**Gulfcoast Orthopaedic Specialists**
**Herbert S. Gates III, M.D.**
**Health History Information**

***Please complete both sides of form***

Patient Name: ________________________________________ Date: ______________ Age: __________

Referred by: ____________________________________ Height: __________ Weight: ___________

Which hand do you use MOST OFTEN? (Circle one) **R** **L** **Both**

What brings you in to see Dr. Gates? ___________________________________________________________

Injury date: _______________ **If not an injury, list date of first symptoms:** __________________________

Were you injured at WORK? _______________ AUTO ACCIDENT? _______________

OTHER? _________________________________________________________________________________

Please list the name of physicians you are currently under the care of:

**Medical Doctor/Internist** ___________________________________________________________________

**Cardiologist** ______________________________________________________________________________

**Pain Management Specialist** _______________________________________________________________

**Rheumatologist** __________________________________________________________________________

Please rate your pain on a scale of 0 to 10 (check box below)

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 No pain | 1 | 2 | 3 | 4 | 5 Moderate pain | 6 | 7 | 8 | 9 | 10 Worst possible pain |

What non-prescription medications have you taken for the pain? ____________________________________

Did this help your pain? (Circle one) Yes No Somewhat N/A

## PREVENTATIVE CARE

Do you smoke cigarettes? **Y** **N** **FORMER SMOKER** If so, how many packs per **day**? _____________

Do you drink alcohol? **Y** **N** If so, how many drinks per **day**? _____________

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Here are some questions about your health and feelings. Please read each questions carefully and check (√) your best answer.

| | | Yes, describes me exactly | Somewhat describes me | No, doesn't describe me at all |
|---|---|---|---|---|
| 1. | I give up too easily | 2 | 1 | 0 |
| 2. | I have difficulty concentrating | 2 | 1 | 0 |
| 3. | I am comfortable being around people | 0 | 1 | 2 |
| | DURING THE PAST WEEK How much trouble have you had with: | None | Some | A Lot |
| 4. | Sleeping | 0 | 1 | 2 |
| 5. | Getting tired easily | 0 | 1 | 2 |
| 6. | Feeling depressed or sad | 0 | 1 | 2 |
| 7. | Nervousness | 0 | 1 | 2 |

Duke Anxiety-Depression Scale Copyright © 1994-2014 by the Department of Community and Family Medicine. Duke University Medical Center Durham, N.C., U.S.A.

Add the scores next to each of the blanks you checked. A total of 5 or greater may indicate depression or anxiety. Consult your primary care provider for further evaluation.

Do you have a history of:

Heart Disease **Y N**
Kidney Disease **Y N**
Diabetes **Y N**
Bleeding Disorder **Y N**
Stomach Ulcers **Y N**
Hepatitis **Y N**
Rheumatoid Arthritis **Y N**
Urinary Incontinence **Y N**
High Blood Pressure **Y N**
Urinary Tract Infections **Y N**
Lung Disease **Y N**
Blood Clots **Y N**
Unexplained Weight Loss **Y N**
Cancer **Y N** type ___________________
Gout **Y N**
Change in bowel habits **Y N**

Have you gotten the Flu vaccine this year? **Y N**

Have you gotten the Pnuemonia vaccine? **Y N**

When was your last colonscopy?____________________

Women: When was you last mammogram?___________________

Women: When was your last Bone Density Test?________________

Please list any hobbies_________________________________________________________________________

Please list any **other** medical conditions not mentioned above_________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**Gulfcoast Orthopaedic Specialists**
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**Health History Information**

Please list all past **surgeries** (including dates) ____________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please list any **FAMILY** medical history and relationship of family member

| Condition | Relationship | Condition | Relationship |
| --- | --- | --- | --- |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

OTHER ___________________________________________________________________________

**PLEASE LIST CURRENT MEDICATIONS AND SUPPLEMENTS INCLUDING DOSAGES**

| | | | | | |
| --- | --- | --- | --- | --- | --- |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**MEDICATION ALLERGIES**______________________________________________________________

**THANK YOU FOR ENTRUSTING YOUR ORTHOPAEDIC NEEDS TO DR. GATES. WE ARE COMMITTED TO PROVIDING YOU THE BEST POSSIBLE CARE AND VALUE YOUR PATRONAGE.**

PLEASE REVIEW OUR OFFICE FINANCIAL POLICIES:
**PAYMENT IS DUE AT TIME SERVICES ARE RENDERED**. WE ACCEPT: CASH, CHECKS, AND MASTERCARD, VISA AND DISCOVER CARDS.

IF YOU HAVE MEDICAL INSURANCE YOU SHOULD REALIZE THAT:

1.) **YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.**
2.) NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER**. IT IS YOUR RESPONSIBLLITY TO KNOW YOUR CONTRACT.**

**PARTICIPATING INSURANCE PLANS:**
We participate in many insurance plans. As a courtesy to our patients, we will file your insurance claim to the primary insurance company. WE DO NOT FILE TO ANY SECONDARY INSURANCE. All charges are your responsibility. All co-pays and deductibles will be collected at time of service.

**MEDICARE:**
At this time, we accept Medicare assignment. If your secondary insurance is not set-up as a "MEDIGAP" or AUTOMATIC CROSSOVER, we will collect the 20% at time of service. As a courtesy, we will file the secondary insurance claim for your reimbursement.

**AUTO INSURANCE AND NON-PARTICIPATING INSURANCE PLANS:**
PAYMENT IN FULL IS REQUIRED. We will file claims as a courtesy for patient's reimbursement.

OTHER CHARGES:
**SURGERY CANCELLATION POLICY:**
A fee of $250.00 will be charged if cancellation for a scheduled procedure is received with less than 48 hour notice.

