

Date \_\_\_\_\_



# Advanced Orthopedics

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Height \_\_\_\_\_ Weight \_\_\_\_\_ Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

The reason(s) for your visit today? \_\_\_\_\_

Date of injury? \_\_\_\_\_ Where did injury occur?  At work  At school  Car accident  Other \_\_\_\_\_

Briefly describe your injury \_\_\_\_\_

Were X-rays taken? \_\_\_\_\_ If yes, where \_\_\_\_\_ Do you have them with you?  Yes  No

Referring Physician or Facility \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Your Primary Care Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Are you/have you been treated for this problem by another physician?  Yes  No Physician \_\_\_\_\_ Phone \_\_\_\_\_

No change in symptoms from last visit of \_\_\_\_\_

### Systemic Symptoms

- Yes Weight change
- Yes Chills
- Yes Fever
- Yes Night sweats
- Yes Feeling tired or poorly
- Other systemic symptoms – \_\_\_\_\_

No Systemic Symptoms

### HEENT Symptoms

- Yes Headache
- Yes Eyesight problems
- Yes Nosebleeds
- Other head related symptoms – \_\_\_\_\_

No HEENT Symptoms

### Neck Musculoskeletal Symptoms

- Yes Neck pain
- Yes Neck stiffness
- Yes Lump or swelling in neck
- Other neck symptoms – \_\_\_\_\_

No Neck Symptoms

### Pulmonary Symptoms

- Yes Shortness of breath
- Yes Cough
- Yes Coughing up blood
- Yes Wheezing
- Other pulmonary symptoms – \_\_\_\_\_

No Pulmonary Symptoms

### Cardiovascular Symptoms

- Yes Chest pain or discomfort
- Yes Fast heart rate
- Yes Palpitations
- Other cardiovascular symptoms – \_\_\_\_\_

No Cardiovascular Symptoms

### Gastrointestinal Symptoms

- Yes Difficulty swallowing
- Yes Heartburn
- Yes Nausea
- Yes Vomiting
- Yes Abdominal pain
- Yes Diarrhea
- Other gastrointestinal symptoms – \_\_\_\_\_

No Gastrointestinal Symptoms

### Genitourinary Symptoms

- Yes Blood in urine
- Yes Painful urination
- Yes Increased urinary frequency
- Other genitourinary symptoms – \_\_\_\_\_

No Genitourinary Symptoms

### Skin Symptoms

- Yes Skin itch/scratch
- Yes Skin lesions
- Yes Rashes
- Other skin symptoms – \_\_\_\_\_

No Skin Symptoms

### Endocrine Symptoms

- Yes Excessive sweating
- Yes Excessive thirst (polydypsia)
- Other endocrine symptoms – \_\_\_\_\_

No Endocrine Symptoms

### Hematological Symptoms

- Yes Easy bleeding
- Yes Easy bruising tendency
- Other hematological symptoms – \_\_\_\_\_

No Hematological Symptoms

### Neurological Symptoms

- Yes Dizziness
- Yes Vertigo
- Yes Motor disturbances
- Yes Sensory disturbances
- Other neurological symptoms – \_\_\_\_\_

No Neurological Symptoms

### Psychological Symptoms

- Yes Sleep disturbances
- Yes Anxiety
- Yes Depression
- Other psychological symptoms – \_\_\_\_\_

No Psychological Symptoms

No change in medical history from last visit of \_\_\_\_\_

### PAST MEDICAL HISTORY

- Yes High blood pressure/ Hypertension
- Yes Diabetes Mellitus
- Yes Heart Disease (CAD)
- Yes Heart attack
- Yes Stroke
- Yes Asthma
- Yes Bronchitis
- Yes Chronic Lung Disease (COPD)
- Yes Esophageal Reflux (GERD)
- Yes Peptic Ulcer
- Yes Blood Clot (DVT)
- Yes Osteoporosis
- Yes Arthritis
- Yes Gout
- Yes Rheumatoid Arthritis
- Yes Psoriasis
- Yes Hepatitis
- Yes Aids/HIV Infection
- Yes Cancer
- Yes Atrial Fibrillation
- Yes Mitral Valve Prolapse
- Yes Renal Failure
- Yes Kidney/Renal Disease
- Yes Bladder infection/ Urinary Tract infection
- Yes Sleep Apnea
- Yes Epilepsy/Seizure
- Yes Tuberculosis
- Yes Obesity
- Yes Scoliosis
- Yes Thyroid Disorders
- Yes Hemophilia
- Yes Fibromyalgia
- No Active Problems

Other past medical history: \_\_\_\_\_

### RELEVANT HISTORY

- Yes Currently pregnant?
- Yes Are you taking blood thinners?
- Yes Past reactions to anesthesia?

### PAST SURGICAL HISTORY

List past surgeries and dates –

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### FAMILY HISTORY

- Yes Cancer
- Yes Heart Disease
- Yes High blood pressure/ Hypertension
- Yes Autoimmune Disease
- Yes Osteoarthritis
- Yes Diabetes Mellitus
- No significant family history of disease

### SOCIAL HISTORY

- Yes  No Smoker –
- If yes: \_\_\_ packs/day x \_\_\_ years
- Yes  No Alcohol –
- If yes:  Less than 2 drinks/day  3 or more drinks/day
- Yes  No Drug Use –
- If yes: specify \_\_\_\_\_

### Office Use Only

Form completed by  Patient  Parent/Guardian  Spouse  Staff  Other \_\_\_\_\_

Name \_\_\_\_\_



## PATIENT INFORMATION

Primary Phone \_\_\_\_\_ (home/cell)      Secondary Phone \_\_\_\_\_ (home/cell)      Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Last      First      Middle      Social Security No. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  Male  Female      Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital Status  M  S  D  W

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Business Phone No. \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Have you obtained a referral from your PCP for this visit? \_\_\_\_\_

Where did injury occur?  At work  At school  Car accident  Other \_\_\_\_\_

In case of emergency who should be notified \_\_\_\_\_ Relationship \_\_\_\_\_ Phone No. \_\_\_\_\_

## INSURANCE INFORMATION

Person responsible for account \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last      First      Middle

Relationship to patient \_\_\_\_\_ Phone No. \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Responsible party employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Business Phone No. \_\_\_\_\_

Insurance Company \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cardholders' DOB \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## SECONDARY/SCHOOL INSURANCE

Insurance Company \_\_\_\_\_

ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Cardholder's Name \_\_\_\_\_ Relationship \_\_\_\_\_ Cardholders' DOB \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone No. \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I hereby authorize any insurance benefits to be paid directly to the Physician. I hereby authorize the release of all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges incurred whether or not paid by an insurance company. Interest of 1½% per month (18% annually) may be charged to overdue accounts. Any collection costs (including attorney's fees) will be charged to delinquent accounts and may be reported to credit rating agencies. I realize that insurance assignment (when applicable) is a courtesy extended by Advanced Orthopedics and that I am ultimately responsible for payment of all services rendered. This agreement will remain in effect until revoked by me in writing. A photo copy of this agreement is to be considered as valid as an original.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian if under 18)



# Advanced Orthopedics

## **NOTICE OF PROTECTED HEALTH INFORMATION (PHI) POLICY (Effective April 1, 2003)**

The privacy of your medical information is important to us. The following information is provided to formally advise you of our PHI policy as per present federal regulations. Your PHI will be used for the purpose of treatment, payment and healthcare operations (TPO). Your signature below acknowledges that we may need to provide your PHI for purposes of treatment, payment and healthcare operations (TPO) on a regular basis. Deborah Lynch is in charge of privacy matters at our office. You can contact her if you have any questions regarding our privacy policy.

### **Use and disclosure of protected information:**

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further notice to you, or written authorization by you. For example, we may disclose your PHI to a pharmacy when we order a prescription for you, or if we refer you to a specialist, we may provide laboratory or test data to the specialist (subject to more stringent New York laws, such as restriction on disclosure of information concerning HIV/AIDS). Employees in our practice may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. We may also disclose your PHI to other health care providers for purposes related to your treatment.

Federal law provides that we may use your medical information to obtain payment for our services without further specific notice to you, or written authorization by you. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment in order to obtain payment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. We may also use your PHI to bill you directly for services rendered and in cases of non-payment to a collection agency. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

Federal law provides that we may use your medical information for health care operations without further specific notice to you, or written authorization by you. For example, our accountants may see names, dates of treatments and procedure codes during audits of our books or we may use your information for risk reduction and claim management purposes with our medical professional liability insurer.

We may use or disclose your medical information, without further notice to you, or specific authorization by you, where: required by law; required for public purposes; required by law to report child abuse; required by a health oversight agency for oversight activities authorized by law, such as Department of Health, Office of Professional Discipline of Offices of Professional Medical Conduct; required by law in judicial or administrative proceedings; required by law enforcement purposes by a law enforcement official; required by a coroner or medical examiner; permitted by law to a funeral director; permitted by law for organ donation purposes; permitted by law to avert a serious threat to health or safety; permitted by law and required by military authorities if you are a member of the armed forces of the United States.

We may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute.

We may use or disclose your PHI for worker's compensation, no fault and similar programs.

We may use a sign-in sheet at the front desk and we may call you in to see the doctor by name.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may mail you a postcard reminding you to make an appointment and we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make a reasonable request for us to use alternative methods of communicating with you in a confidential manner. These requests must be submitted in writing in a clear and concise fashion. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when information is necessary to treat you.

**Rights that you have:**

You have the right to request restrictions on some of the uses or disclosures described above. Except as stated we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information ( a fee for the costs of copying, labor and supplies associated with your request will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosure we make of your medical information except for: disclosures we make to you, or to carry out treatment, payment or healthcare operations, or as requested by your written authorization, or as permitted or required under 45 CFR 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law.

You have the right to receive a paper copy of this notice. To obtain a paper copy of this notice please contact Deborah Lynch.

You have the right to file a complaint if you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing and addressed to Deborah Lynch at the above address. You will not be penalized for filing a complaint.

This privacy policy is subject to change as circumstances dictate. Any changes will be effective upon the release of a revised privacy policy, which will be made available to patients upon request. Please sign and date below acknowledging that you have read this policy and that you consent to the terms of our privacy policy as stated in this notice.

**You may choose up to 2 people (such as relative, friend, or attorney) to share your medical information with. Any changes to this will need to be in writing.**

The person(s) I wish to have access to information in regard to my medical condition is:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Print Name of Patient or Legal Guardian \_\_\_\_\_

## ADVANCED ORTHOPEDICS

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### Pharmacy Information

Please list your pharmacy information so that we may electronically prescribe medications for you, when possible:

Pharmacy Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_

***\*If you do not indicate a preferred pharmacy, we will automatically send your electronic prescription to: Sunrise Pharmacy, located at 285 Sills Rd, Building 8B, in East Patchogue.***

### Current Medications

Please list ALL of the medications you are currently taking:

| Medication Name | Strength | Dosage/Day |
|-----------------|----------|------------|
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |
|                 |          |            |

### Allergies

Please list ALL allergies (drug, food, environmental):

| Allergen | Reaction (rash, nausea, shortness of breath, etc) |
|----------|---|
|          |   |
|          |   |
|          |   |
|          |   |

**WORKERS' COMPENSATION INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ SS#: \_\_\_\_\_

**EMPLOYER INFORMATION** (At time of accident)

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Employer Telephone: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently working? \_\_\_\_\_

If no, last Date of Employment: \_\_\_\_\_

**WORKERS' COMPENSATION CARRIER**

Name of Workers' Compensation Insurance Carrier: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Carrier/Adjuster Telephone: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_ WCB #: \_\_\_\_\_

**INJURY INFORMATION**

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_ Place of Injury: \_\_\_\_\_

How Did the Accident Happen? \_\_\_\_\_

Is your case currently controverted? \_\_\_\_\_ Date of Next Hearing: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Attorney Phone Number: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

I clearly understand and agree that all services rendered to me are directly charged to me and that I am personally responsible in the event that my Workers' Compensation benefit is denied. I also authorize Advanced Orthopedics to bill my private health insurance coverage in the event my Workers' Compensation claim is denied or controverted.

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