Date _____ Next Gen # _____

FIRST STATE ORTHOPAEDICS

□ Dr. Jeremie Axe □ Dr. Michael Axe □ Dr. Bodenstab □ Dr. Brady □ Dr. Crain □ Dr. Ginsberg □ Dr. Gotha
□ Dr. Handling □ Dr. Johnson □ Dr. Kahlon □ Dr. Leitman □ Dr. Manifold □ Dr. Mavrakakis □ Dr. Moran
□ Dr.Newell □ Dr. Pan □ Dr. Pushkarewicz □ Dr. Raisis □ Dr. Rudin □ Dr. Smucker □ Dr. Sowa
□ Dr. Straight □ Dr. Tooze □ Dr. Zaslavsky

PATIENT INFORMATION

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____ Cell ( ) _____
Family Doctor _____ Phone ( ) _____
Referring Dr. _____ Phone ( ) _____
How did you hear about us? _____
Referring Attorney Name _____

Date of birth _____ □ Male
Age _____ □ Female
□ Single □ Married □ Divorced □ Widowed
□ Civil Union
Relationship to responsible person _____
E-Mail: _____
Occupation _____
Employed by _____
Business Phone ( ) _____

OPTIONAL INFORMATION

Preferred Language _____ Race _____ Ethnicity _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT)

Name _____ (LAST) (FIRST) (MI)
Address _____
Development _____
City/State/Zip _____
Home phone ( ) _____

Relationship to Patient _____
Occupation _____
Employed by _____
Business Phone ( ) _____

INSURANCE INFORMATION

PRIMARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to Patient _____
Date of birth _____
SS# TriCare or V.A. _____
Patient's Only

SECONDARY

Subscriber's Name _____ (LAST) (FIRST) (MI)
Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____

Patient's I.D. No. _____
Group/Account No. _____
Relationship to Patient _____
Date of birth _____
SS# TriCare or V.A. _____
Patient's Only

(✓ Box) **□ Auto Accident** **□ Work Injury** **□ Personal Injury**

Insurance Co. Name _____
Insurance Co. Address _____
City/State/Zip _____
Insurance Co. Phone ( ) _____
Name of Adjuster _____
Name of Attorney _____ Phone ( ) _____

Date of Injury _____
State in which injury occurred: _____
Claim Number _____
(Complete the following if accidental injury)
Where Accident Occurred: _____
How Accident Occurred: _____

FIRST STATE ORTHOPAEDICS

WHO MAY WE TALK TO ABOUT YOUR CARE?

You may communicate with the following individuals about my care:

Name	Relationship	Phone Number

FIRST STATE SURGERY CENTER / SPINE CARE DELAWARE/FIRST STATE IMAGING CENTER

The First State Surgery Center and Spine Care Delaware and First State Imaging Center are owned and operated by Physicians of First State Orthopaedics. While our outpatient surgery centers are an appropriate site for your surgical procedure, there are other facilities in the area where such procedures could also be performed. There will be a separate facility fee for surgeries performed at First State Surgery Center or Spine Care Delaware as there would be from any other facility.

FIRST ASSISTANT AT SURGERY

First State Orthopaedics, P.A. employs board certified physician assistants who are trained to perform the duties of a first assistant at surgery and to assist in the office. Our billing to your insurance carrier may include a fee for the physician assistant.

FINANCIAL RESPONSIBILITY STATEMENT / INSURANCE ASSIGNMENT

Please refer to the financial policy. Separate attachment.

I AGREE TO THE ABOVE CONDITIONS

If the patient is a minor, the parent or legal guardian must sign

Signature of patient, parent or legal guardian _____ Date _____

MEDICARE SIGNATURE ON FILE

" I request that payment of authorized Medicare benefits be made on my behalf to First State Orthopaedics, P.A., for any services furnished me by that physician's). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS), which oversees the Medicare program, and its agents any information needed to determine these benefits payable for related services."

