



**HEALTH HISTORY FORM**

Patient Name:		Date of Birth:	Today's Date:								
Height:	Weight:	Which hand do you use most often? (Circle one) RIGHT          LEFT          BOTH									
What brings you to see Dr. Gates today?		How long have symptoms been present? Or list date your symptoms started.									
Please rate your pain on a scale of 0 to 10 (check box below)											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
0	1	2	3	4	5	6	7	8	9	10	
No Pain					Moderate Pain					Worst Possible Pain	
What <b>over-the-counter</b> medications have you taken for the pain?											
Did this help your pain? (Circle one)											
Yes	No	Somewhat	N/A								

Please list the name of physicians you are currently under the care of:	
Medical Doctor/Internist	
Cardiologist	
Pain Management Specialist	
Rheumatologist	
Pulmonologist	

## ACCIDENT/INJURY FORM

Dear Patient or Guarantor,

Your insurance contract provides benefits that may need to be coordinated with other medical insurance which you may be covered under. The primary carrier will pay first when there is more than one insurance company. In order for us to expedite your claim process, the following information must be completed.

Is the reason for your visit due to an accident or injury?    **Yes**   or   **No**

**Date of Accident or Injury:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Where did this accident or injury occur?	
<input type="checkbox"/> Work	<input type="checkbox"/> Auto Accident
<input type="checkbox"/> Sports	<input type="checkbox"/> School
<input type="checkbox"/> Home	<input type="checkbox"/> Business
<input type="checkbox"/> Other:	

What were you doing to cause the injury? Or how did this injury occur?	
<input type="checkbox"/> Lifting	<input type="checkbox"/> Pulling
<input type="checkbox"/> Falling	<input type="checkbox"/> Pushing
<input type="checkbox"/> Reaching	<input type="checkbox"/> Hit by object
<input type="checkbox"/> Other:	

**How** did this accident or injury occur? (Be as specific as possible):

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Were you evaluated at a hospital emergency room, urgent care facility, or another physician's office prior to your appointment today?   **Yes**   or   **No**   (If **yes**, please list where you were seen):

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I have completed this questionnaire to the best of my ability, and carefully reviewed its contents. Any unanswered questions indicate they do not apply.

Patient or Guardian Signature: \_\_\_\_\_    Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

ALLERGIES	
<input type="checkbox"/> No Known Drug Allergies	
Name of medication or food	Reaction (rash, swelling, upset stomach, etc.)

MEDICATIONS:		
<ul style="list-style-type: none"> <li>Please list your medications and vitamins you are currently taking. Include the dosage and how often you take it each day; you may provide a copy of your medication list to our staff.</li> <li>Include ALL blood thinning medications you are currently taking, for example: Baby aspirin, Coumadin or Plavix.</li> </ul>		
Medication Name	Dosage	How often you take it

FAMILY MEDICAL HISTORY: <i>Check all the conditions that apply to members of your family</i>								
	MOTHER	FATHER	SON	DAUGHTER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (include type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> No family members with medical conditions					<input type="checkbox"/> I'm adopted			

**PAST AND CURRENT MEDICAL HISTORY**

Please check ALL conditions that you have been diagnosed with:

**I HAVE NO PAST OR CURRENT MEDICAL CONDITIONS**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Lung Disease                | <input type="checkbox"/> Kidney Disease         |
| <input type="checkbox"/> High cholesterol                             | <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Kidney Stones          |
| <input type="checkbox"/> Stroke                                       | <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Hepatitis (type) _____ |
| <input type="checkbox"/> Heart Attack                                 | <input type="checkbox"/> COPD                        | <input type="checkbox"/> HIV/AIDS               |
| <input type="checkbox"/> Heart Disease                                | <input type="checkbox"/> Epilepsy (Seizure Disorder) | <input type="checkbox"/> Colitis                |
| <input type="checkbox"/> Bleeding Disorder                            | <input type="checkbox"/> Neuropathy                  | <input type="checkbox"/> Thyroid Disease        |
| <input type="checkbox"/> Atrial Fibrillation                          | <input type="checkbox"/> Pulmonary Embolism          | <input type="checkbox"/> Rheumatoid Arthritis   |
| <input type="checkbox"/> Blood Clots                                  | <input type="checkbox"/> Sleep Apnea                 | <input type="checkbox"/> Psoriatic Arthritis    |
| <input type="checkbox"/> Congestive Heart Failure                     | <input type="checkbox"/> Ulcers                      | <input type="checkbox"/> Gout                   |
| <input type="checkbox"/> Cancer: type _____                           | <input type="checkbox"/> Diabetes: Type 1 or Type 2  | <input type="checkbox"/> Osteoporosis           |
| <input type="checkbox"/> Other conditions I have that are not listed: |  |   |

