

Kevin Kessler, M.D
Diplomate American Board of
Orthopaedic Surgery
Naveed Shafi, M.D.



Arthroscopic Shoulder,
Knee and Elbow Surgery
Orthopaedic Surgery

PATIENT INFORMATION

PLEASE PRINT CLEARLY & ANSWER ALL QUESTIONS

DATE: _____ BODY PART: _____ Is this your first visit? _____

Patient Name: _____ Age: _____ DOB: _____

Address: _____ APT#: _____ City: _____

State: _____ Zip: _____ Phone # _____ Cell # _____

Male Female Married Single Divorced Widowed

Patient's Social Security Number: _____ - _____ - _____

Occupation: _____ Work Phone #: _____

Employer Name & Address: _____

Full -Time Part-Time Self Employed Retired

Student: Full-Time Part-Time School: _____

Emergency Contact – Name and Phone #: _____

Family Physician: _____

Phone#: _____

Who Referred You to Us? _____

PRIMARY INSURANCE: _____ PHONE#: _____

ID or CERTIFICATE#: _____ GROUP#: _____

INSURED'S FULL NAME: _____

RELATION: _____ DOB: _____

INSURED SSN: _____ - _____ - _____ TYPE OF INS: MEDICAL SCHOOL AUTO

OTHER: _____

SECONDARY INSURANCE: _____ PHONE#: _____

ID or CERTIFICATE#: _____ GROUP#: _____

INSURED'S FULL NAME: _____

RELATION: _____ DOB: _____

INSURED SSN: _____ - _____ - _____ TYPE OF INS: MEDICAL SCHOOL AUTO

OTHER: _____

COMMENTS: _____

ASSIGNMENT OF BENEFITS

I hereby authorize release of information necessary to file a claim to my insurance carrier and ASSIGN BENEFITS otherwise payable to me, to the Doctor or Group indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. I hereby authorize my insurance carrier to release any information requested regarding my insurance coverage (eligibility dates, deductibles, etc).

SIGNED: _____ DATE: _____

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PATIENT QUESTIONNAIRE

Today's Date _____

Patient's Legal Name: Last _____ First _____ MI _____

Birth date: _____ Age: _____ Gender (circle) Male / Female

Occupation: _____

Main Reason for visit: Pain Swelling Restricted Movement Instability

Other _____

Which Body Part? (Circle) LEFT RIGHT BOTH

Shoulder Elbow, Wrist, Hand, Finger, Hip, Knee, Upper Leg, Lower Leg, Foot,
Toe, Heel, Neck, Mid-Back, Lower Back

Type of Pain: aching, burning, gnawing, stabbing, throbbing, sharp,
dull, occasional, constant, worsening, improving. Other _____

Severity: no pain, mild, moderate, severe, pain level (1-10) _____

When did you get hurt? ___/___/___ ___ Days ___ Weeks ___ Months ___ Years

Timing: acute, chronic, daytime, nighttime, recurrent, intermittent
other _____

How did you get hurt? Fall, bending, lifting, twisting, sports injury, work injury,
MVA, assault, overuse, non-traumatic, other _____

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Alleviating Factors: *Upper Body* – Rest, Lying Down, Ice, Sling, Brace, Splint,
Meds, Injections, Stretching, Exercise, PT

Lower Body - Rest, Lying Down, Ice, Heat, Brace, Splint
Elevation, Limited Weight Bearing, Meds, Injections, Stretching, Exercises,
PT, Cane, Wheelchair, Walker, Viscosupplement Injection.

Aggravating Factors: Sitting, Standing, Lying Down, Walking, Lifting, Carrying
Twisting, Pushing/Pulling, Gripping, Grasping, Squeezing, Reaching Overhead,
Throwing, ROM, Weight bearing, Exercise, Computer Use, Changing Clothes,
Getting out of bed, going from Sit to Stand, Upstairs, Downstairs, Morning,
Daytime, Nighttime, Cold Weather.

