ADVANCED HAND&WRIST SPECIALISTS

Paul M. Guidera, M.D.   Nicole M. Atallah, PA-C

Date _________________

Patient Name ____ Age________ Date of Birth _______________
Last First M.I.

Home Address____ City_______________ State_____ Zip_____________

Married ____ Single ____ Widowed ____ Divorced ____ Separated ____

Home Phone _______________________ Date of injury: _________________

Mobile Phone ______________________

Work Phone _______________________ Social Security No. ___________________ Are you Right____ or Left____ handed?

Patient Occupation ___________________ How long? ______ Employer____________________________ How long?______

Business Address ____
Street City State Zip

Is this a work-related injury? __________ Do you have an attorney? ____
Name and Phone Number

Name of Spouse or Next of Kin____

Occupation ___________________________ Employer ____

Emergency Contact and Phone Number ____

Patient Referred By ____

INSURANCE INFORMATION

Insurance company #1 _______________________________
Member Name ______________________________________
ID or Policy # _______________________________________
Group #____
Address for Claims___________________________________
____

Insurance company #2 _______________________________
Member Name______________________________________
ID or Policy #_______________________________________
Group #____
Address for Claim____________________________________
____

Person Financially Responsible: Patient _____ Spouse _____ Parent _____ Other ________________________

Insurer Date of Birth ______________________

IF THIS IS A WORK RELATED INJURY, WE NEED EMPLOYER'S INSURANCE COMPANY:

____
Name Address Claim #

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the doctor to release any information required in the course of my examination or treatment.

Signed (patient or parent if minor) **X**____

AUTHORIZATION TO PAY: I hereby authorize payment directly to the doctor for the surgical and/or medical benefits. I understand that I am financially responsible for the charges not covered by this authorization. In the event this account is referred to collections, a 35% collection fee will be added to the account.

Signed (Insured person) **X**____

IF PATIENT IS A MINOR PLEASE SIGN

I, ___________________________________, parent or guardian of the above named minor give my consent for medical and/or surgical treatment by doctors of Advanced Hand and Wrist Specialists.

Administrative Office 690 N. Cofco Center Court, Suite 190, Phoenix, AZ 85008
West Valley 4344 W. Bell Rd., Suite 102, Glendale, AZ 85308
Phone 602-812-7520   Fax 602-812-7534

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Patient History Form

Name____ Age______ Birthdate___________ Height_______ Weight_______

Consultation requested by: ________________________________ ☐worker's compensation case ☐legal case

Are you: ☐right handed ☐left handed ☐male ☐female occupation____________________________________

Why are you here today? ____

When did the problem start? ____

How did it happen? ____

What makes it worse? ____

What makes it better?____

For each, circle what **BEST** applies:

- The pain is: RARE INTERMITTENT CONSTANT
- The pain is: DULL SHARP ACHY THROBBING BURNING OTHER ____________________________________
- On a 0 to 10 severity scale (worst =10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle **ALL** that apply:

- Associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER____

Have you ever experienced any injury to or symptoms involving this body part in the past? ☐Yes ☐No

If so, please provide details: ____

Have you had any treatment for this problem? ☐NONE ☐medication ☐therapy ☐splinting ☐injection ☐surgery

____

Medical History: Do you currently or have you ever had any of the following? ☐NONE

☐anemia ☐arthritis ☐asthma / COPD ☐bleeding disorder ☐blood clots
☐cancer ☐chronic pain syndrome ☐circulatory problems ☐depression ☐diabetes
☐drug / alcohol problem ☐gout ☐fibromyalgia ☐heart disease ☐hepatitis
☐high blood pressure ☐HIV / AIDS ☐kidney disease ☐osteoporosis ☐psychiatric illness
☐pregnancy (current) ☐reflux / heartburn ☐seizures ☐sleep apnea / CPAP ☐stomach ulcers
☐stroke ☐thyroid problems ☐other / details____

Medications: ☐NONE ☐additional sheet attached

Medications (including over the counter medicines and nutritional supplements)	Reasons Used	Dose
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Medical Allergies (rash, swelling, or shortness of breath): ☐NONE ☐penicillin ☐sulfa ☐latex ☐metals ☐tape
☐iodine (IV contrast) ☐shellfish ☐poultry products ☐other ____________________

Medication Side Effects (heartburn, nausea, vomiting): ☐NONE ☐anti-inflammatories ☐codeine ☐Percocet
☐Vicodin / Lortab ☐other ____________________

