Confidential Medical History for Robert G. Marx, MD

Name: _____

Date of Birth: _____

Height?	Weight?	Pulse

Reason for your Visit: _____

Referred by: _____

Date of Onset or Injury: _____

Right or Left Side Problem? _____

Right or Left Handed?____

Was this Work –Related? Yes / No Related to an Automobile Accident? Yes / No

Medical or Surgical History? Yes No (please list below)

Surgical Procedure & Date	Reason

Please specify disease if selecting 'Yes' below

Medical History			Do You Have A Problem With The Following?		
Diabetes	Yes	No	Vision/Hearing?	Yes	No
Hypertension	Yes	No	Heart Rhythm?	Yes	No
High Cholesterol	Yes	No	Difficulty Breathing?	Yes	No
Heart Attack/Disease	Yes	No	Digestion/Bowel?	Yes	No
Asthma	Yes	No	Bladder Infections?	Yes	No
COPD or Emphysema	Yes	No	Hi/Low Blood Sugar?	Yes	No
Hepatitis/Liver Disease	Yes	No	Thyroid/Adrenals?	Yes	No
Kidney Disease	Yes	No	Gout or Rheumatoid?	Yes	No
Stomach Ulcers/Reflux	Yes	No	Blood Clots?	Yes	No
Blood Clots/PE	Yes	No	Veins or Arteries?	Yes	No
Bleeding Disorder	Yes	No	Back/Legs/Arms?	Yes	No
Lupus/Crohn's/Psoriasis	Yes	No	Skin Disorders?	Yes	No
Depression	Yes	No			
Osteoarthritis	Yes	No			
Rheumatoid Arthritis	Yes	No	Metal Allergy?	Yes	No
Osteoporosis	Yes	No	Sleep Apnea?	Yes	No
Seizure/Epilepsy	Yes	No			
Cancer	Yes	No			
Thyroid Disease	Yes	No			
Other _____					

Medications and Doses: Please list any prescribed or Over-the Counter Meds

Name

Allergies to drugs? Yes No (please list below)

Name	Reaction

Social History

Occupation: _____

❑ Single ❑ Married
❑ Divorced ❑Widowed

Live alone Yes No
Children Yes No
#_____

Do you smoke? Yes No
Packs per day _____

Do you drink alcohol? Yes No
#Drinks_____ per week or month (circle one)

History of substance abuse? Yes No
What? _____

Family History

Diabetes	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Neurological Disorder	Yes	No
Rheumatoid Arthritis	Yes	No	Stroke	Yes	No
			Blood Disorder	Yes	No

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

HOSPITAL FOR SPECIAL SURGERY

PATIENT REGISTRATION FORM

Dr. Robert G. Marx
Hospital for Special Surgery
535 East 70th Street New York, NY 10021

MR#

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)	PREFERRED NAME	DATE OF BIRTH	SOC. SEC. NUMBER

PERMANENT STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS

MARITAL STATUS	RACE	ETHNICITY	RELIGION

SEX ASSIGNED AT BIRTH	SEX LISTED WITH HEALTH INSURANCE	WHAT IS YOUR GENDER IDENTITY?	PREFERRED PRONOUNS
☐ FEMALE ☐ MALE ☐ INTERSEX	☐ FEMALE ☐ MALE	☐ SAME AS SEX LISTED WITH INSURANCE ☐ OTHER:_____	☐She/Her ☐Ze/Hir ☐He/His/Him

PATIENT INFORMATION

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION?	NOTIFY PCP OF RESULTS?
		☐ YES ☐ NO	☐ ALL ☐ ABNORMAL ☐ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		

PATIENT'S EMPLOYER	PATIENT OCCUPATION		RETIREMENT DATE
		☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMPLOYER PHONE

PHARMACY NAME/ADDRESS	**PHONE**	**FAX**

EMERGENCY CONTACT

FULL NAME CONTACT #1	ADDRESS (no., street, apt#, city, state, zip code)

HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN?	SUPPORT PERSON?
				☐YES ☐NO	☐ YES ☐ NO

GUARANTOR/POLICY HOLDER

GUARANTOR FULL NAME	ADDRESS (no., street, apt#, city, state, zip code)

RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE

EMPLOYER	OCCUPATION		RETIREMENT DATE
		☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	

EMPLOYER ADDRESS (no., street, city, state, zip code)	EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY?	INJURED BODY PART:	HOW DID YOUR INJURY OCCUR?
YES NO DATE OF INJURY	☐ RIGHT ☐ LEFT	

PRIMARY INSURANCE

INSURANCE COMPANY NAME/ADDRESS	POLICY NUMBER	GROUP/PLAN NUMBER

SECONDARY INSURANCE

SUBSCRIBER NAME	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER

INSURANCE COMPANY NAME/ADDRESS	PHONE NUMBER

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/0r insurance carriers. I hereby assign benefits to the Hospital and understand that in the absence of accepted insurance coverage, i/legal guardian am responsible for full payment of services rendered.

EFFECTIVE DATE – These statements shall be effective from the date of the signature below until December 31 of the current year, unless you notify HSS otherwise in writing at the address written above

PATIENT OR GUARDIAN SIGNATURE X_____ **DATE**_____

Robert Marx, MD
Insurance / Financial Policy

Thank you for choosing Dr. Marx as your healthcare provider. Our office is committed to providing high quality care to all of our patients. It is in that quest that we feel it important to establish a clear insurance/payment policy to avoid misunderstandings. The following statements will help you understand our financial policy.

I understand that payment of charges incurred is due at the time of service, unless other definite financial arrangements have been made with the office manager prior to treatment.

Healthcare Plans

We are currently contracted with:

- Empire Blue Cross Blue Shield PPO/EPO/POS/HMO
- Oxford Freedom Plan, Oxford Freedom Select and Oxford Liberty HMO (these may require a referral from your primary care physician)
- United Healthcare
- Cigna
- HIP

We ask you to contact your insurance company to verify we are in-network with your particular plan. It is your responsibility to verify your benefits.

It is understood that we will bill and accept payment as full from these insurance companies only. You will be responsible for all applicable co-pay, co-insurance and deductible that your plan requires to fulfill payment responsibility.

Please keep in mind that your office consultation fee does not include x-rays or additional services (i.e. MRI's, CT scan's). These charges will be billed through the Hospital for Special Surgery and not through our office. It is your responsibility to verify if any authorization or co-pay/coinsurance applies to additional services.

It is also understood that if my insurance carrier is billed and I am reimbursed directly, that I will forward all payment to Dr. Marx's office. I agree that I will be responsible for any remaining balance due. It is also agreed that I am responsible for collection and attorney fees should I default on this agreement and the account is sent to collection.

I have read and understand the financial policy and agreed to the terms. Should there be any questions please do not hesitate to contact our office.

_____ _____

Signature of responsible party Date

_____

Print Name