South Nassau Orthopedic Surgery and Sports Medicine, P.C.

Patient Intake form
(PLEASE PRINT CLEARLY)
PATIENT INFORMATION

Last Name: ______________________ First Name:______________________Middle Initial ____ (Jr/Sr/____)

Street Address:______________________________Apt#______City________________State_____Zip__________

Mark your primary contact number:

[ ]Home # ______________________ [ ]Cell #______________________ [ ] Work #________________

[ ] Emergency Contact Name:____________________ Contact #:______________Relationship:____________

*Email Address: ____

DOB:: _______/_______/________ Age: ________ Social Security #: ________-_______-_______

(Please make sure you read and answer all questions with a circle)

Sex: Male/Female Marital Status: Married / Single / Divorced / Widowed Preferred Language: ________________

If Married:

Spouses Name:____________________ DOB:: _______/_______/________

Race: American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander /

White / Other Race Ethnicity: Hispanic or Latino / Not Hispanic or Latino

Tobacco Use: Past smoker / Current Smoker If tobacco user, what is your preference: Cigarette/Cigar/Chewing How much:____

Alcohol Use: [ ] None [ ] Yes How many drinks per week?____________________

How would you like to be contacted for Health Alert: Phone / Fax / Email / Patient Portal / SMS

If you are a female could you be pregnant? Yes / No Date of last menstrual cycle?________________

If the patient is a student: Grade Level, School / College Name: ________________________

INSURANCE DETAILS (Circle One)

No-fault / Worker Comp / Medical Insurance / Medicare / IME / LIEN ________________

Where were you hurt? Work / Auto Accident / Other Incident:________________________

Primary Insurance Company Name:____________________ID/Policy/Claim#: ________________

Address:______________________________ City:____________________ State: ________ Zip: __________

Who is the policy holder? Patient / Spouse / Parent / Work / Self

Policy Holders Name: __________________________ DOB:_____/_______/________SS#: ________-_______-_______

If above primary insurance is a no-fault, workers comp., Medicare, or a coordination of benefits, complete below:

2nd or Other Medical Ins. Co. Name:______________________________ID/Policy/Claim #________________

Address:______________________________ City:____________________ State: ________ Zip: __________

Policy Holders Name: ____________________DOB:____/____/_____SS#:_____-_____-_____ Relationship:__________

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EMPLOYMENT

Employment Status: [ ] Currently Working [ ] Not Working [ ] Not Working due to injury /accident

Occupation: ______________________ **Dept:** ____________ **Employer Name:** ______________________________

Employer Address:: ____ **CITY** __________ **STATE** ________ **ZIP** __________

Employer Phone #: ______________________________ **Employer Fax # :** __________________________

Primary Care Physician Name: ______________________________ #: __________________________

Referring Physician Name: ______________________________ #: __________________________

Referring Attorney Name: ______________________________ #: __________________________

Preferred Pharmacy: ____

REASON FOR THE VISIT

Please state your current medical problem: ____

Date of accident/injury/onset of pain/problem: ______-_______-_______ (*exact date*)

Cause of injury: [ ] Motor Vehicle Accident [ ] Workers Comp. [ ] Slip & Fall [ ] Sports Injury [ ] Other

Briefly describe what happened:

____

If Motor Vehicle Accident: (*circle where appropriate*)

I was DRIVER / PASSANGER (FRONT / BACK) in a CAR / VAN / TRUCK / TAXI / BUS or on a MOTORCYCLE / PEDESTRIAN / BICYCLE.
Hit by a CAR / VAN / TRUCK / TAXI / BUS / MOTORCYCLE

The vehicle or I was struck from the FRONT(R / L) / REAR (R / L) / SIDE FRONT (R / L) / SIDE REAR (R / L)

I (was) / (was not) wearing a seat belt.

Did you go to the hospital?: [ ]Yes [ ] No

If Yes which hospital?: ______________________

Were you admitted? [ ]Yes [ ] No

Do you have?: HEADACHES / NAUSEA / VOMITING / FAINTING / DIZZINESS / BLURRED VISION / DOUBLE VISION / BOWEL OR BLADDER DISFUNCTION / RECENT FEVER / CHILLS / SWEATS

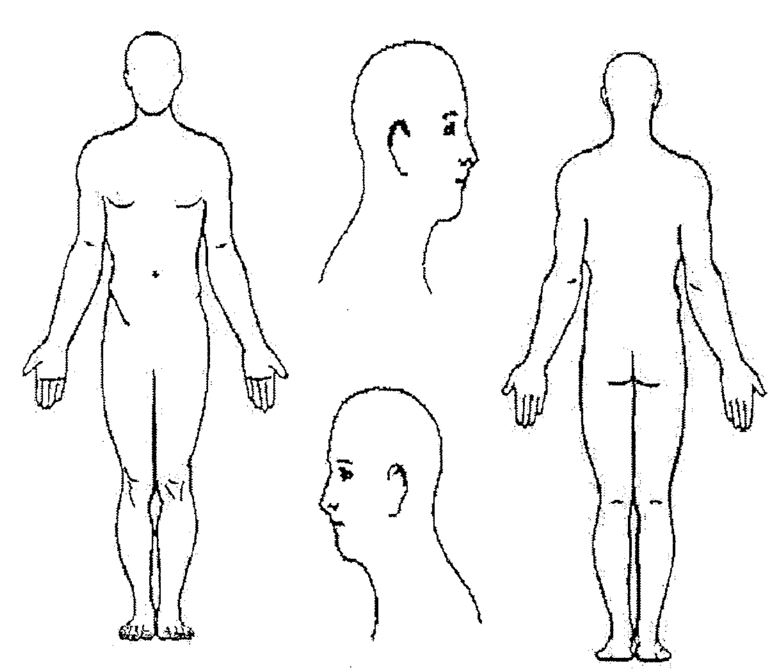
Do you have difficulty? WALKING / RUNNING / STANDING / SITTING / SQUATTING / KNEELING / BENDING

Difficulty LIFTING / CARRYING / PUSHING [_____] lbs

Where does it hurt?

