SRINO BHARAM, M.D., P.C.
BOARD CERTIFIED ORTHOPEDIC SURGEON
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130 E 77th Street, 8 Floor
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TEL (212) 691-3535
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INITIAL APPOINTMENT INFORMATION

Patient Name: _____ Date: _____
Last First Middle

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: ___ Marital Status: _____

Home Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

Social Security: _____ Driver's License: _____ State: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Responsible Party (If other than patient): _____
Last First Middle

Sex: ☐ Male ☐ Female Date of Birth: _____ Age: ___

Home Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

Social Security: _____ Driver's License: _____ State: _____

What condition caused illness: ☐ Auto Accident ☐ Employment Other: _____ Date of Injury: _____

Who referred you: ☐ Physician ☐ Friend ☐ Insurance ☐ Attorney ☐ Web site Other: _____

Name of Referrer: _____
Name Address Telephone

Employer: _____
Company Name Occupation Telephone

Address: _____
Street City State Zip

Name of Insured: _____
Last First Middle

Address of Insured: _____
Street City State Zip

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child Other: _____

Insurance Information: _____
Company Name Telephone

Address: _____
Street City State Zip

ID #: _____ Group #: _____ Claim #: _____

Primary Care Physician: _____
Last First Middle

Address: _____
Street City State Zip

Patient Authorization

Claims Authorization – I hereby authorize any treating physician to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self-insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer('s) including a reasonable time thereafter,
until its final consummation. This authorization shall be binding upon my dependent's, and our heirs, executor's, administrators and me.

Assignment of Benefits – Private and Federal (Medicare) – I authorize payments of medical and surgical benefits, including Medicare benefits, to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it s agents any information needed to determine these benefits payable for related services. I understand that any service deemed "Non-Covered" by my carrier are my sole financial responsibility, as outlined in my coverage manual. Prompt and complete payment of said services is also my sole responsibility.

Credit Card Authorization – I authorize, when requested by me over the phone, the use of my credit card for outstanding charges.

Litigation Disclaimer – It is understood and agreed that I am requesting examination and treatment for medical purposes.

Patient Name (print): _____

Patient Signature: _____ Date: _____

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HEALTH QUESTIONNAIRE

Patient Name:_____ Telephone:_____ Date:_____

Reason for Visit: _____

Height: _____ Weight: _____

SOCIAL HISTORY:

Is there anyone at home to take care of you? ☐ Yes ☐ No

Have you ever used any of the following substances?

Tobacco ☐ Never ☐ Previously, but I quit ☐ Currently- Frequency: _____

Alcohol ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

FAMILY HISTORY:

If any blood relative has suffered any of the following – please circle the number and indicate which relative.

1) Epilepsy	5) Diabetes	9) Anemia	13) Heart Disease	17) Alcoholism
2) Migraine	6) Thyroid	10) Bleeds easily	14) Stroke	18) Hepatitis
3) Mental Illness	7) Hayfever	11) Osteoporosis	15) Hypertension	19) Cancer
4) Glaucoma	8) Asthma	12) Arthritis	16) High Cholesterol	20) Bleeding problems

MEDICATION HISTORY:

List all medications you are currently taking, including those you buy without a prescription.

_____

_____

Indicate the year of your last test vaccine for:

Tetanus/Td_____ Influenza (flu)_____ Pneumonia _____ Hepatitis _____

Indicate the year of your last test/exam for:

Rectal Stool_____ Cholesterol _____ Eye_____ TB_____ Hepatitis_____

HOSPITAL ADMISSIONS:

List the illness or operation and the year it occurred.