Signed: Medicare Beneficiary _____ Date _____

THE PATIENT / GUARANTOR IS RESPONSIBLE FOR ALL ACCOUNT BALANCES AFTER INSURANCE HAS PAID

First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

CERVICAL SPINE INTAKE FORM

□ **Dr. Ginsberg** □ **Dr. Mavrakakis** □ **Dr. Moran** □ **Dr. Newell** □ **Dr. Rudin** □ **Dr. Straight** □ **Dr. Zaslavsky**

PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

CONCERN

(Describe your neck pain, please check all that apply.)

□ **Neck Pain** □ **Arm Pain** □ **Right** □ **Left** □ **Bilateral**

Date of Injury/Onset of Pain: _____ □**Auto Accident** □**Work Comp** □**Personal Injury** **Dates off work:** _____

Work Status: □ Currently working _____ hrs/wk

□ Not working □ unemployed □ retired

Severity : □ 0 (no pain) □ 1□ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (excrutiating pain)

Status of Pain: □ Improved □ No change □ Worse □ Resolved

Frequency of Pain: □ Daily □ Constant □ Intermittent □ Occasional

Location of Pain: □ Resolved

	R	L	BL
Neck	□	□	□
Arm	□	□	□
Shoulder	□	□	□
Intrascap	□	□	□

Other: _____

□ Neck Pain = Arm Pain
□ Neck Pain > Arm Pain
□ Neck Pain < Arm Pain
□ Neck Pain Only
□ Arm Pain Only

Radiation of Pain: □ None

	R	L	BL
Neck	□	□	□
Trap	□	□	□
Shoulder	□	□	□
Tricep	□	□	□
Bicep	□	□	□
Elbow	□	□	□
Inside Forearm	□	□	□
Outside Forearm	□	□	□
Thumb	□	□	□
Index Finger	□	□	□
Middle Finger	□	□	□
Ring Finger	□	□	□
Pinky	□	□	□
All Fingers	□	□	□
Hand/Palm	□	□	□

□ Other _____

Weakness: □ None

	R	L	BL
Wrist	□	□	□
Arm	□	□	□
Shoulder	□	□	□
Hand	□	□	□
Finger	□	□	□
Elbow	□	□	□

□ Other _____

Numbness/Tingling: □ None

	R	L	BL
Neck	□	□	□
Trap	□	□	□
Shoulder	□	□	□
Tricep	□	□	□
Bicep	□	□	□
Elbow	□	□	□
Inside Forearm	□	□	□
Outside Forearm	□	□	□
Thumb	□	□	□
Index Finger	□	□	□
Middle Finger	□	□	□
Ring Finger	□	□	□
Pinky	□	□	□
All Fingers	□	□	□
Hand/Palm	□	□	□

□ Other _____

Quality of Pain:
□ Severe
□ Aching
□ Shooting
□ Dull
□ Resolved
□ Other _____

Aggravated By: □ None
□ Lifting □ Sleeping
□ Sitting □ End of Day
□ Driving □ Mornings
□ Office Work □ All Activities
□ Other: _____

Relieved By: □ None
□ Changing Positions □ Medication: _____
□ Sitting □ Rest
□ Heat □ Stretching
□ Exercise □ Other: _____

Associated Symptoms / Pertinent Negatives: □ All No
□ Balance Disturbances
□ Bladder Incontinence
□ Bowel Incontinence
□ Spasms
□ Gait Disturbances
□ Change in Handwriting
□ Difficulty w/ Fine Motor Control
□ Other: _____

Symptoms Improved With:
□ PT □ Time
□ Injections □ Meds
□ **Other:** _____

Symptoms Failed to Improve With:
□ PT □ Time
□ Injections □ Meds
□ **Other:** _____

Other/Notes: _____

_____

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ **None**

PATIENT'S MEDICAL CONDITION

Height: ___ft ___in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:**_____

My Weight in the last 6 months has: ☐ **Not Changed** ☐ **Increased** _____**lbs.** ☐ **Decreased** _____**lbs.**

PATIENT'S MEDICAL HISTORY

(Please check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benigin Prostatic Hyertrophy
- ☐ Cancer
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease (Heart valve problems)
- ☐ Other: _____
- ☐ **None**