**OFFICE CANCELLATION & NO SHOW POLICY:**
A fee of $50.00 will be charged if cancellation for a scheduled office visit is received with less than 24 hours notice from the appointment time.

**Additional charges:**
$50.00 for returned checks
$5.00 charge for x-ray copies due at time of pick up.
$5.00/page for form completion and a $10 minimum fee for review of CD's and excess record review that requires additional time by the provider.
$250.00 for Long Term Disability form completion

________________________________________
Signature

# HERBERT S GATES III, M.D.

MEDICARE PATIENTS ONLY: Please read each of the following and answer as they apply to you.

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Are you coming to this office for an illness or accident that has been covered from the VA (Veteran's Administration)? |
| ☐ | ☐ | Do you or your spouse work full-time, if so, do you have coverage through the insurance at that job? |
| ☐ | ☐ | Are you eligible for any benefits under the Federal Black Lung Program? |
| ☐ | ☐ | Are you coming to this office for an illness, accident, or injury that is the result of an automobile accident? |
| ☐ | ☐ | Do you have Medicare due to a disability? |
| ☐ | ☐ | Are you covered by the Federal End Stage Renal Disease Program? |
| ☐ | ☐ | Are you presently receiving Worker's Compensation? |
| ☐ | ☐ | Do you have Medicaid coverage supplement to your Medicare? |
| ☐ | ☐ | Do you have Medical coverage supplement to your Medicare? |
| ☐ | ☐ | Is this a Medicare HMO? |

If you answered Yes to ANY of the above questions:_______________________________________________
Name of Company

Insured's Name:__________________________________________________

Policy Number:____________________________Group Number:__________________________

**Please sign so we may have your Medicare authorization on file:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature__________________________________________________ Date: ____________________

# GULFCOAST ORTHOPAEDI C SPECIALISTS, L.L.P.

**Herbert S. Gates III, M. D.**

Diplomate of the American Board Of Orthopaedic Surgery
Certificate of Added Qualifications in Hand Surgery

## CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give consent to this practice and all health care providers furnishing care within the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.
**I** give my permission for this practice to access my medication list from pharmacy databases. This will insure that my health care providers have my most updated medication list on file at all times.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Please be advised that our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by contacting our Privacy Officer.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the above address. You may deliver your revocation by any means you choose but it will be effective only when we actually receive the revocation. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: ________________________________________ Date: _________________

Print name of patient: ________________________________________________

If you are signing as the patient's representative:

Print your name: ____________________________________________________

Describe your authority: _______________________________________________

**Dr. Herbert Gates III M.D.**

# PATIENT INFORMATION

| *Patient:* First Name | Middle | Last | Age | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Preferred Name/Nickname: | Social Security Number: | Marital Status: (Please Circle One) |
|---|---|---|
| | | Single Married<br>Divorce Unmarried Widowed |

| Primary Language Spoken: (Please Circle One) | Ethnicity: (Please Circle One) | Race: (Please Circle One) |
|---|---|---|
| English Spanish Chinese<br>German Haitian Hindi<br>Korean Persian French | Non-Hispanic/Latino Hispanic/Latino<br>**Gender:** Male Female Other | White African American/Black<br>Asian American Indian<br>Other |

| Mailing Address: | City | State | Zip Code |
|---|---|---|---|
| | | | |

**Out of Town Mailing Address :**

| Home Phone Number | Out of Town Phone Number | Cell Phone Number |
|---|---|---|
| | | |

**Email Address**

| Occupation | Employer | Employer Phone Number |
|---|---|---|
| | | |

| Emergency Contact | Relationship | Phone Number |
|---|---|---|
| | | |

| Who referred you? | ❑ Dr. | ❑ Other |
|---|---|---|
| | | |

| Pharmacy Name: | Pharmacy Phone Number OR LOCATION of Pharmacy: |
|---|---|
| | |

Dr. Herbert Gates III M.D.

<table>
<tr><td colspan="2">Is this a liability case? ❑ YES ❑ NO</td><td colspan="3">Name of Attorney:</td></tr>
<tr><td>If an accident, Where did it happen?<br>❑ Home ❑ Work<br>❑ Other__________________________</td><td>Date of Injury:</td><td colspan="3">How did injury/accident occur? (Please give details)</td></tr>
<tr><td colspan="5"><u>INSURANCE INFORMATION</u></td></tr>
<tr><td>Person responsible for payment</td><td colspan="4">Primary Insurance Company (Please have your card ready to be copied)</td></tr>
<tr><td>Policy Holder's Name</td><td colspan="4">Insurance Company's Address</td></tr>
<tr><td rowspan="2">Policy Holder's Date of Birth:</td><td colspan="4">Guarantor (If patient is a minor):</td></tr>
<tr><td colspan="4">Social Security Number of Guarantor:</td></tr>
<tr><td>Policy Holder's Employer</td><td>Policy #</td><td>Group #</td><td colspan="2">Guarantor's Date of Birth:</td></tr>
</table>

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. You are responsible for bills and services rendered in this office and payment is required for all services <u>at the time that they are rendered</u>, unless prior arrangements have been made.

As a courtesy, our office will file the appropriate insurance for you. *However*, you are required to pay any unmet deductible, non-covered services and co-payments. If we are forced to pursue collection against you for payment of our service, you will be liable for all costs and expenses incurred by such collection efforts including, without limitation, reasonable attorney's fees.

I give permission to release information relating to my medical treatment to my insurance company in order to process my claim for services and authorize payment of medical benefits to myself or party who accepts assignment. My signature below signifies my understanding of this policy, and acceptance of the terms stated herein.

**Signature**____________________________________ **Date**___________