Patrick Birmingham, MD
Arthroscopy and Joint Preservation
Patient Intake Form

PLEASE COMPLETE ENTIRE FORM

Patient Information

Date of Birth	SS #	Gender	Marital Status

Patient's First Name	Last Name	MI

Street Address (city, state, zip)

Home Phone #	Work Phone #	Cell #

E-mail Address:

Guarantor (The person responsible for the bill)

First Name - if same, write same	Last Name	MI

Address (city, state, zip)

DOB	SS#	Gender	Marital Status	Relationship to Patient

Home #	Work #	Cell #

Employer	Occupation

Primary Insurance Information

Subscribers Name	Subscribers Last Name

Subscribers DOB	Subscribers SS#	Subscribers Gender	Subscribers Relationship to Patient

Primary Insurance Carrier (ie: BCBS, GHI)	Policy ID #	Group #	Co-payment:
			$

Workers Compensation & No Fault Information

Name of Carrier (ie: Stamford, RPMG, NYFD etc)	Adjuster Name	Adjuster Phone #

Claims Address

Policy #	Claim #	Date of Accident or Injury	❐ N/F ❐ W/C

Additional Questions

Whom may we thank for referring you?
Please tell us why you are here today (ie: hip, knee pain, shoulder injury, etc.):

The above information is true to the best of my knowledge.

Signature of Patient or Guardian:_______________________________________ Date:____________________

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INITIAL EVALUATION FORM

Name:____ Age:__________ Date:________________

Occupation / job?____ Did another doctor send you to us? Yes / No

Name of provider: ______________________________

Involved Site? Shoulder Hip Knee Other:____________________

Which side(s)? Right / Left / Both Dominant hand/arm? Right / Left

Problem(s) (Please check all that apply): ☐Pain ☐ Weakness ☐ Instability/dislocation ☐ Stiffness ☐Swelling ☐ Other:________________

☐ Buckling ☐ Locking ☐ Grinding ☐ Clicking ☐ Catching

Difficulty with functional activities: ☐Walking ☐Stairs ☐Running ☐Squatting ☐Pivoting/twisting ☐Sitting w/ knee bent

☐Sitting for long time w/ hip flexed ☐Lifting objects ☐ Other:________________________________

How did you injure yourself? ☐No Specific Injury ☐Sports Related____________ ☐Auto-DOA:____________ ☐Work-DOI:____________

Sports level: ☐ None ☐ Recreational ☐ College ☐ Professional

How long have you had symptoms/pain? ________Days ________Weeks ________Months ________Years

Briefly describe your injury:____

Location of your pain:____

Given diagnosis (if known):____

Non-surgical treatments (ie; injection, physical therapy, etc)____

Previous surgery for this injury:____

Severity of Pain: None Mild Moderate Severe

Pain Worse With:____

Pain Better With: ____

Do you have pain at night? Yes No Does it wake you up at night? Yes No

Are you currently working? Yes No Retired Full Duty Limited Duty

Do you have any imaging studies? X-rays MRI CT Scan

Please list ALL Allergies:____

Do you have any of the following medical conditions: (please circle): Heart problems Ulcers Diabetes Cancer Seizures

Liver Problems/Hepatitis Kidney Disease Blood Clots Asthma

Sleep Apnea Stroke Other:______________________________

Please list all medications including over the counter medications and herbal supplements:______________________________

____

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Health History Questionnaire

Patient Name:____Date:____________________

Date of Birth:____ Gender:_______________________

Please mark if you have a history of any of the following:

__High Blood Pressure
__Heart Disease
__Asthma
__Diabetes
__Hepatitis
__HIV/AIDS
__Clotting Disorders
__Kidney Disease
__Convulsions
__Stroke
__Paralysis
__Shortness of Breath
__Heart Palpitations
__Heart Murmurs
__Tuberculosis
__Mitral Valve Prolapse
__Cancer:________________
__Anxiety
__Depression
__Seizures
__Sleep Apnea
__Smoke
__Excessive Alcohol Use
__Women - Pregnant/ Nursing

Do you have any other health issues or concerns? Yes No
Please list your concerns:____

____

Do you have any allergies? Yes No
Please list all allergies & reactions:____

____

Have you had prior surgery? Yes No
Please list ALL surgeries:____

____

Do you take any medication? Yes No
Please list ALL medications including over the counter:_____________________________________

____

Please describe why you are here today, and your symptoms:____

____

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