PATIENT'S SURGICAL HISTORY

(Please check all that apply)

- ☐ ACL Surgery
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Athroscopy (Scope) Details: _____
- ☐ Back Surgery - Details: _____ _____
- ☐ CABG
- ☐ Cardiac (Heart) Valve Replacement
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Discectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus Surgery
- ☐ Muscle Biopsy
- ☐ Neck Surgery - Details: _____ _____
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Gender Specific

Female
- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Male
- ☐ Prostatectomy
- ☐ TURP

☐ Other: _____

☐ **None**

PATIENT'S FAMILY HISTORY

Is your Father Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Is your Mother Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Are any of your siblings deceased? ☐ Yes ☐ No If yes: ☐Brother ☐Sister age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: ☐Yes ☐No ☐Former/Year Quit _____ **Consume Alcohol**: ☐Yes ☐No ☐Former/Year Quit _____

History of Substance Abuse: ☐Yes ☐No **Age Started:** _____ **Drug Type(s):** _____ _____

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____

First State Orthopaedics
www.FirstStateOrtho.com
4745 Ogletown-Stanton Road, Suite 225
Newark, DE 19713
302-731-2888 · Fax 302-731-7049

LUMBAR SPINE INTAKE FORM

□ **Dr. Ginsberg** □ **Dr. Mavrakakis** □ **Dr. Moran** □ **Dr. Newell** □ **Dr. Rudin** □ **Dr. Straight** □ **Dr. Zaslavsky**

PATIENT INFORMATION

Date: _____ **Name:** _____ **Age:** _____ **FSO MR #:** _____

CONCERN

(Describe your back pain, please check all that apply.)

□ **Back Pain** □ **Leg Pain** □ **Right** □ **Left** □ **Bilateral**

Date of Injury/Onset of Pain: _____ □**Auto Accident** □**Work Comp** □**Personal Injury** **Dates off work:** _____

Work Status: □ Currently working _____ hrs/wk

□ Not working □ unemployed □ retired

Severity : □ 0 (no pain) □ 1□ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 (excrutiating pain)

Status of Pain: □ Improved □ No change □ Worse □ Resolved

Frequency of Pain: □ Daily □ Constant □ Intermittent □ Occasional

Location of Pain: □ Resolved

	R	L	BL
Back	□	□	□
Leg	□	□	□
Buttock	□	□	□
Groin	□	□	□

Other: _____

□ Back Pain = Leg Pain
□ Back Pain > Leg Pain
□ Back Pain < Leg Pain
□ Back Pain Only
□ Leg Pain Only

Radiation of Pain: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Weakness: □ None

	R	L	BL
Hip	□	□	□
Leg	□	□	□
Knee	□	□	□
Foot	□	□	□
Ankle	□	□	□

□ Other _____

Numbness/Tingling: □ None

	R	L	BL
Buttock	□	□	□
Back of Thigh	□	□	□
Outside Thigh	□	□	□
Front of Thigh	□	□	□
Back of Calf	□	□	□
Outside Calf	□	□	□
Inside Calf	□	□	□
Ankle	□	□	□
Top of Foot	□	□	□
Bottom of Foot	□	□	□
Outside Foot	□	□	□
Big Toe	□	□	□

□ Other _____

Quality of Pain:
□ Severe
□ Aching
□ Shooting
□ Dull
□ Resolved
□ Other _____

Aggravated By: □ None
□ Bending
□ Changing Positions
□ Lifting
□ Sitting
□ Driving
□ Walking
□ Standing
□ Other: _____
□ End of Day
□ Mornings
□ All Activities

Relieved By: □ None
□ Changing Positions
□ Sitting
□ Laying Down
□ Standing
□ Heat
□ Exercise
□ Medication: _____
□ Rest
□ Stretching
□ Other: _____

Associated Symptoms / Pertinent Negatives: □ All No
□ Balance Disturbances
□ Bladder Incontinence
□ Bowel Incontinence
□ Spasms
□ Gait Disturbances
□ Weakness
□ Change in Handwriting
□ Other: _____

