# New York Queens Medicine & Surgery, PC

*Orthopaedics & Rehabilitation*

Appointment with Dr. : ____________________________________

## DEMOGRAPHICS

| | | |
|---|---|---|
| Name: | Age: | Sex: |
| Social Security #: - - | Date of Birth: | |
| Street Address: | | |
| City: | State: | Zip Code: |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated | | ☐ Domestic Partner |
| Home Phone: | Cell Phone: | |
| Email Address: | | |
| Emergency Contact Name: | | Telephone Number: |

| | | |
|---|---|---|
| Employer Name: | Occupation: | |
| Employer Address: | | |
| City: | State: | Zip Code: |
| Business Phone: ( ) | | |
| Work Status? | If not, last date worked: | |

| | | |
|---|---|---|
| Referred By: | | Phone: ( ) |
| Address: | | |
| City: | State: | Zip Code: |

## PRIMARY INSURANCE INFORMATION

☐ **NO INSURANCE** (SELF PAY→SEE OUT OF NETWORK/FINANCIAL PRIVATE PAY SECTION FORM)

IS THIS CLAIM RELATED TO: (PLEASE CHECK)

☐ WORKERS COMP. ☐ NO-FAULT DATE OF ACCIDENT: ______________________

| | | |
|---|---|---|
| Insurance Carrier: | | |
| Address: | | |
| City: | State: | Zip Code: |
| Policy/ Claim #: | Group/ WCB#: | |
| Adjuster: | Tel: | Fax: |
| Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other______________________ | | |
| Insured's Name (if applicable): | | |
| SS No. | DOB: | |

## SECONDARY INSURANCE INFORMATION

| | | |
|---|---|---|
| Insurance Carrier: | | |
| Address: | | |
| City: | State: | Zip Code: |
| Policy/ Claim #: | Group/ WCB#: | |
| Adjuster: | Tel: | Fax: |
| Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other______________________ | | |
| Insured's Name (if applicable): | | |
| SS No. | DOB: | |

# FINANCIAL POLICY

We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial arrangements for this medical care. Our commitment is to provide the very best healthcare to our patients while recognizing the need to limit services to only those medically necessary. The responsibility for payment of fees for these services is the direct obligation of the patient.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may participate in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referral and establishes the limit on your coverage for medical services. For insurance plans we participate with, we will seek to obtain verification of your eligibility, however, even when such eligibility and/or benefits are verified by this office, your insurance plan will not guarantee the accuracy of their confirmation of coverage or benefits, and that you are eligible and that your benefits are in force.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any deductibles, co-payments and/or coinsurance. You agree to accept responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your insurance plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your insurance plan.

You will receive monthly statements. The first statement will show all charges, with subsequent statements showing any insurance payments (it takes 4-6 weeks for most insurance carriers to pay). You are responsible for any unpaid balances.

NOTE: Some procedures that are performed in our office involve sending specimens to the hospital laboratory department for analysis. When this occurs you may receive separate billings from the laboratory and/or hospital for their services.

Payment Policy Schedule*:

- Co-payments/Deductibles/Coinsurance: Full payment at the time of service.
- Medical materials: Full payment at the time of service.
- Non-covered service: Full payment at the time of service.
- Missed Appointments Fee: The office requires 48 hours notice (not including Saturday & Sunday) to cancel an appointment. Failure to provide this notice or for missed appointments will result in a $25.00 charge to your account. This charge will not be covered by insurance, but will have to be paid by you personally.
- Surgery payment: Surgery payment is handled on a case-by-case basis. Prepayment of 100% is due 14 days prior to surgery and only includes the surgeon's surgical fee.
- Collections: All balances that reach 90 days past due will be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible or all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

Other charges/fees*:

- Returned check fee: $25.00
- Completion of disability paperwork: $25.00
- Copies of medical records: $0.75/page
- Cancellation of surgery: $300 (within 7 days of surgery other than for medical reason)

*subject to change at any time

We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any further questions about the information above or any uncertainty regarding our financial policy, please don't hesitate to ask us. We are here for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of medical benefits to the New York Queens Medicine & Surgery, PC when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize the New York Queens Medicine & Surgery, PC to use or disclose any information for treatment, payment and health care operations. I authorize that the physicians and/or employees the New York Queens Medicine & Surgery, PC can contact me or leave me a message if they are unable to contact me directly. I authorize this office to release any medical information pertaining to medical history and/or information necessary to expedite insurance claims, and request direct payment of benefits to the above provider. I understand that I am responsible for all deductibles, co-pays and cost shares as determined by my insurance coverage.

Patient (or authorized) signature______________________________ Date______________

Print Name ______________________________________________

Relationship (if not signed by patient)______________________________

**56-45 Main Street, Flushing, NY 11355**

# RECEIPT OF: HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Effective Date 4/14/03

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
New York Hospital Queens is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our hospital, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our hospital. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Signature**__________________________________**Date**________________
**Patient / Health Care Agent / Guardian / Relative Signature**
(This signature indicates that you have received a copy of the Notice of Privacy Practices.)

