Meeks and Zilberfarb Orthopedics
1101 Beacon Street. Brookline, MA 02246
Tel: 617-232-2663 Fax: 617-232-6342

Jeffery L. Zilberfarb, MD

NEW PATIENT HEALTH HISTORY

NAME:_____ DATE:_____

DATE OF BIRTH:_____Height:_____Weight:_____

ALLERGIES and what type of reactions:_____

_____

Occupation:_____

Name of primary care physician:_____

What condition brings you to the office and how have you been treating it?

_____

How long has it been bothering you?_____

Pain scale: Mild 0 1 2 3 4 5 6 7 8 9 10 Severe

Have you been hospitalized in the past 2 years and if so for what reason?

_____

Do you have a history of excessive bleeding?_____

Have you ever been diagnosed with cancer or a tumor? If so when and what type?

_____

Are you on a special diet?_____

Alcohol use: Never / 1 time a month or less / 2-4 times a month / 4 or more a week

Tobacco use: Current smoker / Former smoker / Never smoker

List all medications you are taking at this time:

_____

_____

_____

List all past surgical procedures along with dates and left or right side:

_____

_____

_____

Family history of blood clots or pulmonary embolism:_____

Father: alive / deceased / osteoarthritis / hyperlipidemia / gout /diabetes / hypertension

Mother: alive / deceased / osteoarthritis / hyperlipidemia / gout /diabetes / hypertension

Children's ages:_____

Circle any of the following which you have had or have currently:

- Anemia
- Arthritis
- Artificial Heart Valve
- Asthma
- Atrial Fibrillation
- Bi-polar
- Blood Transfusion
- Cortisone Therapy
- Depression
- Diabetes
- Epilepsy or Seizures
- Gastrointestinal Problems
- Gout
- Heart Disease or Attack
- Heart Murmur
- Heart Pacemaker
- Heart Surgery
- Hepatitis (infectious or serum)
- High Blood Pressure
- High Cholesterol
- HIV (Positive AIDS)
- Kidneys/Bladder Problems
- Liver Disease
- Lung Disease
- Persistent Fevers
- Problems with Anesthesia
- Pulmonary embolism
- Rheumatic Fever
- Shortness of Breath
- Skin Rashes
- Stroke
- Thyroid Disease
- Tuberculosis (TB)
- Ulcers
- Vein Thrombosis (Blood Clot)
- Any Disease, Condition or Problem not listed:

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Patient Information:

Last Name: _____First Name: _____ MI: _____Suffix: _____

Home Address: _____ Zip Code: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Date of Birth: _____ Gender: _____ Receive text messages: YES or NO

Marital Status:_____ Social Security Number: _____

Email Address: _____

Primary Language: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to report

Race: ☐Asian ☐Native American or Alaska Native ☐Other:
☐Black or African American ☐Native Hawaiian or Pacific Islander ☐Refuse to report
☐Hispanic ☐White

Insurance Information:

Primary Health Insurance: _____ Secondary Health Insurance: _____

ID number: _____ ID number: _____

Group number: _____ Group number: _____

Insurance Address: _____Insurance Address: _____

Is this visit a result of a **Motor Vehicle Accident** or **Worker's Compensation Claim**? If yes, please fill out:

Claim #_____Date of Injury: _____ Injured Body Part:_____

Insurance Company name: _____

Mailing Address for Claims: _____

Claim Adjuster's Name: _____

Phone Number:_____ Fax Number: _____

Please note, we do not await settlement proceedings for payment

Medical Information:

Pharmacy: _____ Phone: _____ Fax: _____

Emergency Contact: _____ Phone: _____Relationship: _____

Authorization:

I authorize the release of medical information necessary to process medical benefits and I authorize payment of medical benefits to Meeks and Zilberfarb Orthopedics for services by their office:

Signed: _____ Date:_____

meeks&zilberfarb
ORTHOPEDICS AND SPORTS MEDICINE

LOUIS W. MEEKS, MD, FACS
Founder
1996-2015

JEFFREY L. ZILBERFARB, MD
Assistant Clinical Professor
Orthopedic Surgery
Harvard Medical School
in Sports Medicine

