PATIENT'S NAME___________________________________ DATE: ____________

SOCIAL SECURITY NUMBER_____________________ E-MAIL_____________________

DATE OF BIRTH____________ PHONE #: _______________

PATIENT'S MEDICAL HISTORY

Alcoholism___
Allergies/Hay fever___
Anemia___
Anxiety___
Asthma___
Atrial Fibrillation___
Blood Clot/DVT____
Blood Transfusion___
Coronary artery disease___
Cancer___
Cardiac Pacer___
Cardiovascular Disease___
Congestive heart failure___
Cirrhosis___
Colitis___
COPD___
Chronic renal failure___
Crohn's Disease___
Cerebrovascular accident

Depression___
Diabetes Type 1___
Diabetes Type 2___
Epilepsy___
Fracture___
Gastric Ulcer____
Gastrointestinal Disease___
GERD___
Glaucoma____
Heart Murmur____
Hepatitis____
High Cholesterol___
Hyperlipidemia___
Hypertension___
Hyperthyroidism___
Hypothyroidism___
Joint Pain___
Kidney infection___

Kidney Stone___
Migraines___
Multiple Sclerosis___
Obesity___
Old MI___
Osteoarthritis___
Osteoporosis____
Pneumonia___
Progressive Neuro Disorder___
Pulmonary Disorder___
Rheumatic Fever___
Rheumatoid Arthritis___
Sexually Transmitted Disease___
Terminal Illness___
Thyroid Disorder___
Transient Ischemic Attack (TIA)___
Tuberculosis___

Other Medical History ____

FAMILY HISTORY

GENERAL FAMILY HISTORY

Adopted___
Unknown Paternal Hx___

Denial of any knowledge of significant family history___
Unknown Maternal Hx___

Alcoholism___
Anemia___
Anxiety___
Asthma___
Birth Defects___
Coronary artery disease___
Cardiovascular Disease___
Congestive heart failure___
Cancer___

Congenital Anomaly___
COPD___
Crohn's Disease___
Depression___
Diabetes___
Epilepsy___
GERD___
Hypercholesterolemia___
Hyperlipidemia___

Hypertension___
Hypothyroidism___
Kidney Disease___
Liver Disease___
Multiple Births___
Osteoarthritis___
Osteoporosis___
Pulmonary Disease___
Stroke___

Other Conditions____

SURGICAL HISTORY

No Prior Surgical History___

Appendectomy___	Endometrial Ablation___	Laparoscopy___
Breast Lumpectomy___	Gallbladder___	Mastectomy___
Cataract Surgery___	Heart Surgery___	Myomectomy___
Colectomy___	Hemorrhoidectomy___	Oophorectomy___
Cone Biopsy___	Hernia___	Tonsil/Adenoidectomy___
D&C___	Hysterectomy___	Tubal Ligation___

Other Surgical History____

MEDICATION ALLERGIES	REACTIONS
______________________	____
______________________	____
______________________	____

CURRENT MEDICATIONS	DOSAGE	ORDERING PHYSICIAN
______________________	__________________	________________________________
______________________	__________________	________________________________
______________________	__________________	________________________________
______________________	__________________	________________________________

SOCIAL HISTORY

SMOKING

Current Smoker___ Packs Per Day______ Years________

Former Smoker___ Date Quit________

Never Smoked___

ALCOHOL

Non Drinker___ Occasional___ Social___ Moderate___ Heavy___

CAFFEINE

None___ Servings Per Day______

MARITAL STATUS:

Married____ Single____ Divorced____ Widow____

DOCTORS (PLEASE LIST ALL)

____

____

____

HEIGHT:_____ WEIGHT:_______ BLOOD PRESSURE: _____ PULSE:______

PHARMACY:

WHAT **LOCAL** PHARMACY DO YOU USE:

NAME:____

ADDRESS: ____

PHONE #:____

WHEN WAS YOUR LAST FLU SHOT? ____

HOW DID YOU HEAR ABOUT DR. JOSEPH TAURO?

____

Joseph C. Tauro, M.D.

Assistant Professor of Orthopedic Surgery
New Jersey Medical School
Director, Ocean County Sports Medicine Center

Sports Injuries **Minimally Invasive**
Arthroscopic Surgery **Joint Replacement**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO INSURANCE CARRIER
AND ASSISGNMENT OF BENEFITS TO JOSEPH C. TAURO, M.D.

COMMERCIAL INSURANCE

I hereby authorize release of medical information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO JOSEPH C. TAURO, M.D.

OUT OF NETWORK PATIENTS:
I understand that my benefits will be paid at an out of network rate and payment may come to me. I am responsible to bring in or mail payment and explanation of benefits. We are out of network with most insurances.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of this signature is as valid as the original.

Signature of Patient:_________________________________ Date:______________________

9 Hospital Drive **Toms River, New Jersey 08755** **(732) 341-6226**

Joseph C. Tauro, M.D.

Assistant Professor of Orthopedic Surgery
New Jersey Medical School
Director, Ocean County Sports Medicine Center

Sports Injuries **Minimally Invasive**
Arthroscopic Surgery **Joint Replacement**

PATIENT NAME: ____

PLEASE CHECK THE **ONE** THAT APPLIES TO YOU

_____ I give my permission to leave a message in regard to blood work, results, outside testing, appointment changes, etc. , either on my answering machine or with a family member who answers my home telephone.

_____ If I am unable to be reached by phone, NO MESSAGE pertaining to myself is to be left on my home answering machine or with a family member.

PATIENT'S SIGNATURE:___________________________________ DATE:____________________________

This is to certify that I, _________________________________, request that my medical information be only released to (include any person, family, doctors, you wish to have your medical information sent to).

NAME(S):	**RELATIONSHIP:**
___________________________________	____
___________________________________	____
___________________________________	____
___________________________________	____

_____ I do not want to have any of my health-related information released to anyone other than myself.

PATIENT'S SIGNATURE____ DATE: ____________

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