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**SURGICAL HISTORY: *You may also provide a list of your surgical history to our staff***

Surgical Procedure (Include body part, left or right)	Approximate Date of Surgery
<input type="checkbox"/> <b>CHECK THIS BOX IF YOU HAVE NEVER HAD SURGERY BEFORE</b>	
<b>Do you have a pacemaker, heart stents, or aneurysm clips?    Yes    No</b>	

Please answer these questions about your health and feelings. Read each question carefully and circle 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 <u>WEEK</u> 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.**

*Please list dates for the following questions below to the best of your ability*

Have you had the Flu vaccine this year? **Yes** **No** \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had the Pneumonia vaccine this year? **Yes** **No** \_\_\_\_/\_\_\_\_/\_\_\_\_

When was your last colonoscopy? \_\_\_\_/\_\_\_\_/\_\_\_\_

Women: When was your last mammogram? \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have any hobbies? \_\_\_\_\_

Do you smoke cigarettes? If yes, how many packs per day?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Former Smoker (Quit date: _____)
Do you smoke cigars? If yes, how many cigars per day?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No
Do you drink alcohol? If yes, how many drinks per day?	<input type="checkbox"/> Yes _____ <input type="checkbox"/> No <input type="checkbox"/> Socially

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

**Address:** 681 Goodlette Road North Suite #220 Naples, FL 34102 **Phone:** 239-263-4511 **Fax:** 239-263-5562

**PATIENT INFORMATION**

<b>Patient:</b>					
<b>First Name</b>	<b>Middle</b>	<b>Last</b>	<b>Age</b>	<b>Date of Birth</b>	
<b>Preferred Name/Nickname:</b>		<b>Social Security Number:</b>		<b>Marital Status: (Please Circle One)</b> Single Married Divorced Unmarried Widowed	
<b>Primary Language Spoken: (Please Circle One)</b> English Spanish Chinese German Creole Hindi French Other _____		<b>Ethnicity: (Please Circle One)</b> Not Hispanic or Latino Hispanic/Latino		<b>Race: (Please Circle One)</b> White Black Asian Native American Other _____	
<b>Local Mailing Address:</b>			<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Out of Town Mailing Address:</b> Dates: _____ to _____ (Example: March to October)					
<b>Home Phone Number</b>		<b>Out of Town Phone Number</b>		<b>Cell Phone Number</b>	
<b>Email Address</b>					
<b>Occupation</b>		<b>Employer</b>		<b>Employer Phone Number</b>	
<b>Emergency Contact</b>		<b>Relationship</b>		<b>Phone Number</b>	
<b>Who referred you to our office?</b> <input type="checkbox"/> Dr. <input type="checkbox"/> Other					

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Pharmacy Name:		Pharmacy <u>Phone Number</u>	
Is this a liability case? <input type="checkbox"/> YES <input type="checkbox"/> NO		Name of Attorney:	
If an accident, Where did it happen?  <input type="checkbox"/> Home <input type="checkbox"/> Work  <input type="checkbox"/> Other _____	Date of Injury:	How did injury/accident occur? (Please give details)	
<b><u>INSURANCE INFORMATION</u></b>			
Person responsible for payment		Primary Insurance Company (Please have your card ready to be copied)	
Policy Holder's Name		Insurance Company's Address	
Policy Holder's Date of Birth:		Guarantor (If patient is a minor):	
		Social Security Number of Guarantor:	
Policy Holder's Employer	Policy #	Group #	Guarantor's Date of Birth:

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 at the time that they are rendered, 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** \_\_\_\_\_

**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 RESPONSIBILITY 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 hour notice from the appointment time.

**Additional charges:**

\$50.00 for returned checks

\$10.00 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

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Signature



**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: \_\_\_\_\_

Specializing in Sports Medicine, Upper Extremity & Reconstructive Microsurgery  
681 Goodlette Rd. N., Ste 220, Naples, FL 34102 Ph (239) 263-4511 Fax (239) 263-5562

## HERBERT S GATES III, M.D.

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

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