

Name: \_\_\_\_\_ Date/Birth: \_\_\_\_\_ SEX: M – F \_\_\_\_\_

Address: \_\_\_\_\_ SS# \_\_\_\_\_ Age: \_\_\_\_\_

Marital  
Status: \_\_\_\_\_

(Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) **\*\* Referred by:** \_\_\_\_\_

Drivers License# \_\_\_\_\_ Cell Phone # ( ) \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Primary Ins.: \_\_\_\_\_

Occupation: \_\_\_\_\_ Address: \_\_\_\_\_

Employer: \_\_\_\_\_ ID # \_\_\_\_\_

Address: \_\_\_\_\_ Secondary Ins.: \_\_\_\_\_

ID # \_\_\_\_\_

(Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) **\*\* Primary** \_\_\_\_\_

Work Phone # ( ) \_\_\_\_\_ **Physician's Name:** \_\_\_\_\_

**Name/Phone Number Emergency Contact.** **\*\* Primary** \_\_\_\_\_

( ) \_\_\_\_\_ **Physician Phone No.:** ( ) \_\_\_\_\_

**PERSON RESPON. FOR BILLING–SELF/SPOUSE/PARENT/GUARDIAN:** (CIRCLE ONE)

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

SS# \_\_\_\_\_ Insured D/O/B: \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ Employer: \_\_\_\_\_

(Town) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

**IF AUTO/WORKERS COMP. INJURY, PLEASE COMPLETE THE FOLLOWING:**

Insured's Name: \_\_\_\_\_ Date/Accident: \_\_\_\_\_

Ins. Company: \_\_\_\_\_ Policy# \_\_\_\_\_

Address: \_\_\_\_\_ Claim # \_\_\_\_\_

First day out of work: \_\_\_\_\_ Workers Comp.# \_\_\_\_\_

Representative: \_\_\_\_\_ Phone # ( ) \_\_\_\_\_

I hereby authorize and request Paul Yerys, M.D./Jeffrey Meyer, M.D., Peter Lesniewski, M.D. to perform all necessary medical care, x-rays and other professional services on behalf of the above named patient. I agree to pay for all such services when statement is rendered, and I understand that I am personally responsible to pay same. I hereby authorize payment directly to the doctors for surgical and/or medical benefits if applicable. I hereby authorize a photocopy of this to be as valid as the original. All charges shall be fixed by you at regular rates. I further acknowledge that in the event my account remains past due and is referred to an outside collection agency, I agree, to authorize said entities to communicate with my insurance company regarding my past due account and further authorize said entities to obtain and/review my credit report.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Info #1)



# PAST MEDICAL HISTORY

(Continued)

## **PAST SURGERIES:** (list all)

1. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_
2. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_
3. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_
4. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_
5. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_
6. \_\_\_\_\_  
 Right                       Left                      Date \_\_\_\_\_

## **HOSPITALIZATIONS:** (Aside from surgeries/Year/Reasons) None

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

## **REVIEW OF SYSTEMS:**

Height: \_\_\_\_\_ft. \_\_\_\_\_inches.                      Weight: \_\_\_\_\_lbs.

Are you right or left handed?                       Right                       Left

Last Tetanus Shot?     In past 5-years                       More than 5-years                      Approx. \_\_\_\_\_

Have you Received Hepatitis-B vaccination??     Yes     No     Unsure

(Forms/PMH-sheet pg2)

## PAST MEDICAL HISTORY

(Continued)

**Are you experiencing any problems with the following:**

**(Please check off yes or no and circle all that apply)**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
General Health (weight loss, sweats, fevers)	ف	ف	Circulation	ف	ف
Eyes	ف	ف	Gout	ف	ف
Ears, Nose Throat	ف	ف	Stroke/Seizures	ف	ف
Heart/Hypertension	ف	ف	Diabetes/Thyroid	ف	ف
Lungs	ف	ف	(Recent/ongoing)		
Ulcer/Bowels/Liver	ف	ف	Infection	ف	ف
Acid Reflux	ف	ف	Cancer	ف	ف
Kidney/Urinary Tract	ف	ف	Skin	ف	ف
Prostate	ف	ف	Emotional/Psychiatric		
Rheumatoid arthritis	ف	ف	Disorders	ف	ف
			Gynecologic	ف	ف

If **YES**, explain: \_\_\_\_\_

**ORTHOPEDIC PROBLEMS:** (Check all areas with which you have had problems)

ف Back    ف Neck    ف Shoulder    ف Arm    ف Hand    ف Elbow  
 ف Wrist    ف Hip    ف Knee    ف Leg    ف Ankle    ف Foot

**ALLERGIES/ADVERSE DRUG REACTIONS:**

List your past allergies:

ف Environmental

**Drug**

**Reaction**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

(Forms/PMH-sheet pg3)

## PAST MEDICAL HISTORY

(Continued)

### WOMEN ONLY:

Are you pregnant?                      ڤ Yes                      ڤ No                      ڤ Maybe  
 Have you reached menopause?      ڤ Yes                      ڤ No                      ڤ Maybe

### SOCIAL HISTORY:

Marital Status:              ڤ Single              ڤ Married              ڤ Divorced              ڤ Other

Occupation: \_\_\_\_\_

Do you **Smoke**?                      ڤ Yes                      ڤ No  
 If Yes,                      ڤ Cigarettes, \_\_\_\_\_ packs per day for \_\_\_\_\_ years.  
    ڤ Cigars                      ڤ Chewing tobacco  
    ڤ Other: \_\_\_\_\_

**Quit:** ڤ              When: \_\_\_\_\_

Do you drink **Alcoholic** beverages?              ڤ Yes              ڤ No  
 Type: \_\_\_\_\_ Amount/Frequency: \_\_\_\_\_

Are you at risk for **HIV** (Aids) ?              ڤ Yes              ڤ No  
 For example – blood transfusion(s), intravenous drug use, unprotected sexual contact.

Details: \_\_\_\_\_

### FAMILY HISTORY:

List serious medical problems that your blood relatives (father, mother, sisters, brothers, etc.) have experienced:

1. Relative \_\_\_\_\_ ڤ Living              ڤ Deceased

Problem \_\_\_\_\_

2. Relative \_\_\_\_\_ ڤ Living              ڤ Deceased

Problem \_\_\_\_\_

3. Relative \_\_\_\_\_ ڤ Living              ڤ Deceased

Problem \_\_\_\_\_

(Forms/PMH-sheet pg4)

## PAST MEDICAL HISTORY

(Continued)

### **FAMILY HISTORY:** (Continued)

4. Relative \_\_\_\_\_ ف Living ف Deceased

Problem \_\_\_\_\_

5. Relative \_\_\_\_\_ ف Living ف Deceased

Problem \_\_\_\_\_

### **SURGICAL RISK FACTORS:**

Have you ever been treated for a blood clot....

.....in your leg(s)? ف Yes ف No

.....in your lung(s)? ف Yes ف No

Have you or any relatives had a problem with....

.....Bleeding ف Yes (self) ف No ف Yes (Relative)

.....Anesthesia ف Yes (self) ف No ف Yes (Relative)

Have any of your relatives died during or soon after surgery? ف Yes ف No

Details to "yes" responses: \_\_\_\_\_

### **PEDIATRIC PATIENTS:**

ف Not/Applicable

Birth History:

ف Normal Full Term

ف Breech

ف Premature

ف First Born

(Forms/PMH-sheet pg5)

PAUL YERYS, M.D.  
JEFFREY MEYER, M.D.  
PETER LESNIEWSKI, M.D.



***Island Sports Medicine***

Orthopedic Surgery  
Arthroscopic Surgery  
Joint Replacement  
Spine Surgery  
Trauma Foot &  
Upper Extremity

## **GUARANTEE AGREEMENT**

For and in consideration of services rendered by **Drs. Yerys/Meyer/Lesniewski**, to the patient whose name appears below, the undersigned hereby promises to pay **Drs. Yerys/Meyer/Lesniewski** any co-payment, co-insurance or fees required by my coverage with any insurer/HMO or other third party payer. In addition, I promise to pay for all services that are not covered by my benefit plan with any such insurer/HMO/or other third party insurer. I further understand that all bills are payable and become due upon presentation.

I hereby assign to **Drs. Yerys/Meyer/Lesniewski**, all monies and/or benefits to which I may be entitled from my coverage with any insurer/HMO/third party payer/government agencies or those who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents.

If copies of x-rays are necessary and your insurance company does not pay, you will be responsible for any fees incurred for the copies or interpretation of same.

I hereby authorize and direct **Drs. Yerys/Meyer/Lesniewski** to release to any insurer/HMO/third party payer/governmental agencies or to whoever is financially liable for my medical care, all information needed to substantiate payment for such medical care and, if required, for pre-certification/prior approval purposes.

**A service fee of \$10.00 will be added to your bill if we must bill you for your co-payment.**

**In an effort to keep waiting time to a minimum and to allow us availability of appointments for our patients, a patient will be charged \$30.00 fee for failure to show or cancel scheduled appointments.**

\_\_\_\_\_  
(SIGNATURE OF PATIENT, OR PARENT/GUARDIAN)

\_\_\_\_\_  
DATE

(FORMS/GUARANTEE-6-16-05)