□ **Patient is unable to sign due to medical reasons** □ **Patient refuses to sign**

□ **Other (Please Explain)** ______________________________________________

**This Acknowledgement Form will become a part of your permanent medical record.**

**New York Queens Medicine & Surgery, PC**
*Orthopaedics & Rehabilitation*

# INITIAL VISIT QUESTIONNAIRE

Patient Name: ______________________________________________ Date: ____________________

Age: __________ Sex: __________ Height: __________ Weight: __________ Dominant Hand: L R

What is the reason for this visit? ❑ Pain ❑ Numbness ❑ Weakness ❑ Swelling ❑ Stiffness ❑ Other: ______________________

How were you referred to this office?
❑ Another doctor (please print name and office phone/fax #): ________________________________
❑ Emergency Room ❑ Insurance Company ❑ Physical Therapist
❑ Friend or relative (Tell us who: ______________________) ❑ Other: ______________________

What body part is involved? (Please mark the table below)

| SHOULDER/ARM ❑L ❑R | HIP/GROIN/THIGH ❑L ❑R | NECK/UPPER BACK ❑ |
|---|---|---|
| ELBOW ❑L ❑R | KNEE ❑L ❑R | MID-BACK ❑ |
| FOREARM/WRIST ❑L ❑R | LEG/ANKLE ❑L ❑R | LOWER BACK ❑ |
| HAND/FINGERS ❑L ❑R | FOOT/TOES ❑L ❑R | |

How long ago did it start? _____ Days _____Weeks _____Months _____Years

In this section, check the ONE BOX that best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

❑ NO INJURY (or onset was: ❑ Gradual or ❑ Sudden) Please indicate why do you think it started in the comments section.

❑ AUTO ACCIDENT Date: ______________ Please specify where and how it happened in the comments section.

❑ PEDESTRIAN STRUCK BY CAR Date: ______________ Please specify where and how it happened in the comments section.

❑ INJURY (❑ Accident ❑ Sport) Date: ____________ Please specify where and how it happened in the comments section.

What sport? ______________________ School? ____________________________

❑ INJURY AT WORK From a: ❑ lift ❑ twist ❑ fall ❑ bend ❑ pull ❑ reach ❑ excessive use Date of Injury: ________________

COMMENTS (BRIEFLY DESCRIBE YOUR SYMPTOMS HERE):

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

On a scale of 0-10 (10 is the worst), how severe is your pain? (please circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning

The pain is ❑ Constant ❑ Comes and Goes (intermittent) Does your pain wake you from your sleep? ❑ Y ❑ N

Do you have: ❑ Swelling ❑ Bruising ❑ Numbness/Tingling ❑ Weakness ❑ Loss of control of bowel/bladder ❑ Locking/Catching ❑ Giving away

Since my problem started, it is: ❑ Getting better ❑ Getting worse ❑ Unchanged

What makes your symptoms worse: ❑ Standing ❑ Walking ❑ Lifting ❑ Exercise ❑ Twisting ❑ Lying in bed ❑ Bending ❑ Squatting
❑ Kneeling ❑ Stairs ❑ Sitting ❑ Other: ______________________________

What makes your symptoms better: ❑ Rest ❑ Elevation ❑ Ice ❑ Heat ❑ Other: ______________________________

What treatments have you had for this condition? ❑ None ❑ Casting/Bracing ❑Cane/Crutch ❑ Injections (Please circle one: Steroid or Gel)

❑ Surgery ❑ Medications ❑ Physical Therapy

Are you here today as a result of an ER visit? ❑ Y ❑ N Who saw you in the ER? ______________________________

What tests have you had for this problem? ❑ X-Rays ❑ MRI ❑ CAT Scan ❑ Bone Scan ❑ Nerve Test (EMG/NCV) Where?________________

**Past or Other Orthopaedic Medical History**

Have you had a prior problem with this same orthopaedic condition in the past? ❑ Y (explain below) ❑ N

______________________________________________________________________

Do your other joints have: ❑ morning stiffness lasting over 30 minutes ❑ joint pain or swelling ❑ back pain ❑ gout
❑ rheumatoid arthritis ❑ osteoporosis
❑ prior fracture (which bone ______________________________) ❑ none of the aforementioned

# GENERAL PATIENT HISTORY

**Past Medical History**

Medical History (please check all conditions that you have or have had in the past): ❑ None

❑ High Blood Pressure ❑ High Cholesterol ❑ Heart Attack ❑ Arrhythmia
❑ Vascular Disease ❑ Anemia ❑ Blood Clots ❑ Stroke
❑ Hypothyroid ❑ Diabetes ❑ Osteoporosis ❑ Lupus
❑ Asthma or COPD ❑ Enlarged Prostate ❑ HIV ❑ Hepatitis
❑ Seizures ❑ Depression ❑ Anxiety ❑ Heart Failure
❑ Kidney Failure ❑ Cancer (location/year ______________________________) ❑ Other ______________________________

