



**S. Robert Rozbruch, MD**  
**Orthopaedic Surgery**

Please note that it is a requirement for the physician to document this information. Please answer all questions. Answer "none" if appropriate.

Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Telephone: home: \_\_\_\_\_ work: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
Chief Complaint: \_\_\_\_\_

**Referral Information**

Who referred you to Dr. Rozbruch? \_\_\_\_\_  
Are they a former patient of this office? \_\_\_\_\_  
Information on the doctor to whom you would like a report sent:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
Telephone: \_\_\_\_\_  
Did this doctor refer you here? \_\_\_\_\_

**History of Present Illness:**

Location: Where is the pain? \_\_\_\_\_  
Quality: Circle one or more: \_\_\_\_\_ sharp, dull, aching, shooting, traveling  
Timing: When did it first start? \_\_\_\_\_  
Context: What causes the pain? \_\_\_\_\_  
Frequency: How many times per week is it a problem? \_\_\_\_\_  
Modifying Factors: What makes it worse? \_\_\_\_\_  
What helps make it better? \_\_\_\_\_  
Prior Treatment: \_\_\_\_\_

**Past Medical History:**

Major illness or injury: \_\_\_\_\_  
Past Surgery: \_\_\_\_\_  
Current Medications and what they are used to treat:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Allergies to medications: \_\_\_\_\_  
Other Allergies: \_\_\_\_\_

**Family History:**

Diseases that have been in your family: \_\_\_\_\_

**Social History:**

Marital Status: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Alcohol use: How many drinks per week? \_\_\_\_\_  
Smoking: How many packs per day? \_\_\_\_\_  
Person you wish doctor to call in case of emergency or after surgery:  
Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Review of Systems:**

Please list any problems in the following systems: Indicate "none" if appropriate.

Eyes: \_\_\_\_\_  
Ear, nose, throat: \_\_\_\_\_  
Cardiovascular: heart: \_\_\_\_\_  
Peripheral circulation: \_\_\_\_\_  
Respiratory, Lungs: \_\_\_\_\_  
Gastrointestinal, digestive system, liver: \_\_\_\_\_  
Genitourinary: \_\_\_\_\_  
Renal, kidney: \_\_\_\_\_  
Integumentary, skin: \_\_\_\_\_  
Neurologic: \_\_\_\_\_  
Psychiatric: \_\_\_\_\_  
Endocrine, Hormonal, Diabetes: \_\_\_\_\_  
Hematologic, Blood: \_\_\_\_\_  
Immunologic, immune compromise: \_\_\_\_\_

Medical Record Number \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT**

*By signing below, I acknowledge that I have been provided a copy of my physician's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by this practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.*

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative

\_\_\_\_\_  
Print Name of Patient or Patient's Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Date

If you have any questions about this notice or would like further information, please contact the office manager.

|   |
|---|
| <p><b>For Office Use Only:</b> If the patient does not sign this acknowledgement and consent form, record here the good faith efforts made to obtain this acknowledgement and consent.</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|

**S. Robert Rozbruch, M.D.**  
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And Reconstruction  
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Mail to: 535 East 70<sup>th</sup> St.  
Office Address: 519 East 72<sup>nd</sup> Street 2<sup>nd</sup> Fl suite 204  
New York, New York 10021*

**Financial Policy For Medicare Patients**

Dr. Rozbruch is a participating Medicare Provider and will submit all claims directly to Medicare. Payment for the 20% differential is to be paid immediately upon receipt of our bill, or if you do not have secondary insurance, it must be paid in the office.

If secondary insurance carrier information is provided including policy, group, plan numbers along with the correct mailing address for claims to be submitted and telephone number of the insurance company, our billing company will automatically submit these for you. Please be advised that if Medicare should reject your charges as not covered, you will be responsible for the Medicare allowable fee for the charges.

You are responsible for your deductibles, and if any of our services are billed against your deductible, you must reimburse the doctor for these services. The deductible is the patient's financial responsibility.

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**Patient's (Or Responsible Party) Signature**

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**Date**

**Financial Interest Disclosure Form**  
**Medical Staff, Allied Health Professional Staff,**  
**Residents, and Fellows**

As your treating physician and as a member of the Medical Staff of the Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with Small Bone Innovations and Biomet, Inc., orthopedics device companies whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with Small Bone Innovations and Biomet, Inc.:

I am a consultant and product developer of Six Fix, a monolateral external fixator for Biomet, Inc. for which I receive royalties. I am also a consultant and designer of the Ankle Distraction Frame for Small Bone Innovations for which I receive royalties.

I DO NOT RECEIVE ANY PAYMENTS FROM THE COMPANY FOR USE OF THE COMPANY'S PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact Thomas P. Sculco, MD, Surgeon-in-Chief, at 212-606-1475, the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

**Signature** \_\_\_\_\_  
**Patient/Parent/Guardian/Health Care Agent** **Date**

**Print Name** \_\_\_\_\_  
**Patient/Parent/Guardian/Health Care Agent**

\_\_\_\_\_  
**Relationship to Patient**

**PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD**