

John D. MacGillivray, M.D.

Medical Profile

Name: _____ **Today's Date:** _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____

Primary Care Physician/Internist: _____ *****REQUIRED*****

Telephone/FAX: _____ *****REQUIRED*****

Chief Complaint

Why are you seeing the doctor today? _____

Current problem is the result of a (n): Check all that apply

Car Accident Work Accident Accident Other _____

This occurred during: Check all that apply

Lifting Pulling Twisting Falling Bending
 Reaching Squatting Hit by Object Not known

List all medications you are currently taking:

Medication	Dose	How long?	Side Effects

ALLERGIES TO MEDICATION: [] YES [] NO

Name of Medication: _____ Reaction: _____

Review of Systems

Are you currently having or have you had problems with your:

	Circle	Describe all <u>Yes</u> responses
Eyes	No Yes	_____
Ears, Nose, Throat	No Yes	_____
Lungs, Breathing	No Yes	_____
Digestion	No Yes	_____
Bowel movement	No Yes	_____
Bladder problem	No Yes	_____
Diabetes	No Yes	_____
High blood pressure	No Yes	_____
Bleeding problems	No Yes	_____
Balance problems	No Yes	_____
Numbness/tingling	No Yes	_____
Blackout/fainting	No Yes	_____
Psychological problems	No Yes	_____
AIDS/HIV	No Yes	_____
Cancer	No Yes	_____
Arthritis	No Yes	_____
Polio	No Yes	_____
TB	No Yes	_____
Epilepsy	No Yes	_____

Current Specialists None _____

Cardiologist _____

Rheumatologist _____

Hematologist _____

Oncologist _____

Pain Management _____

Current Medical Conditions

Sleep Apnea _____ HepC _____

Pacemaker _____ Hemophilia _____

Insulin Diabetic _____ Coumadin _____

Liver Disease _____ Heparin _____

Sickle Cell _____

Reviewed By: _____ MD

Date: _____

(NEXT PAGE)

Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____

Height _____ Weight _____ Blood pressure _____

Treatment to Date

[] Medication: Name _____ [] Physical Therapy: _____

[] Cortisone: Effect _____ [] Surgery: Type _____

Past Surgical History

List Type of Surgery	Year	Complications

Have you ever had general anesthesia? No Yes
Have any problems with anesthesia? No Yes Describe: _____

Family History

Loose Joints:	
Arthritis:	
Diabetes:	
Gout:	

Social History

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? No Yes What? _____

Smoke currently? No Yes ___ Packs per day for ___ years.

Quit smoking? This year >1 year >5 years >10 years

Previously smoked... ___ Packs per day for ___ years

Drink alcohol? Daily 1-2x/week 1-2x/year

Medical Information Release: I authorize the staff of Dr. John D. MacGillivray MD to discuss my medical history and medical condition with the following persons:

_____ Relationship _____
_____ Relationship _____
_____ Relationship _____

Patient's Signature _____

Date: _____

John D. MacGillivray, M.D.
Hospital for Special Surgery
535 East 70th Street
New York NY 10021
(212) 606-1896

FINANCIAL POLICY

Thank you for choosing John D. MacGillivray, M.D. as your health care provider. We are committed to your treatment being successful. All patients must read and sign our Financial Policy before seeing Dr. MacGillivray.

Patients with Non Participating Plans

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA OR MATERCARD.

Patients Enrolled in Participating Plans

The billing office will submit to your carrier; however you will be responsible for all deductibles and co-pays.

If you do not bring in your insurance identification card with you, payment in full is expected the day of service. Your insurance card must contain your policy, group or plan numbers, also the correct mailing address for claims to be submitted and the telephone number of the insurance company for verification.

In the event that your insurance changes to a plan in which Dr. MacGillivray does not participate refer to the above paragraph concerning Non Participating Plans.

If this is a work-related or motor vehicle injury you must bring all pertinent information regarding your accident and billing information with you. Such as your claim, or case number, date of injury, description and location of injury and the guarantors mailing address and telephone number. If you are unable to supply the necessary insurance information, payment in full must be made at the time of service.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for paying the difference between your insurance company's arbitrary determination of usual and customary rates, and the rates of Dr. MacGillivray's fee schedule.

Minor Patients

The adult accompanying a minor to this office is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment has been pre-authorized to an approved health care carrier. Visa, MasterCard, cash or checks are acceptable at the time of service.

I have read Dr. MacGillivray's Financial Policy and agree to be bound to this Financial Policy.

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____

NO-FAULT AND WORKERS' COMPENSATION

Patient Name: _____ Date: _____

IS THIS A RESULT OF MOTOR VEHICLE ACCIDENT? YES / NO
(IF YES, COMPLETE NO-FAULT SECTION)

IS THE INJURY WORK RELATED? YES / NO
(IF YES, COMPLETE WORKERS' COMPENSATION SECTION)

NO-FAULT:

CARRIER NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
CARRIER TELEPHONE #: _____
POLICY #: _____
CLAIM/FILE# _____
DATE OF ACCIDENT _____
PLACE OF ACCIDENT _____

WORKERS' COMP:

INSURANCE CARRIER NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
INSURANCE TELEPHONE #: _____
WCB CASE # _____
CARRIER CASE # _____
DATE OF ACCIDENT _____
EMPLOYER _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
EMPLOYER TELEPHONE #: _____

John D. MacGillivray, M.D.
Hospital for Special Surgery
535 East 70th Street
New York NY 10021
(212) 606-1896

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and **NOT** in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate **IN ANY WAY** in the litigation, except to provide a true and accurate copy of any medical records and x-rays in the possession and control of this office pursuant to an authorization by the undersigned. *

Signed: _____

Date: _____

* Upon payment of usual copying charges