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

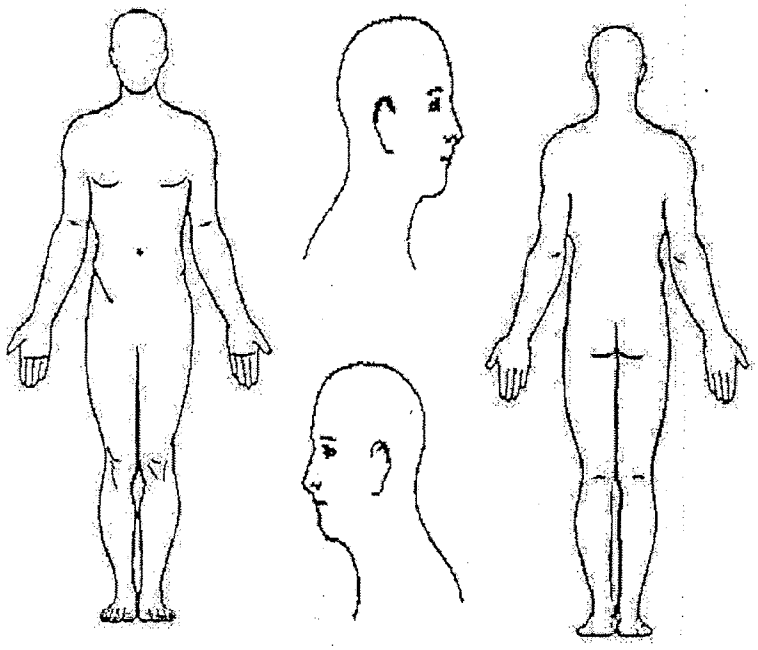
Do you have difficulty? WALKING / RUNNING / STANDING / SITTING / SQUATTING / KNEELING / BENDING

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)

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.

Patient or Representative Name (please print)

Patient or Representative Signature

Date

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

OFFICE COPY

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: _____

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway Menands ALBANY 12241 (866) 750-5157
State Office Building 44 Hawley Street BINGHAMTON 13901 (866) 802-3604
369 Franklin Street BUFFALO 14202 (866) 211-0645
130 Main Street W. ROCHESTER 14614 (866) 211-0644
935 James St. SYRACUSE 13203 (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number ☐WCB ☐DB ☐Discrimination and/or Date of Accident

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:

Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, _____, represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

Claimant's Name

South Nassau Orthopedic Surgery And Sports Medicine, P.C.
64 S. Central Ave.
Valley Stream, NY 11580
(516) 825-1101

_____, at

Name of a Specific Person, Corporation, Association or Public or Private Entity

_____.

Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

✓ _____ _____

Claimant's Signature (ink only -- use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ Date _____

Provider's Name and Address _____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

CLAIMANT'S AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
(Pursuant to HIPAA)

INSTRUCTIONS

To the Claimant: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) set standards for guaranteeing the privacy of individually identifiable health information and the confidentiality of patient medical records. By completing and signing this form, you authorize your health care provider to file medical reports with the parties that you choose (such as the Workers' Compensation Board, your employer's insurance carrier, your attorney or representative, etc.) by checking the appropriate boxes below.

You have the right to refuse to sign this Authorization. If you sign, you have the right to revoke this Authorization at any time by mailing a request to revoke to the health care provider. You have the right to receive a copy of this Authorization.

IMPORTANT: Failure to execute this authorization may interfere with your ability to obtain workers' compensation benefits.

CLAIMANT'S NAME	CLAIMANT'S SOCIAL SECURITY NUMBER	CLAIMANT'S DATE OF BIRTH

LIST ALL WCB CASE NUMBER(S) AND CORRESPONDING DATE(S) OF ACCIDENT FOR WHICH YOU ARE GRANTING AUTHORIZATION

I, _____, hereby authorize my treating health provider,
Claimant's Name

So Nassau Orthopedic Surg.and Sports Medicine, to disclose the following described health information:
Health Provider's Name

_____

_____

_____

This information can be disclosed to the following parties: *(check all that apply; give names and addresses, if known)*

☐ New York State Workers' Compensation Board

☐ My current/former employer _____

☐ Workers' compensation insurance carrier(s) _____

☐ Third-party administrator _____

☐ My attorney/licensed representative _____

☐ The Uninsured Employer's Fund (this fund is responsible for paying the medical bills and lost wage benefits when an employer is uninsured.)

☐ Special Funds Conservation Committee (for cases under Section 25-a or 15-8 of the Workers' Compensation Law)

Section 25-a: If your claim is being reopened after being previously closed, the Special Fund for Reopened Cases may be responsible for paying your medical bills and lost wage benefits.

Section 15-8: If you had a medical condition that existed prior to this injury, the Special Fund for Second Injuries may be responsible for reimbursing your employer's insurance carrier after a period of time has elapsed.

Redisclosure: I understand that once the above-referenced health care provider discloses health information based on this Authorization, that health information is no longer protected by HIPAA and the Privacy Rule.
Expiration Date: This Authorization expires upon the final closing of the workers' compensation claim(s) for which it is executed.

I have had the opportunity to review and understand the content of this Authorization. By signing this Authorization, I confirm that it accurately reflects my wishes.

_____ _____ _____
Printed Name of Claimant or Legal Representative | Signature of Claimant or Legal Representative | Date

If Authorization signed by a legal representative on behalf of claimant, state relationship to claimant_____ and basis for authority (e.g. claimant is a minor; patient is deceased and representative is the claimant in a workers' compensation proceeding or represents the estate) _____

TO THE HEALTH PROVIDER: Keep the original of this Authorization on file. A copy must be given to the patient/claimant upon request. DO NOT SEND TO THE NEW YORK STATE WORKERS' COMPENSATION BOARD.