HERBERT GATES III, M.D.
ORTHOPAEDIC HAND AND UPPER EXTREMITY SURGERY

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)

☐ 0 No Pain	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5 Moderate Pain	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 Worst Possible Pain

What **over-the-counter** 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?	
□ Work	□ Auto Accident
□ Sports	□ School
□ Home	□ Business
□ Other:	

What were you doing to cause the injury? Or how did this injury occur?	
□ Lifting	□ Pulling
□ Falling	□ Pushing
□ Reaching	□ Hit by object
□ Other:	

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

_____

_____

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):

_____

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	
□ No Known Drug Allergies	
Name of medication or food	Reaction (rash, swelling, upset stomach, etc.)

MEDICATIONS:		
• 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. • Include ALL blood thinning medications you are currently taking, for example: Baby aspirin, Coumadin or Plavix.		
Medication Name	**Dosage**	**How often you take it**

FAMILY MEDICAL HISTORY: *Check all the conditions that apply to members of your family*								
	MOTHER	FATHER	SON	DAUGHTER	GRANDFATHER	GRANDMOTHER	BROTHER	SISTER
Heart Disease	□	□	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□	□	□
High Blood Pressure	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Cancer (include type)	□	□	□	□	□	□	□	□
Lung Disease	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Blood Clots	□	□	□	□	□	□	□	□
□ No family members with medical conditions					□ 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

❑ High blood pressure	❑ Lung Disease	❑ Kidney Disease
❑ High cholesterol	❑ Asthma	❑ Kidney Stones
❑ Stroke	❑ Emphysema	❑ Hepatitis (type) _____
❑ Heart Attack	❑ COPD	❑ HIV/AIDS
❑ Heart Disease	❑ Epilepsy (Seizure Disorder)	❑ Colitis
❑ Bleeding Disorder	❑ Neuropathy	❑ Thyroid Disease
❑ Atrial Fibrillation	❑ Pulmonary Embolism	❑ Rheumatoid Arthritis
❑ Blood Clots	❑ Sleep Apnea	❑ Psoriatic Arthritis
❑ Congestive Heart Failure	❑ Ulcers	❑ Gout
❑ Cancer: type_____	❑ Diabetes: Type 1 *or* Type 2	❑ Osteoporosis

❑ Other conditions I have that are not listed:

_____

_____

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
□ **CHECK THIS BOX IF YOU HAVE NEVER HAD SURGERY BEFORE**	
Do you have a pacemaker, heart stents, or aneurysm clips? Yes No	

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 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

_____*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?	□ Yes _____ □ No □ Former Smoker (Quit date: _____)
Do you smoke cigars? If yes, how many cigars per day?	□ Yes _____ □ No
Do you drink alcohol? If yes, how many drinks per day?	□ Yes _____ □ No □ 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

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

Preferred Name/Nickname:	**Social Security Number:**	**Marital Status: (Please Circle One)** Single Married Divorced Unmarried Widowed

Primary Language Spoken: (Please Circle One)	**Ethnicity: (Please Circle One)**	**Race: (Please Circle One)**
English Spanish Chinese German Creole Hindi French Other _____	Not Hispanic or Latino Hispanic/Latino **Gender:** Male Female Other	White Black Asian Native American Other _____

Local Mailing Address:	**City**	**State**	**Zip Code**

Out of Town Mailing Address: **Dates:** _____ **to** _____ **(Example: March to October)**

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 to our office? ❑ **Dr.** ❑ **Other**

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Pharmacy Name:		**Pharmacy Phone Number**	
Is this a liability case? ❑ **YES** ❑ **NO**		**Name of Attorney:**	
If an accident, Where did it happen? ❑ **Home** ❑ **Work** ❑ **Other**_____	**Date of Injury:**	**How did injury/accident occur? (Please give details)**	
INSURANCE INFORMATION			
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 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 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

_____

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
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