_____

_____

SURGICAL HISTORY:

	Yes	No
Have you ever had any surgeries? (Please list on back)	☐	☐
Have you been hospitalized within the last year?	☐	☐
Have there been any changes in your medical condition within the last year?	☐	☐
Have you been treated for a medical condition in the last year?	☐	☐
Have you received any blood transfusions?	☐	☐
Have you ever had an infection in an incision after surgery?	☐	☐
Have you ever had problems with anesthesia?	☐	☐
Have you or a family member ever had a bleeding problem after surgery?	☐	☐

ALLERGIES & SENSITIVITIES:

Have you experienced any reaction following the administration of any of the following:

	Yes	No	Unsure
Penicillin or other antibiotics	☐	☐	☐
Morphine, Codeine, Demerol, or other narcotics	☐	☐	☐
Aspirin or other pain medication	☐	☐	☐
Sulfur Drugs	☐	☐	☐
Tetanus Antitoxin or other serums	☐	☐	☐
Adhesive tape or surgical tape	☐	☐	☐
Any foods (i.e. eggs, milk, chocolate, etc.)	☐	☐	☐

Other: _____

MEDICAL HISTORY: Mark (c) for current problems or (√) and indicate age when you had any of the following symptoms or diseases.

Decreased hearing
Ringing in ear(s)
Ear infections – *frequent*
Dizzy/fainting spells
Failing vision/eye pain
Double or blurred vision
Nose bleeds – *recurrent*
Sinus trouble
Sore throats – *frequent*
Jaundice/hepatitis
Hayfever/allergies
Pneumonia/pleurisy
Bronchitis/chronic cough
Asthma/wheezing
Shortness of breath:
on exertion/lying flat
Chest pain
High blood pressure
Heart murmur
Swollen ankles
Irregular pulse
Osteoporosis

Leg pain – *when walking*
Varicose veins - *Phlebitis*
Cold numb feet
Loss of appetite - *recent*
Difficulty swallowing
Heartburn/peptic ulcer
Persistent nausea/vomiting
Abdominal pain - *chronic*
Gallbladder trouble
Chicken pox/Polio/Mumps
Diarrhea/Constipation
Diverticulosis/Crohn's/Colitis
Seizures
Bloody or tarry stools
Hemorrhoids/hernia
Numbness/tingling sensation
Headaches - *frequent*
Arthritis/Rheumatism
Back pain – *recurrent*
Bone fracture/joint injury
Palpitations
Hair loss

Pain on urination
Blood in urine/kidney stones
Urinary infections - frequent
Sexually transmitted disease
Sexual problems
Weight loss/gain - *recent*
Anemia/bruise easily
Blood transfusions
Cancer
Rheumatic fever/scarlet fever
Diabetes
Thyroid Disease
Inflammatory bowel syndrome
Stroke
Tremors/hands shaking
Urination – overactive bladder
Overnight more than 2x
More than 8 x/24 hrs
Urgency to urinate/leakage
Stress incontinence – urine
Decrease in force/flow
leakage on exercise/movmnt

Rashes/Hives
Psoriasis/Eczema
Depression/Nervousness
Agitation/Memory Loss
Any sleeping difficulty
Moodiness/suicidal thoughts
Phobias/mental illnesses
Feelings of worthlessness
Hoarseness - *prolonged*
Chronic Fatigue
Measles/German measles
Tuberculosis
Herpes
AIDS/HIV
Alchohol ___oz per wk
Coffee/tea ___ cups per day
Smoking ___ cig/day __yrs
Exercise
Street drugs
Acupuncture/tattoos
Foot pain - Gout

Males:	Females:
Prostate problems	Menstrual Flow:
	Reg/Irreg/Pain or cramps
	Days of flor
	Length of cycle
	Date of 1st day of last period
	Pain/bleeding during or after sex
	Number of: Pregnancies ___ Miscarriages ___ Abortions ___ Live Births ___
	Birth Control Method
	BC Pill Name
	Flushing/Menopause
	Date of last Pap test
	Normal/ Abnormal
	Date of last mammogram
	Normal/ Abnormal

If you answered yes to any of the above questions on either page, please explain in detail, use the back of the page if necessary.

_____
_____
_____
_____
_____
_____
_____
_____