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

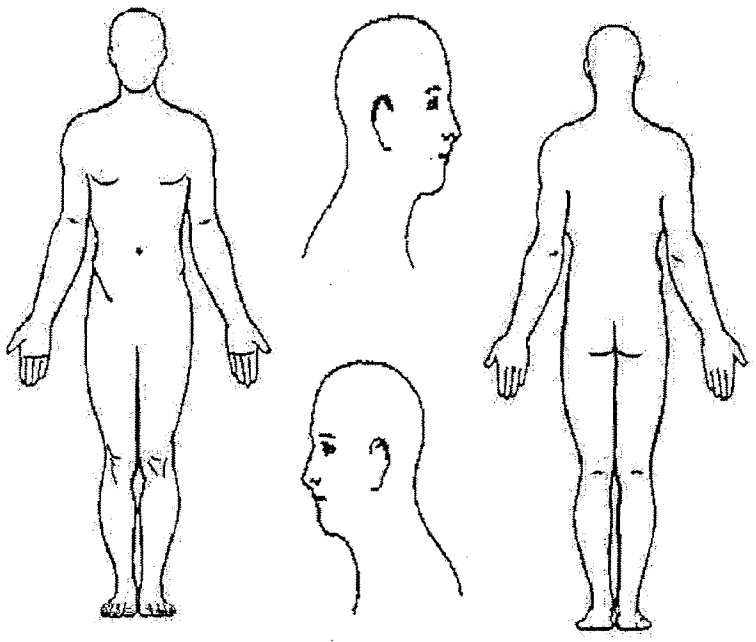
Do you have difficulty? WALKING / RUNNING / STANDING / SITTING / SQUATTING / KNEELING / BENDING

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	_____Depression	_____Psychiatric disorder
_____Arthritis	_____Diabetes mellitus	_____Schizophrenia
_____Autoimmune disease	_____Drug abuse	_____Sexual abuse
_____Back/Neck pain	_____Headaches	_____Stroke
_____Bleeding disorder	_____Heart disease	_____Liver disease
_____Cancer	_____Kidney disease	_____Hypertension
_____Chronic pain	_____Other:_____	

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):

_____Date:_____

(Patient/Guardian / care taker Signature)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ (Print patient's name), ("Assignor") hereby assign to South Nassau Orthopedic Surgery & Sports Medicine PC (Print hospital or health care provider name), ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ (Print accident date), not withstanding any other agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	(Signature of Patient)
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	(Signature of Provider)
64 South Central Ave,	
	(Date of signature)
Valley Stream, NY, 11580-5444	
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

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

PATIENT ACCIDENT/INJURY HISTORY FORM

PLEASE COMPLETE THIS FORM, PRINTING CLEARLY, AND RETURN IT WITH ONE FORM OF ID (i.e. (Driver's License, Voter Registration Card, Alien Restistration Card, Passport)

Patient Name:_____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ What is you dominant hand? [] Right or [] Left

Date of Accident/Injury: _____

YOUR JOB DESCRIPTION:_____

YOUR JOB TITLE: _____

Place of Accident/Injury:_____
(provide address, town, state, (if out of the country, please provide appropriate information))

HISTORY: Describe how the accident/injury occurred: _____

_____

_____

_____

Please list the area(s) of your body that became injured as a result of this accident/injury:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Patient Signature:_____ Date:_____

South Nassau
ORTHOPEDIC SURGERY
AND SPORTS MEDICINE, P.C.

IRREVOCABLE DOCTOR'S LIEN

TO ATTORNEY: _____

_____

_____

I, _____, hereby authorize South Nassau Orthopedic Surgery and Sports Medicine, P.C. to furnish you, my attorney, with full reports of examinations, diagnosis, treatment, prognosis, etc., of myself in regard to the accident of _____ in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to South Nassau Orthopedic Surgery and Sports Medicine, P.C. such sums as may be due and owing South Nassau Orthopedic Surgery and Sports Medicine, P.C. for professional services rendered me both by reason of this accident and by reason of any other bills that are due and to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said South Nassau Orthopedic Surgery and Sports Medicine, P.C. I hereby further give a lien on my case to South Nassau Orthopedic Surgery and Sports Medicine, P.C. against any and all proceeds of any settlement, judgement or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to South Nassau Orthopedic Surgery and Sports Medicine, P.C. for all professional bills submitted by South Nassau Orthopedic Surgery and Sports Medicine, P.C. for services rendered me and that this agreement is made soley for South Nassau Orthopedic Surgery and Sports Medicine, P.C.'s protection and in consideration of the P.C. awaiting payment, and I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Patient/Guardian Signature: _____ Date: _____

Address: _____ Town: _____ State: _____ Zip: _____

I have been advised that if my attorney does not wish to cooperate, South Nassau Orthopedic Surgery and Sports Medicine, P.C. will not await payment, but may declare the entire balance due and payable.

The undersigned attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect South Nassau Orthopedic Surgery and Sports Medicine, P.C.

Attorney's Signature: _____ Date: _____

Attorney: Please date, sign, and return one copy to the doctor's office.

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.

f
Patient or Representative Name (please print)

f
Patient or Representative Signature

f
Date

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

OFFICE COPY

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

Orthopedic Surgery
RICHARD L. PARKER, MD
FRANCIS J. LANZONE, MD
NEIL WATNIK, MD

Orthopedic Spine Surgery
ARON D. ROVNER, M.D.

Neurology
KERIN B. HAUSKNECHT, MD
Radiology
Musculoskeletal Consultant
MARK J. DECKER, MD

Pain Management
NEIL B. KIRSCHEN, MD
ROBERT IADEVAIO, MD
JACOB J. RAUCHWERGER, MD

ALL NO FAULT PATIENTS

If you have been notified by your insurance company to attend an Independent Medical Examination (IME), you must attend. Your failure to attend will result in the denial of your No Fault Medical benefits due to policy violations. If you are denied benefits due to not attending an IME, you will be personally responsible for payments of any and all medical bills relating to treatment associated with your no-fault claim.

If you have any questions, please speak with my staff.

Richard L. Parker, MD

X _____

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131 Merrick Road, Suite 2, Merrick, New York 11566*(516) 377-5900