

Jeffrey S. Gitt, D.O., P.C.
Justin X. Mussomeli, M.D.

CONFIDENTIAL BILLING INFORMATION

You were referred to us by: _____

Your primary care physician is: _____

PATIENT NAME: _____
Last First Middle

ADDRESS _____
Street City State Zip

PHONE: _____
Home (cell #)

AGE ___ BIRTHDATE _____ SEX ___ MARITAL STATUS ___ SOC. SEC. # _____

EMPLOYER: _____ **BUSINESS PHONE:** _____

Employer's Address

PARENT/SPOUSE'S NAME: _____ **PARENT/SPOUSE'S SS#:** _____

PARENT/SPOUSE'S BIRTHDATE: _____

PARENT/SPOUSE'S EMPLOYER: _____ **BUSINESS PHONE:** _____

STUDENT: Yes _____ No _____ Full Time: _____ Part Time: _____

SCHOOL NAME: _____

Emergency Contact - other than a relative in the same home:

Name _____

Address _____

Phone No. _____

Jeffrey S. Gitt, D.O., P.C.
Justin X. Mussomeli, M.D.

Address correspondence to:
3815 E. Bell Rd. #2400
Phoenix, AZ 85032
(602) 482-2116
FAX: 482-9563

PATIENT'S NAME: _____ **DATE:** _____

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENT TO:

Jeffrey S. Gitt, D.O., P.C.

AND I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY COPAYMENTS, DEDUCTIBLES, COINSURANCE AND ALL CHARGES WHICH ARE CONSIDERED TO **BE NOT A COVERED BENEFIT BY MY INSURANCE COMPANY**. I UNDERSTAND THAT VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF BENEFITS. ACTUAL PLAN COVERAGE AND BENEFIT PAYMENTS ARE DETERMINED WHEN A CLAIM IS RECEIVED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES IF IT IS DETERMINED THAT THE INSURANCE INFORMATION I HAVE PROVIDED IS NO LONGER IN EFFECT.

DELINQUENT ACCOUNTS WILL BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY WITHOUT NOTICE. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 60 DAYS. IN THE EVENT MY ACCOUNT IS TURNED OVER FOR COLLECTION, I WILL PAY ALL REASONABLE COLLECTION, COURT AND ATTORNEY COSTS AT THE TIME THE ACCOUNT IS CONSIDERED DELINQUENT.

SIGNED: _____

RELEASE OF INFORMATION:

I hereby authorize release of medical information to my referring physician and/or to any other physicians who have been or may become involved in my medical care. I also authorize release of information that may be necessary in the processing of any insurance claims.

Signature: _____ Date: _____

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

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PATIENT HISTORY

NAME: _____ AGE: _____
Last First Middle

Main complaint and symptoms (briefly describe what and where it hurts):

When did this problem FIRST START? _____
(date)

Describe the frequency and duration of symptoms:

Please describe treatments tried and how effective they are:

Have you consulted other doctors for this problem? _____

Have you been treated by a physical or occupational therapist? _____

Are your symptoms due to an accident? _____
yes no

Is a LEGAL CASE pending? _____
yes no

If due to an accident, describe what happened and where:

Please circle all symptoms that you have

Review of Systems

- 1. Constitutional:** weight change decreased energy fever chills night sweats
- 2. Psychiatric:** depression feelings of hopelessness anxiety irritability
panic attacks excessive worrying rapid mood changes
- 3. Neurologic:** memory problems confusion concentration problems
insomnia excessive sleepiness snoring stop breathing during sleep
headaches slurred speech
arm/hand pain arm/hand numbness leg/foot pain leg/foot numbness
arm/hand weakness leg/foot weakness
dizziness loss of balance falling fainting tremor seizures
- 4. Eyes:** eye pain blurred vision double vision flashing lights light sensitivity
- 5. ENT:** ringing in ears ear pain hearing loss sound sensitivity loss of smell
tooth pain jaw pain jaw popping/clicking grinding teeth
- 6. Musculoskeletal:** neck pain upper back pain lower back pain joint pain cramps
- 7. Cardiovascular:** heart disease chest pain/pressure palpitations ankle swelling
- 8. Respiratory:** asthma shortness of breath coughing wheezing
- 9. Gastrointestinal:** liver problems stomach ulcers nausea vomiting belly pain
constipation diarrhea
- 10. Genitourinary:** kidney problems kidney stones frequent urinary tract infections
painful urination urinary urgency or hesitancy urinary incontinence
- 11. Integument:** new rashes easy bruising skin ulcerations nail changes

PAST MEDICAL HISTORY: (all illnesses diagnosed, controlled or not)

- | | |
|----------|-----------|
| 1) _____ | 7) _____ |
| 2) _____ | 8) _____ |
| 3) _____ | 9) _____ |
| 4) _____ | 10) _____ |
| 5) _____ | 11) _____ |
| 6) _____ | 12) _____ |

OPERATIONS: (Please list all, even minor ones such as tonsillectomy)

- | | |
|----------|----------|
| 1) _____ | 5) _____ |
| 2) _____ | 6) _____ |
| 3) _____ | 7) _____ |
| 4) _____ | 8) _____ |

ALLERGIES: (for example: IV contrast dye, penicillin, latex, etc)

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

MEDICATIONS: (including supplements and herbs)

	Dose	Times per day
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____
8) _____	_____	_____
9) _____	_____	_____
10) _____	_____	_____
11) _____	_____	_____
12) _____	_____	_____

(Continue on back of page if necessary)

Personal and Social History:

Are you presently working? _____ Occupation: _____

If disabled:

Date Disability began: _____

Cause of Disability: _____

Highest level of Education: _____

How many steps to the entrance to your home? _____

How many floors in your home? _____

Have you ever smoked? _____

Do you currently smoke? _____ How long? _____ How much? _____

If you quit, what year did you quit? _____ How long did you smoke? _____

Do you drink alcohol? _____ Weekly amount: _____

Do you drink coffee? _____ Caffeinated? _____ Weekly amount: _____

Do you drink soda? _____ Caffeinated? _____ Weekly amount: _____

Have you used illegal drugs? _____ If yes, What? _____

Family History: *Please circle all diseases anyone in your family has*

Stroke TIA Seizures/epilepsy Headaches/Migraine Multiple Sclerosis

Heart disease Diabetes Hypertension High Cholesterol Cancer

Other neurologic disease (please explain): _____

Do any diseases run in your family?: _____

Please fill out Family Member health information bellow:

	Age (s)	Living	Medical issues (If Deceased please state cause)
Father	_____	_____	_____
Mother	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Son(s)	_____	_____	_____
Daughter(s)	_____	_____	_____