Diplomates, The American Board of Orthopedic Surgery

General Orthopedics Sports Medicine/ Minimally Invasive Surgery

Musculoskeletal/Sports Medicine

ANNIE GREGORY
Practice Manager

1101 Beacon Street
Suite 5 West
Brookline, MA 02446

PH: (617) 232-2663
F: (617) 232-6342

PLEASE READ CAREFULLY AND SIGN BELOW:

REFERRAL: I understand that I am responsible for fees incurred if I neglect to contact my primary care physician to obtain referrals for services if such referrals are required by my health insurance policy.

RELEASE: I consent to the release of medical information and records related to my diagnosis and treatment to such parties as are necessary to enable my doctor to bill for the services provided to me.

ASSIGNMENT: I hereby authorize payment of medical/surgical benefits directly to this office. I agree to pay for all services provided by my doctor that are not reimbursed by a third party, provided that my doctor is not prohibited, under the terms of an applicable third party agreement, from billing me for such services.

Print:_____

Signature:_____

Date:_____

E-mail:
jzilberf@bidmc.harvard.edu
agregory@bidmc.harvard.edu

Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL

An Affiliate of NEW ENGLAND BAPTIST® HOSPITAL

Meeks & Zilberfarb Orthopedics
1101 Beacon Street, 5th
Floor Brookline, MA 02446
617-232-2663

Patient name:

HIPAA Notice of Patient Privacy Practices

I acknowledge receipt of Meeks & Zilberfarb Orthopedics practice privacy notice. I may request an additional copy of the privacy notice at any time.

Signed _____ Date: _____

Permission to Communicate with Your Primary Care Physician, Other Community Care Providers and/or Mental Health Providers:

In order to ensure continuity of care, it is often necessary to communicate information to your primary care physician and other community care providers including mental health providers, and to your insurance company. These communications may include information about your medical treatment and mental health or substance abuse treatment. This information is limited to that which is necessary to the determination of coverage and the coordination of your care.

Many insurance companies require us to document whether or not you will allow your clinician to communicate with your primary care physician, Health Insurance Company and/or mental health providers.

Signed _____ Date: _____

Consent for RX Hub Inquiry

I hereby provide my consent for Meeks & Zilberfarb Orthopedics to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Signed _____ Date: _____

Doctors affiliated with Beth Israel Deaconess Medical Center (BIDMC) and other doctors who participate in the Beth Israel Deaconess Care Organization (BIDCO) participate in a **Health Information Exchange (HIE).** The HIE is a secure computer network that, with my permission, will allow my BIDMC and BIDCO providers to view all of my health information (medical records). The HIE protects the confidentiality, privacy and security of the information. By making my health information available electronically, my BIDMC and BIDCO providers will be able to better coordinate my care. By signing this form, I give my permission to my BIDMC and BIDCO providers to view my health information electronically via the HIE.

I understand that my health information may contain (now or in the future) certain types of sensitive information:

- HIV/AIDS status
- genetic testing
- treatment for substance abuse (alcohol or drug)
- venereal disease(s)
- mammography records
- family planning services
- confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- if I am an emancipated minor, information about my treatment and diagnosis (but not shared with my parents)

By signing this form, I agree to the release of *all* my health information, including sensitive information, to my BIDMC and BIDCO providers through the HIE.

If you do not wish for sensitive information to be released in connection with the HIE, please do not sign this consent.

I understand that BIDMC, BIDCO, and my health care provider have taken reasonable steps to protect my confidentiality.

This Authorization will stay in effect from the date of my signature below until my provider is no longer participating in the HIE. I have the right to take back my consent (revocation), in writing, at any time. My revocation will be effective when my provider receives it. I may also contact my provider's Privacy Officer by mail at [insert address], by telephone at [insert number] or by email at [insert email address].

I have read this Authorization form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form. By signing this form I authorize my health care provider to use or disclose my health information in order to participate in the HIE.

_____ _____

Signature of Patient Date

_____

Print Patient Name

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date