Confidential Medical History for Robert G. Marx, MD

Name: ____

Date of Birth: ______________________________________

Height?	Weight?	Pulse?

Reason for your Visit: ______________________________________

Referred by: ____

Primary Care Physician: ____________________________________

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

Please SPECIFY disease if selecting 'Yes' below by circling which if multiple options:

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/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/Psoriasis	Yes	No	Skin Infections?	Yes	No
Crohn's/Ulcerative Colitis	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	History of MRSA?	Yes	No
Thyroid Disease	Yes	No			
Other ______________________					

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Surgical History? Yes No (please list below)

Surgical Procedure & Date	Reason

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

Name

Allergies to drugs or metals? Yes No (please list below)

Name	Reaction

Social History

Occupation: ____________________	**Do you smoke?** Yes No **Packs per day** _____
☐ Single ☐ Married ☐ Divorced ☐ Widowed	**Do you drink alcohol?** Yes No **#Drinks**________ **per week or month (circle one)**
Live alone Yes No **Children** Yes No # _____	**History of substance abuse?** Yes No **What?** ____________

Family History – Mother (M)/Father (F)

Diabetes	**Yes M/F**	**No**	**Cancer**	**Yes M/F**	**No**
Heart Disease	**Yes M/F**	**No**	**Neurological Disorder**	**Yes M/F**	**No**
Rheumatoid Arthritis	**Yes M/F**	**No**	**Stroke**	**Yes M/F**	**No**
			Blood Disorder	**Yes M/F**	**No**

Patient Signature: ________________________________ Date: __________

Reviewed by: __________________________________ 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
- United Healthcare
- Cigna
- HIP
- Aetna
- Emblem (certain plans only)

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 and if a referral is required.

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

Revised 7/17