Arthroscopic Surgery &
Sports Medicine Center

Matthew P. France, MD

Fellow American Academy of Orthopaedic Surgeons • Arthroscopy Association of North America
Diplomate American Board of Orthopaedic Surgery • Fellowship Trained Shoulder and Knee Specialist

Phone: 908-722-1122 Fax: 908-722-0002 Website: mfrancemd.com

Need to bring checklist for new patients:

_____ **Fully completed personal data / medical history forms (see attached)**

_____ **Copies of insurance card(s) and Health Savings / Flex Spending Accounts**

_____ **Most recent Xrays &/or MRI films (*NOT disks* – we need the actual *films*)**

_____ **Reports for all Xrays &/or MRI studies performed**

_____ **Copies of Operative Report(s), if applicable**

_____ **Shorts for knee examinations**

_____ **Camisole or full length sports bra for female shoulder examinations**

Dear Patient:

Please review the above list and bring all requested items to your appointment with you. Please do not send any information or diagnostic tests to the office prior to your examination.

It is imperative that you obtain the requested copies of Xray / MRI / Operative Notes.

If you should have any questions or concerns please do not hesitate to contact our office at 908-722-1122

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Full **Legal** Name: _____
(FIRST) (MI) (LAST)

Address: _____
(STREET) (CITY) (STATE) (ZIP)

Age: _____

Home #: _____ **Date of Birth:** _____/_____/_____

Work #: _____ **Ext:** _____ **Gender:** Male Female

Cell #: _____ **Marital Status:** S M D W

Facsimile #: _____ **Social Security #:** _____--_____--_____

Employer: _____
Address: _____

Occupation: _____

Due to this work injury are you currently: **Working full duty** **Working Modified Duty** **Not working**

Work Comp Insurance

In case of an emergency contact : _____ Phone # _____

Pharmacy : _____ Phone # _____

- I understand all medical records pertaining to this occupational injury are the property of the Workers' Compensation carrier. Furthermore, I understand that my supervisor / employer / nurse case manager and/or Workers' Compensation carrier will periodically receive written and/or verbal updates as to medical care proposed or rendered to me. I understand this could include protected health information (PHI), including, but not be limited to, description of injury, diagnosis, prognosis, proposed treatments, surgical procedures, medical care currently being rendered as well as aspects of my past medical history that are pertinent to my current medical condition.
-Dr. France does not testify, nor make court appearances. Narrative reports are prepared at his discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek further orthopaedic treatment elsewhere.

Signature: _____ **Date:** _____

Patient Name:_____ **Date:**_____

***** Please be advised that all questions need to be answered <u>in full</u> !! If not applicable to you please print N/A in proper area. Please ask a staff member if you are uncertain.**

1) What problem are you here for today? (For example: <u>Right</u> Shoulder or <u>Left</u> Knee...)

2) When did this happen or start??

3) Where did this happen?

4) How did this happen?

5) Have you ever had a problem like this in the past?

6) Any MRI's/X-Rays done for this condition? ***(<u>List where and date of the exams & bring copy of reports to your visit</u>)***

<u>Please list the following:</u> (THESE QUESTIONS <u>MUST</u> BE ANSWERED!)

<u>1) Other medical conditions and the treating physician(s):</u>

<u>2) Previous surgeries (please include dates):</u>

<u>3) Medications that you are taking, dosages and what they are for:</u>

<u>4) ARE YOU ALLERGIC TO ANYTHING, IF SO, PLEASE LIST THE MEDICATION AND YOUR REACTION TO IT?</u> NO / YES

Have you ever had a seizure?	Yes	No	Do you have lung / kidney / liver disease?	Yes	No
Do you have high blood pressure?	Yes	No	Do you have hepatitis / AIDS / HIV?	Yes	No
Do you have a pacemaker?	Yes	No	Do you have heart disease?	Yes	No
Do you have ulcers?	Yes	No	Do you have diabetes?	Yes	No
Do you smoke?	Yes	No	Do you have asthma?	Yes	No
Could you be pregnant?	Yes	No	Do you have bleeding tendencies?	Yes	No
Do you have cancer?	Yes	No	What is your weight?		
Do you have Sleep Apnea?	Yes	No	What is your height?		

