the NHLA Alternative Dispute Resolution Services Rules of Procedure for Arbitration. This shall be conclusive and binding on the parties. All costs of arbitration shall be shared equally by the parties, and each party shall be responsible for its own legal expenses incurred.

b. Any party seeking resolution of such a dispute shall request arbitration not later than twenty-four (24) months from the date he knew or should have known the dispute regarding the event giving rise to the arbitration request was irresolvable through informal means. A failure to act hereunder shall constitute a waiver of any and all rights or claims relating to the dispute.

Signature of Patient_____**Date**_____

Signature of Witness_____**Date**_____