What treatment have you tried for the above condition? (Circle): Injection, Ice,
Medication, PT, Other _____

Is a Work Related Injury? YES NO

If referred to the office, by whom? _____

Physician: _____

Address: _____

Phone: _____

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History and Physical Examination

PatientName: _____ Age: _____ Height: _____ Weight: _____

Presenting Complaint: _____

History of Present Illness: _____

Drug Allergies: _____

Medications: _____

PAST MEDICAL HISTORY

Heart Disease	Yes	No	Heart Attack	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No	Stroke	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	Murmurs	Yes	No	Rheumatic Fever	Yes	No
Lung Disease	Yes	No	Bleeding Disorders	Yes	No	Anemia	Yes	No
Sickle cell	Yes	No	Kidney Disease	Yes	No	Arthritis	Yes	No
Gout/pseudogout	Yes	No	Kidney stones	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	GI disease	Yes	No	Polio	Yes	No
Seizure disorder	Yes	No	Neuromuscular disease	Yes	No	Psychological	Yes	No
Trauma	Yes	No	Blood clots or phlebitis	Yes	No	Blood transfusion	Yes	No
HIV	Yes	No	Migraine	Yes	No		Yes	No

Other _____

PAST SURGICAL HISTORY/HOSPITAL ADMISSIONS

FAMILY HISTORY

Have you or any family member had any complications from anesthesia? _____

SOCIAL HISTORY

Tobacco _____ Alcohol _____ Substance use _____ Marital Status: M/S/D

Occupation _____ Aspirin Use _____ Date Stopped: _____

REVIEW OF SYSTEMS	PHYSICAL EXAM
	VITALS
	GENERAL
	HEENT
	HEART
	LUNGS
	ABDOMEN
	NEUROMUSCULAR
	EXTREMITIES

IMPRESSION/DIAGNOSIS: _____

PLAN: _____

PHYSICIAN SIGNATURE _____ DATE: _____

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Incident Report

Dear Member,

Your insurance contract provides for benefits to be coordinated with other medical insurance by which you may be covered. The primary carrier pays first when there is more than one insurance company or health care provider. In order to expedite your claim(s) process, please complete the following information:

NOTE: If the reason for your medical care was not due to an accident related injury, do not complete Section 1 of the questionnaire. You should complete Section I and III only when applicable.

Patient Name: _____
Provider Name: _____ Date of Service: _____

SECTION I

Is the reason for your visit to your doctor due to an injury caused by an accident?

Yes ___ No ___

If so, please indicate:

Auto _____ Home _____ School _____ Other _____

Dale of Accident _____ How and where accident happened: _____

Was a third party responsible for the injury? Yes ___ No ___

If so, provide the following:

Name of individual or company: _____

Name and address of attorney representing third party insurance company or party responsible: _____

SECTION II

Full name of your spouse: _____

Spouse's Birth date: _____ Social Security Number: _____

Spouse's Employer: _____

Employer's Address: _____

Telephone Number: _____

Is your spouse covered by any other Health Insurance Company: ___ Yes ___ No

If YES, give name, address and telephone number of Health Insurance Company:

Telephone Number: _____

Policy Number: _____ Effective Date: _____

Type of Coverage: ___ Family ___ Couple ___ Single

Do you have Medicare coverage?

Part A ___ Effective Date _____ Part B ___ Effective Date _____

SECTION III (Information to be filled out only if auto accident)

Were you in your own or someone else's vehicle? _____

Name of your insurance company: _____

Amount of PIP coverage: _____ Amount of Deductible: _____

If represented by an attorney, please provide the following: Attorney name, address and telephone #:

Subscriber/Member Signature _____ Date _____

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CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information:

Your protected health information will be used by Kevin J. Kessler, MD. / Or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices:

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information; Kevin J. Kessler, MD. may not agree to restrict the use or disclosure of your protected health information.

If Kevin J. Kessler, MD. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You may revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices:

Kevin J. Kessler, MD. reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and give my permission to Kevin J. Kessler, MD. to use and disclose my health information in accordance with the HIPAA Privacy Act Standard Law.

Name of Patient (Print)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

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Dear Patient,

We ask that you read and sign the following page as it concerns all of us. Due to the many changes in Insurance Policies, it is no longer an easy task to interpret each individual policy. Our office staff tries to stay aware of these changes, it is not always possible. We therefore, urge you as the patient, to please check with you insurance company regarding your coverage.

IT IS YOUR RESPONSIBILITY TO KNOW YOUR INDIVIDUAL COVERAGE.

Failure to comply could result in you as the patient, BEING RESPONSIBLE for all costs incurred. Remember, your insurance policy is between you and your insurance company, not between your doctor and your insurance company.

To assist you in finding out your coverage, feel free to ask for assistance in finding phone numbers and addresses of your insurance company, many insurance companies today require referral forms from your primary care physician or group. If your insurance meets this requirement it will be your responsibility to furnish this referral at the time of your appointment. Failure to do so may require you to reschedule your appointment.

Some insurance companies state you may not go out of network. Many companies have instituted a mandatory second opinion program, and these are constantly changing day by day. It is impossible to keep up with these changes and often we are not aware of them until it is too late.

Patient's Name (or Patient's Representative's Name)

Patient's Signature (or Patient's Representative's Signature)

Date