Surgical History: ☐NONE **Circle all that apply**

☐Eyes/ENT	cataracts, vision correction, sleep apnea, tonsils, sinus surgery, thyroid, other ______
☐Heart	bypass, valve replacement, stent, other ______
☐Lung	resection, other______
☐G I	appendix, gall bladder, hernia, other______
☐Gynecologic	c-section, hysterectomy, tubal ligation, other______
☐Urologic	prostate, bladder, vasectomy, other ______
☐Orthopedic	joint replacement, arthroscopy, fracture surgery, spine, other ______
☐Vascular	carotid, aneurysm, bypass, other ______
☐Neurosurgical	aneurysm, tumor, craniotomy, other ______
☐Cancer	skin, breast, other ______
☐Other	______

Anesthesia Complications: ☐NONE. If yes, explain: ____________________

Other Current Symptoms: **Circle all that apply**

☐yes	☐no	Constitutional	unexpected weight loss, weight gain, fever, chills, night sweats, fatigue______
☐yes	☐no	Eyes	blurred / double vision, eye pain, redness, watering ______
☐yes	☐no	ENT	headache, difficulty swallowing, nose bleeds, ringing in ears, earaches ______
☐yes	☐no	Cardiovascular	chest pain, palpitations, fainting, murmurs ______
☐yes	☐no	Respiratory	shortness of breath, wheezing, coughing, painful breathing, snoring ______
☐yes	☐no	Gastrointestinal	heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stools ______
☐yes	☐no	Genitourinary	urinary frequency, urgency, difficulty, pain, bleeding, incontinence______
☐yes	☐no	Musculoskeletal	other joint pains, swelling, instability, stiffness, redness, heat, muscle pain______
☐yes	☐no	Skin	skin changes, poor healing, rash, itching, redness ______
☐yes	☐no	Neurological	numbness / tingling, unsteady gait, dizziness, tremors, seizures ______
☐yes	☐no	Psychological	nervousness, anxiety, depression, hallucinations ______
☐yes	☐no	Hematologic	easy bleeding, bruising ______
☐yes	☐no	Endocrine	excessive thirst or urination, heat / cold intolerance ______
☐yes	☐no	Allergic	reaction to foods or environment______
☐yes	☐no	Other	______

Family History (mother / father / siblings): ☐NONE OF THE BELOW

☐anesthesia complications______ ☐bleeding disorder______
☐cancer ______ ☐diabetes ______
☐gout ______ ☐heart disease______
☐malignant hyperthermia______ ☐arthritis ______
☐other ____________________

Social History:

Martial Status: ☐single ☐married ☐divorced ☐widowed ☐separated
Alcohol Use: ☐none ☐rare ☐daily
Tobacco Use: ☐none ☐previous When quit: ______ ☐current packs / day______

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Recreational Drug Use ☐none ☐previous ☐current drug_________________ last used _________________________

Additional information that you would like for us to know:____
____

Patient or responsible party signature ____________________________________ date _________________

Physician review ____ date _________________

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NOTICE TO PATIENTS

State law, A.R.S. §32-1401 (24)(ff), requires that a physician notify a patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and whether these are available elsewhere on a competitive basis. (I/We) support this law, because it helps patients make reasoned financial decisions concerning their medical care.

In compliance with the requirements of this law, you are being advised that (I/We) have a direct financial interest in the diagnostic or treatment agency or in the non-routine goods or services named below. Further, as indicated below, goods or services that (I/We) have prescribed are available elsewhere on a competitive basis.

DIAGNOSTIC OR TREATMENT AGENCY OR NON-ROUTINE GOODS AND SERVICES:

Gateway Surgery Center

THESE SERVICES ARE AVAILABLE ELSEWHERE ON A COMPETATIVE BASIS

The law provides for the acknowledgement of your having read and understood these disclosures by dating and signing this form in the spaces provided below. (I/We) will keep the signed original in your patient file; you will receive a copy upon request.

Signature ____

Date ____

Name of Patient ____

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Medical Information Authorization

Patient Name ____

Date of Birth ______________________

○ I **DO NOT** authorize the personnel of **Advanced Hand & Wrist Specialists** to release any medical information generated by the office.

○ I **DO** authorize the personnel of **Advanced Hand & Wrist Specialists** to release all medical information generated by the office to my family members and friends listed below.

I may revoke this authorization in writing at any time.

1. Name____ Phone Number ____________________
Relationship to patient____

☐ Medical information

☐ May change or updated any demographic or appointment information

2. Name____ Phone Number ____________________
Relationship to patient____

☐ Medical information

☐ May change or updated any demographic or appointment information

3. Name____ Phone Number ____________________
Relationship to patient____

☐ Medical information

☐ May change or updated any demographic or appointment information

____ ____________________
Patient Signature Date

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