



**PINNACLE**

Orthopedic & Spine Specialists

700 Michigan Ave.  
Buffalo, NY 14203

(716) 854.5700 tel  
(716) 854.5800 fax

[heal@pinnacle-orthopedics.com](mailto:heal@pinnacle-orthopedics.com)

Your Appointment is: \_\_\_\_\_

- Co pays due at time of visit.
- Bring Photo ID and insurance cards.
- Paperwork must be completed.
- Must bring all films, reports and test results for your injury.
- Must arrive ½ hour before appointment.
- Cannot arrive later than ½ hour after appointment.

**Cameron B. Huckell, M.D.**

Adult & Pediatric  
Spinal Surgery

**Graham R. Huckell, M.D.**

Joint Replacement & Arthroscopy  
General Orthopedics

**A. Marc Tetro, M.D.**

Hand, Shoulder & Elbow Surgery,  
Arthroscopy & Microsurgery

**Kathleen Miller, CPA, MBA**

CEO

# Pinnacle Orthopedic & Spine Specialists

## PATIENT MEDICAL PROFILE

**PATIENT NAME** (First, Middle, Last): \_\_\_\_\_ Pg 1/2

Marital Status: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Status \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

**PRIMARY COMPLAINT** (what is your primary medical problem to be addressed at your first visit):

\_\_\_\_\_  
\_\_\_\_\_

### Medical History Questionnaire:

Sex: \_\_\_ M \_\_\_ F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Medications:** (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies:** (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Smoking:** \_\_\_ Yes \_\_\_ No If yes: \_\_\_\_\_ Packs per Day for \_\_\_\_\_ years

**Alcohol** \_\_\_ Yes \_\_\_ No  
If yes -- How much \_\_\_\_\_ How often \_\_\_\_\_

**Surgical History:** Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Anesthesia Problems with surgery? \_\_\_\_\_

### **Personal Medical History & Review of Systems:**

Please indicate with an "X" any medical problems that you currently have or have had in the past.

**NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

#### **Lungs / Pulmonary – breathing disorders**

- |                                    |   |  |
|------------------------------------|---|--|
| <input type="checkbox"/> asthma    | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest / ventilator |
| <input type="checkbox"/> COPD      | <input type="checkbox"/> pneumonia          | <input type="checkbox"/> sleep apnea                     |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis       | <input type="checkbox"/> other: _____                    |

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**PATIENT NAME:** \_\_\_\_\_

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**Personal Medical History (continued):**

**Cardiac / Heart and peripheral vascular disease**

- chest pain / angina
- heart attack, myocardial infarction
- congestive heart failure
- other: \_\_\_\_\_
- high blood pressure
- heart murmur, valve disorder
- mitral valve prolapse
- irregular heartbeat, arrhythmia
- peripheral vascular disease
- deep vein thrombosis
- bleeding problems

**Neurologic Disorders**

- stroke or TIA
- peripheral neuropathy
- other: \_\_\_\_\_
- parkinson's
- MS
- cerebral palsy
- polio

**Bone & Joint Disorders**

- osteoarthritis
- rheumatoid arthritis
- other: \_\_\_\_\_
- gout
- lupus
- osteomyelitis
- ankylosing spondylitis
- scleroderma

**Gastrointestinal Disorders**

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed / bleeding ulcer
- diverticulitis
- Colitis - inflammatory bowel
- hepatitis - Type \_\_\_\_\_
- liver disease
- other: \_\_\_\_\_

**Genitourinary Disorders**

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: \_\_\_\_\_

**Metabolic & Other Disorders**

- Diabetes x \_\_\_\_\_ years
- thyroid problems
- alcohol or drug dependency
- HIV Positive test
- skin disorder \_\_\_\_\_
- psoriasis
- tooth abscess, gingivitis
- AIDS
- Depression or anxiety (circle)
- sickle cell disease
- high cholesterol or lipids
- other: \_\_\_\_\_

Cancer: any type -- please specify \_\_\_\_\_

Other medical problems NOT included above (explain) \_\_\_\_\_

**Family History:**

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- bleeding problems
- Peripheral neuropathy
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : \_\_\_\_\_
- congestive heart failure
- other heart : \_\_\_\_\_
- MS or Parkinson's
- Lupus, ankylosing spondylitis
- Other bone & joint: \_\_\_\_\_
- inflammatory bowel disease
- other GI : \_\_\_\_\_
- dialysis, kidney failure
- psoriasis
- sickle cell disease
- Anesthesia complications: \_\_\_\_\_
- sleep apnea
- irregular heartbeat, arrhythmia
- other neuro : \_\_\_\_\_
- gout
- hepatitis - Type \_\_\_\_\_
- other: \_\_\_\_\_
- high cholesterol or lipids
- any skin ulcer

Cancer : any type -- please specify \_\_\_\_\_

Other medical problems NOT included above (explain) \_\_\_\_\_

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**Patient Name** \_\_\_\_\_  
(First) (Middle) (Last)  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

**Private Health Insurance**

**PRIMARY**

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_  
Patient ID# \_\_\_\_\_ Group # \_\_\_\_\_

**SECONDARY**

Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Relationship to pt. \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_  
Patient ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Workers Compensation OR No-Fault Insurance Information**

WCB/NF Insurance Co. \_\_\_\_\_  
Insurance Claim # \_\_\_\_\_ NYS WCB# \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

**EMPLOYER** at time of injury \_\_\_\_\_  
Year began employment \_\_\_\_\_ Date last worked \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Telephone \_\_\_\_\_

**Date of Injury** \_\_\_\_\_

**Insurance Authorization**

I authorize the release of any medical information necessary to process my insurance claims. I also authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event of my failure to pay any sums due and my account is referred to a collection agency for collection, I agree to be responsible for all applicable fees. A copy of my signature below is as valid as the original. I agree that a photocopy for this form may be used in lieu of the original.

Patient Signature \_\_\_\_\_

# **Pinnacle Orthopedic & Spine Specialists**

## **Patient Policy**

MINORS- You may have 1 person accompany you into the exam room. You May not leave any minor unaccompanied in the building. If you arrive with more than one minor and do not have an adult that can watch them during your exam, you will need to reschedule your appointment.

LATE- Patients arriving 30 minutes or more after the appointment time will usually be rescheduled. If the doctor is behind his scheduled appointment by 1 hour, you will be asked if you would like to reschedule.

CO-PAY- This is due prior to your examination. You may have separate co-pay for the office visit, xray, and therapy.

## **HIPAA Protection**

We will not divulge any information regarding your treatment, appointment dates and times etc., without your written consent. In the space provided below, kindly print clearly any person(s) to whom we may provide said information. Please note that a carbon copy of your narrative report(s) will not automatically be sent to the contacts listed below.

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Patient Signature & Date



**Pinnacle Orthopedic & Spine Specialists**

**Patient Treatment Waiver**

Patient Name\_\_\_\_\_

Identification #\_\_\_\_\_

Provider Name\_\_\_\_\_

Date\_\_\_\_\_

Please check the appropriate box

( ) I understand that the physician I am seeing today is not my primary care physician, and therefore assume responsibility for paying the bill.

( ) I do not have a referral letter or authorized referral number. I understand that the referral letter or number is required prior to scheduling this visit in order to assure that it is a covered benefit. I have decided I want to continue with this visit today, and therefore assume responsibility for paying the bill.

( ) I understand it is my responsibility to verify that this provider participates in my healthcare plan. If the provider does not I assume responsibility for paying the bill.

Patient Signature \_\_\_\_\_

Patient printed Name\_\_\_\_\_

## **Pinnacle Orthopedic & Spine Specialists**

### **Provider Notice of Privacy Practices**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW CAREFULLY.

**Uses and Disclosures:** We use health information about you for treatment, to obtain payment or treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

**Your rights:** In most cases, you have the right to look at or get a copy of health information about you. If you request your medical records and come to the office to pick them up, we will provide you with a CD for free. You also have a right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**Our legal duty:** We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints:** If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complain to the U.S. Department of Health and Human Services, 65 Court Street Suite 506, Buffalo NY 14202.

If you have questions or complaints, please contact:

CEO: Kathleen Miller

Address: 700 Michigan Avenue, Buffalo NY 14202

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_



**Pinnacle Orthopedic & Spine Specialists**

**Electronic Communication Authorization**

I agree to allow Pinnacle Orthopedic & Spine Specialists to send a text message to my cell phone or an email to the email address I have provided to them in my new patient packet, regarding my healthcare appointments. This may include reminders of upcoming appointment dates and times, cancellations, rescheduling of appointments, and office closings.

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_