Place the following where you feel these symptoms

P= Pain, **B**= Burning, **S**= Stabbing, **N**= Numbness, **X**= Pins and Needles



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CURRENT MEDICAL HISTORY

ALLERGIES: [ ] None

[ ] Food :____

[ ] Drugs ____

[ ] Other:____

CURRENT MEDICATIONS: [ ] None

List if any:____

PAST MEDICAL HISTORY: HYPERTENSION / DIABETES / ARTHIRITIS / CARDIAC / GYNOCOLOGICAL
OTHER:____

PAST SURGICAL HISTORY:____

FAMILY HISTORY: (Write M= Mother, F= Father, S=Sibling, K= Kids, GM= Grandmother, GF= Grandfather, R= Relative)

__________Alcoholism
__________Arthritis
__________Autoimmune disease
__________Back/Neck pain
__________Bleeding disorder
__________Cancer
__________Chronic pain

__________Depression
__________Diabetes mellitus
__________Drug abuse
__________Headaches
__________Heart disease
__________Kidney disease
__________Other:____________________________

__________Psychiatric disorder
__________Schizophrenia
__________Sexual abuse
__________Stroke
__________Liver disease
__________Hypertension

SOCIAL HISTORY:

Do you currently use recreational drugs? [ ] No [ ]Yes Please describe:____________________________

Do you exercise? [ ] No [ ]Yes Please describe:________________________How often:__________

Do you live? [ ] Alone [ ] with spouse [ ] with spouse and children [ ] with significant other

Do you need assistance in walking / getting up ? [ ] No [ ]Yes (ie: Crutches, walker, wheelchair, cane, etc.)

Please describe:____________________________

ALL THE INFORMATION PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(PLEASE SIGN BELOW):

X____ Date: X____________________

(Patient/Guardian / care taker Signature)

SOUTH NASSAU ORTHOPEDIC SURGERY AND SPORTS MEDICINE, P.C.

NOTIFICATION TO PATIENTS CONCERNING INSURANCE COVERAGE, CO-PAYMENTS, BILLING, AND COLLECTION PRACTICES.

Due to the ever changing coverage of insurance plans, in order to accommodate our patients, the providers at South Nassau Orthopedic Surgery and Sports Medicine, P.C. will continue to participate with many managed care plans, medicare, workers' compensation, and no-fault. However, there are some insurance plans the doctors are not particpating providers in (i.e. HealthNet, Medicaid, Child Health Plus) and it will be your responsibility to inquire with your insurance company as to our participating status with your plan prior to treatment.

It will also be your responsibility to know the benefits and exclusions of your plan, whether there are deductibles, co-insurance, and copayments for services rendered, if certain procedures are covered or need pre-certification, to obtain referrals if required by your plan for participating physicians, to provide complete and accurate insurance information, and to provide your insurance identification card(s) and photo identification.

ALL COPAYMENTS ARE DUE AT TIME OF SERVICE. THERE WILL BE A $25.00 SERVICE CHARGE TO BILL FOR COPAYMENTS THAT ARE NOT PAID AT TIME OF THE OFFICE ENCOUNTER.

ANY CHECKS RETURNED FROM THE BANK ARE SUBJECT TO A $25.00 BANK SERVICE FEE.

CO-INSURANCES, DEDUCTIBLES, OR DENIED CLAIMS WILL BE BILLED TO YOU UPON NOTICE FROM YOUR INSURANCE COMPANY. IF THE BALANCE IS NOT PAID WITHIN 45 DAYS, YOU WILL BE CHARGED A SERVICE FEE OF $25.00

We will submit a claim for any services rendered to you to your insurance company, but any procedure not covered by your plan or denied by your plan due no referral or non-compliance will be your responsibility for payment.

If you have any questions concerning the above information, please ask the receptionist. Please sign below indicating that you have read and understand this notification concerning insurance and copayment responsibility.

Print Patient/Guardian's Name	Signature Patient/Guardian	Date

64 South Central Avenue, Valley Stream, New York 11580 • (516) 825-1101
131 Merrick Road, Suite 1, Merrick, New York 11566 • (516) 377-5900

ACKNOWLEDGEMENT FORM

NOTICE OF PRIVACY PRACTICES

THE NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on the last page of the ***NOTICE OF PRIVACY PRACTICE*** form.

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES.*** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the ***NOTICE OF PRIVACY PRACTICE*** form. I further understand that the practice will offer me updates to the ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way.

X ____

Patient or Representative Name (please print)

X ______________________________________ X ______________

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient was unable to sign because

____

OFFICE COPY