Symptoms Improved With:
□ PT
□ Injections
□ **Other:** _____
□ Time
□ Meds

Symptoms Failed to Improve With:
□ PT
□ Injections
□ **Other:** _____
□ Time
□ Meds

Other/Notes: _____

_____

OVER

REVIEW OF SYSTEMS

Do you have any of the following symptoms? *(Please check all that apply)*

Constitutional:
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats

Cardiovascular:
- ☐ Chest Pain
- ☐ Cyanosis (blue coloration of skin)
- ☐ Irregular Heartbeats/Palpatations

Integumetary/Skin:
- ☐ Rash

Metabolic/Endocrine:
- ☐ Cold Intolerant
- ☐ Heat Intolerant

HEENT:
- ☐ Headache
- ☐ Vision Loss

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting

Neurological:
- ☐ Difficulty Walking
- ☐ Dizziness

Hematologic/Blood:
- ☐ Bleeding

Respitory:
- ☐ Cough
- ☐ Dyspnea

Genitourinary:
- ☐ Dysuria
- ☐ Hematuria

Immunological:
- ☐ Enviromental Allergies
- ☐ Food Allergies

☐ **None**

PATIENT'S MEDICAL CONDITION

Height: ___ft ___in **Weight:** _____lbs **Blood Pressure:**_____/_____ **List details of any diet program:**_____

My Weight in the last 6 months has: ☐ **Not Changed** ☐ **Increased** _____**lbs.** ☐ **Decreased** _____**lbs.**

PATIENT'S MEDICAL HISTORY

(Please check all that apply)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benigin Prostatic Hyertrophy
- ☐ Cancer
- ☐ Cerebrovascular Accident (Stroke)
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Degenerative Joint Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ DVT (Blood Clot)
- ☐ Fibromyalgia
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Gout
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lyme Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ PVD
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Seizure Disorder
- ☐ Sleep Apnea
- ☐ SLE (Lupus)
- ☐ Spinal Stenosis
- ☐ Thyroid Disease
- ☐ Valvular Disease (Heart valve problems)
- ☐ Other: _____
- ☐ **None**

PATIENT'S SURGICAL HISTORY

(Please check all that apply)

- ☐ ACL Surgery
- ☐ Angioplasty
- ☐ Angio w/stent
- ☐ Appendectomy
- ☐ Athroscopy (Scope) Details: _____
- ☐ Back Surgery - Details: _____ _____
- ☐ CABG
- ☐ Cardiac (Heart) Valve Replacement
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Colectomy
- ☐ Colostomy
- ☐ Discectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Laminectomy
- ☐ LASIK
- ☐ Meniscus Surgery
- ☐ Muscle Biopsy
- ☐ Neck Surgery - Details: _____ _____
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy

Gender Specific

Female
- ☐ Cesarean Section
- ☐ Hysterectomy
- ☐ Mastectomy

Male
- ☐ Prostatectomy
- ☐ TURP

☐ Other: _____

☐ **None**

PATIENT'S FAMILY HISTORY

Is your Father Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Is your Mother Living? ☐ Yes ☐ No If no, age deceased _____ cause of death _____

Are any of your siblings deceased? ☐ Yes ☐ No If yes: ☐Brother ☐Sister age deceased _____ cause of death _____

Family history of chronic/inherited diseases: _____

PATIENT'S SOCIAL HISTORY

Tobacco Use: ☐Yes ☐No ☐Former/Year Quit _____ **Consume Alcohol**: ☐Yes ☐No ☐Former/Year Quit _____

History of Substance Abuse: ☐Yes ☐No **Age Started:** _____ **Drug Type(s):** _____ _____

Activity Level: ☐Sedentary ☐Moderate ☐Vigorous **Type of Exercise**: _____ _____

SIGNATURE

Date: _____ **Signature of Patient, Parent or Guardian:** _____

FIRST STATE ORTHOPAEDICS

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of First State Orthopaedics Notice of Privacy Practices.

Print Name

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of First State Orthopaedics Notice of Privacy Practices but acknowledgment could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)