**Surgical History**

Have you ever had surgery? ❑ Y ❑ N

| Surgery Procedure | Please specify Right, Left, or Bilateral (if applicable) | Most Recent Year | Previous Surgery Year | Surgeon/Hospital/State |
|---|---|---|---|---|
| *EXAMPLE: Knee Arthroscopy* | *Left* | *2006* | *1998* | *Dr. Rosen/NYHQ/NY* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Medication History**

Please list all medications you are currently taking, including prescription and non-prescription medications (or attach a list)

| Name | Strength (if any) | Route of Administration (if any) | How many times a day? | When you began taking medication |
|---|---|---|---|---|
| *EXAMPLE: Lasix* | *40mg tablet* | *By mouth* | *1x/day* | *2004* |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies and Adverse Reactions**

Are you allergic to any medications? ❑ Y ❑ N If yes, please list medication and describe reaction: ______________________________

______________________________________________________________________

Other allergies (contrast dye, food, etc.):

______________________________________________________________________

Are you allergic to latex? ❑ Y ❑ N

Do you have an adverse reaction to:

Anesthesia? ❑ Y ❑ N Anti-inflammatories (including Aleve/Advil)? ❑ Y ❑ N Pain killers? ❑ Y ❑ N

## Social History

**Alcohol History**

❑ I drink alcohol (How frequently? *Please circle*: Social Occasional Moderate Heavy)
❑ I do not drink alcohol, but I used to drink alcohol
❑ I have never drank alcohol

**Drug History**

❑ I use drugs or marijuana (Please indicate type of drugs used and frequency of drug usage: ______________________________________________)
❑ I do not use drugs or marijuana, but I used to use drugs or marijuana (When did you quit? ______________________________________________)
❑ I have never used drugs or marijuana

**Smoking History**

❑ I use tobacco (How many cigarette packs per day? ____________________)
❑ I do not use tobacco, but I used to use tobacco (How many cigarette packs per day? ____________________ When did you quit? ________________)
❑ I have never used tobacco

## Family History of Medical Problems

- Father: ❑ Yes ❑ No If yes, explain/list: ______________________________________________
- Mother: ❑ Yes ❑ No If yes, explain/list: ______________________________________________
- Grandparents:
  - Maternal ❑ Yes ❑ No If yes, explain/list: ______________________________________________
  - Paternal ❑ Yes ❑ No If yes, explain/list: ______________________________________________
- Siblings:
  - Maternal ❑ Yes ❑ No If yes, explain/list: ______________________________________________
  - Paternal ❑ Yes ❑ No If yes, explain/list: ______________________________________________

Have you or a family member ever had a reaction to anesthesia? ❑ Y (explain) ______________________________________________ ❑ N
Do any direct relatives have the same condition you are being seen for today? ❑ Y ❑ N

## Review of Systems

Have you had any of these symptoms? (Please circle)

| BODY SYSTEM | SYMPTOMS | | | | |
|---|---|---|---|---|---|
| *SKIN* | frequent rashes | skin ulcers | lumps | psoriasis | |
| *CONSTITUTIONAL* | weight loss | loss of appetite | fevers | chills | |
| *NEUROLOGIC* | headaches | dizziness | seizures | | |
| *EYE* | blurred vision | double vision | vision loss | | |
| *ENT* | hearing loss | hoarseness | trouble swallowing | | |
| *CARDIOVASCULAR* | chest pain | palpitations | blood clots | | |
| *PULMONOLOGY* | chronic cough | shortness of breath | | | |
| *GASTROINTESTINAL* | heartburn, ulcers | nausea, vomiting | blood in stool | liver disease | hepatitis |
| *GENITOURINARY* | painful urination | blood in urine | kidney problems | | |
| *HEMATOLOGIC* | easy bleeding | easy bruising | anemia | | |
| *ENDOCRINE* | thyroid disease | heat intolerance | cold intolerance | | |
| *INFECTIOUS DISEASE* | HIV positive | | | | |
| *PSYCHIATRIC* | depression | drug/alcohol addiction | sleep disorder | | |

**Work History**

Current Work Status: ❑ Regular ❑ Light Duty (How long? _________) ❑ Not working due to this problem Disabled Retired Student
Title/Position: ______________________________________
When is the last date you worked your regular job? ______________________________________________

Are you currently receiving or plan to apply for: Disability ❑ Y ❑ N Worker's Comp ❑ Y ❑ N Unemployment ❑ Y ❑ N
Do you plan to be working 6 months from now? ❑ Y ❑ N

Patient Signature: ______________________________________________ Date: __________________________