Arati Mallik Dunbar, M.D.

Orthopaedic Surgery
Sports Medicine

Welcome to our office! It is our goal to provide our patients with quality care on a personal basis. Please answer the following questions to the best of your ability.

Patient Information:

Patient Name: ____

Home Address: ____

City: __________________ State: __________ Zip: ________________

Home Phone: ________________ Work: ______________ Cell: ____________

Date of Birth: ________________ SS# __________________________ M or F

E-mail address: ____

Employer: ________________________ Occupation: __________________

Spouse/Parent Name: ____

Emergency Contact: _________________________ Phone: ______________

Medical Insurance:
<u>Please be sure to give your insurance card to the receptionist to copy, thank you.</u>

Name of Insurance: ____

Policy#: ________________________ Group#: _____________________

Subscriber Name: ________________________ Date of Birth: ______________

Subscriber Social Security: _____________________________________

Secondary Insurance: ___________________ Policy#: ____________________

Subscriber Name: _________________ DOB: ________ SS#: ______________

Name of primary physician: _____________________________________

Pharmacy: _________________ Address: ______________ Phone: ___________

Is your injury work related? Yes or No

Claim Adjuster: _________________________ Phone: __________________

Claim #: __________________________ Date of injury: _________________

How did you hear about us?

- ☐ Patient: ___________________________________
- ☐ Insurance: _________________________________
- ☐ Physician: _________________________________
- ☐ Other: _____________________________________

Who referred you to our office: ___________________________________

Please answer the following questions as best you can so we can help you more effectively:

1. Are you right or left handed? RIGHT or LEFT

2. Where (as specifically as possible) is the pain, weakness, or instability for which you scheduled today's appointment?

3. How long have you had this problem? Date of injury?

4. Was there an event or specific activity associated with the onset of your symptoms?

5. What activities are associated with onset or worsening of your pain? Does your pain inhibit work leisure activities?

6. Is your problem: improving/ worsening/ stable (please circle one)

7. Please circle your treatments thus far and we will discuss them: pain medication / anti-inflammatory / brace / splint/ cast/ice / physical therapy/ rest / injections / surgery

8. Please circle any symptoms you have had: Swelling / redness / pain / stiffness / crunching or popping sound locking / giving way / deformity / instability / numbness / tingling-burning

9. Do you have any other health conditions?

10. Have you ever had surgery for any reason? When? For what? Any problems with anesthesia?

11. Please list all of your medications:

12. Please list any allergies to drugs or medications:

13. Is there any family history of arthritis, unusual joint problems, or abnormal reactions to Anesthetic agents?

14. Do you smoke? If so, how many packs per day?

15. Do you drink alcohol? If so, how many drinks per week?

16. Please list your participation in sports and/or regular exercise program:

17. Have you had previous X-rays, or other diagnostic studies for this problem? If so, what and when? Have you seen another doctor for this condition?

18. Please circle Yes or No to the following questions:

1.	Fevers	Yes No
2.	Significant weight gain or loss	Yes No
3.	Any vision changes/problems	Yes No
4.	Hearing changes/problems	Yes No
5.	Chest pain or shortness of breath with activity	Yes No
6.	Any heart or valve problems	Yes No
7.	Wheezing or coughing	Yes No
8.	History of pneumonia or pulmonary embolism	Yes No
9.	Skin disease/rashes/other problems	Yes No
10.	History of hepatitis or liver disease	Yes No
11.	History of blood in urine or pain while urination	Yes No
12.	History of abnormal bruising or bleeding	Yes No
13.	History of abnormal weakness, paralysis, numbness, stroke	Yes No
14.	History of recurrent infections	Yes No

Briefly describe any yes answers to the above questions:

Insurance Authorization/Financial Responsibility

Positive verification of your health coverage cannot be made at this time.

Services will be provided with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible.

By signing this form you agree that if this or any other visit precedes or exceeds the effective dates of your insurance coverage, you will be financially responsible for all related fees incurred. You also agree that if you fail to obtain prior authorizations as required by your health insurance, or receive services which are not a covered benefit stipulated in your Insurance Evidence of Coverage you will he held financially responsible for those services.

I hereby authorize Dr. Arati Mallik Dunbar to release any and all information necessary to secure the payment of benefits.

The office policy for co-pays that are not collected at the time of service is a $10 fee that will be charged which the insurance company will not be responsible for.

Our cancellation policy will be effective 10/1/2008. Your appointment has been reserved especially for you. We will remind you of your appointment via phone, however any appointments not cancelled within 24 hours notice will be charged a $25 fee.

I have read the above and understand my possible financial responsibility to Dr. Dunbar and hereby affix my signature as acknowledgement of this understanding.

Signature: ____ Date:______________

Patients Name (Printed) ____