<u>For shoulder/upper arm injuries:</u> Are you Right Hand Dominant or Left Hand Dominant

PATIENT HEALTH HISTORY

Patient Name:_____ **Today's Date:**_____

FAMILY MEDICAL HISTORY:

	Age	Disease	If Deceased, Cause of Death
Father:			
Mother:			
Siblings:			
Children:			

REVIEW OF ANATOMICAL SYSTEMS: Please circle complaint / remark only if applicable to your health

Constitutional Symptoms:
- Good general health lately
- Recent weight change
- Fever
- Fatigue
- Headaches

Eyes:
- Eye disease or injury
- Wear glasses / contact lenses
- Blurred / double vision

Ears / Nose / Mouth / Throat:
- Hearing loss / ringing
- Earaches or drainage
- Chronic sinus problems / rhinitis
- Nose bleeds
- Swollen glands in neck
- Sore throat / voice change

Endocrine:
- Glandular / hormone problem
- Heat / cold intolerance
- Skin becoming dryer

Cardiovascular:
- Heart trouble
- Chest pain / angina
- Palpitations
- Swelling in legs / hands

Respiratory:
- Chronic coughs
- Spitting up blood
- Shortness of breath
- Wheezing

Gastrointestinal:
- Loss of appetite
- Change in bowel patterns
- Nausea / Vomiting
- Frequent diarrhea
- Rectal bleed / blood in stool
- Abdominal pain

Psychiatric:
- Memory loss / confusion
- Nervousness
- Depression
- Insomnia

Genitourinary:
- Frequent urination
- Burning / painful urination
- Blood in urine
- Kidney stones
- Female – irregular periods
- Post-Menopausal

Musculoskeletal:
- Joint pain
- Joint stiffness / swelling
- Weakness of muscles / joints
- Muscle pain / cramps
- Back pain
- Cold extremities
- Difficulty walking

Hematologic / Lymphatic:
- Slow to heal after cuts
- Bleeding/bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands

Integumentary: (Skin / Breast)
- Rash / itching
- Change skin color / hair / nail
- Varicose Veins
- Breast pain / lumps

Neurological:
- Frequent/recurring headaches
- Light headed / dizzy
- Convulsions / seizures
- Numbness / tingling sensation
- Tremors
- Paralysis
- Head injury

Allergic / Immunologic:
Medication, food and / or environmental allergies: please list

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature of Patient / Guardian:_____ **Date:**_____

Arthroscopic Surgery & Sports Medicine Center (ASSMC): Notice of Privacy Policies

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review the below carefully.

At ASSMC we are committed to treating & using protected health information about you responsibly. This notice describes the personal information we collect and how & when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 3/15/03 and applies to all protected health information as defined by federal regulations.

Understanding your health record: Each time you visit our office a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment plan and recommendations. This information, often referred to as your health or medical record, serves as a: basis for planning your care / treatment, means of communicating with other health professionals regarding your care, legal documents describing the care you received, means by which an insurance company can verify services billed were actually provided, source of data for medical research, source of information for state/federal public health officials, a tool with which we can assess & continually work to improve the care we render and outcomes we achieve. Understanding what is in your record and how your health information is used helps you: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your health information rights: Although your health record is the physical property of ASSMC, you have access to this information. You have the right to: obtain a paper copy of this notice of information practices (hanging on wall by front entrance are copies), obtain a copy of your health record, amend your health record if incorrect, obtain an accounting of disclosures, request restrictions on certain uses and disclosures of your information & revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our responsibilities: ASSMC is required to: maintain the privacy of your health information, provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you, abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices & to make the new provisions effective for all protected health information we maintain. Should our practices change we will notify you in writing during your next office visit. We will not use or disclose your health information without your authorization, except as described in this notice. We will discontinue to us or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to report a problem: If you have questions and would like additional information you may contact our Privacy Officer at 908-722-1122. If you believe your privacy has been violated, you can file a complaint with our Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either aforementioned.

Examples of disclosures for treatment, payment and health operations: We will use your health information for treatment purposes; we will use your health information for payment purposes; we will use your health information for regular health operations; we will use your health information to communicate to authorized family members / guardians; we will use your information to communicate with your insurance company &/or workmans' compensation carrier and nurse case managers; we will use your health information to communicate with appropriate public health / law enforcement departments as mandated; we will use your health information to respond to valid legal subpoena's.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

^^^

~ HIPAA Patient Consent Form ~

Patient consent to the use and disclosure of health information for treatment, payment or healthcare operations.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via facsimile. I authorize the office to contact me at any of my personal phone numbers (home &/or cell phone) listed in this chart and authorize them to leave detailed information regarding my medical care.

I fully understand and accept the terms of this consent.

Patient Printed Name:____________________________________

Patient / Parent or Legal Guardian Signature:____________________________ **Date:**__________________

Please list below any restrictions to the release of this medical file:

^^^

For office use only: **Consent rec'd by:** **Date:**