

SPECIALTY ORTHOPAEDICS, PLLC
PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. All information will be confidential. PLEASE PRINT.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY NO: _____ MARITAL STATUS: _____

DATE OF BIRTH: _____ AGE: _____ MALE _____ FEMALE _____

EMPLOYER: _____ OCCUPATION: _____

MOTHER'S FIRST NAME: _____ FATHER'S FIRST NAME: _____

MEDICAL INSURANCE COMPANY: _____

ADDRESS: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ DOB: _____

PRIMARY/REFERRING PHYSICIAN: _____

" " ADDRESS: _____

" " PHONE #: _____

REASON FOR SEEING DOCTOR: _____

IN CASE OF EMERGENCY NOTIFY: _____

Whom may we thank for referring you? _____

***** IF THIS IS NO FAULT OR WORKERS COMPENSATION:

Date of accident/injury: _____ CLAIM/FILE #: _____

INSURANCE CARRIER: _____ ADDRESS: _____

BRIEF DESCRIPTION OF INCIDENT: _____

ARE YOU PRESENTLY WORKING? YES _____ NO _____

AUTHORIZATION: I hereby give my permission to Specialty Orthopaedics to release any of my (or my child's) medical information to my insurance carrier necessary to process this claim. I accept responsibility for payment of any bills rejected and/or denied by my insurance company. I also authorize payment of insurance benefits otherwise payable to me directly to the doctor.

SIGNATURE-PATIENT OR GUARDIAN: _____ DATE: _____

Specialty Orthopaedics, PLLC
PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Referring Doctor or Person: _____

Age: _____ Height: _____ Weight: _____

Occupation: _____

Hobbies/Sports: _____

What are we seeing you for today (please be specific): _____

Do any other joints hurt you? If so, please list them: _____

Do you use any ambulatory aides? (cane, crutches, walker, etc.) _____

Number of stairs at home: _____

Which leg do you use first when going up stairs? _____

Do you need arm support to get up from a chair? _____

Can you cut your toenails? _____

What do you use for pain medicine? _____

List any previous orthopedic surgeries (include side and date): _____

Please list any medical problems: _____

Who is your primary care doctor? _____

Do you see any other doctors for medical problems? If so, please list _____

Please list any allergies to medication, food, or environmental (including latex): _____

MEDICAL HISTORY:

YEAR Illnesses:

_____ Heart trouble _____ Angina _____ Heart Attack _____ Heart Failure _____ Heart Murmur _____
 _____ Valve Disease _____ Water on lungs _____ Coronary artery disease _____ Other _____
 _____ High Blood Pressure _____
 _____ Stroke _____
 _____ Ulcers: Stomach _____ Duodenal _____ Colon _____
 _____ Diabetes (high blood sugar) _____
 _____ Liver disease: Hepatitis _____ Type A _____ Type B _____ Type C _____ Other _____ Cirrhosis _____
 _____ Kidney disease: Stones _____ Infections _____ Other _____
 _____ Lung disease: Emphysema _____ TB _____ Chronic bronchitis _____ Cancer _____
 _____ Frequent Pneumonia _____ Asthma _____ Other _____
 _____ Blood disorders: Anemia _____ Leukemia _____ Bleeding tendency _____ Other _____
 _____ Eye disease: Glaucoma _____ Cataract _____ Other _____
 _____ Cancer: Type and Site _____
 _____ HIV positive (AIDS): YES _____ NO _____
 _____ Psychological difficulties: Depression/anxiety _____ Psychosis _____ Other _____
 _____ Arthritis: Osteoarthritis _____ Rheumatoid _____ Gout _____ Other _____
 _____ NO MAJOR ILLNESSES _____

YEAR Surgeries:

YEAR

_____ Tonsillectomy	_____ Hysterectomy: Total _____ Partial _____
_____ Cardiac Bypass	_____ Angioplasty
_____ Appendectomy	_____ Prostate operation
_____ Gallbladder	_____ Biopsy (type & results)
_____ Hernia repair	_____ Fractures (explain)
_____ Vasectomy (males)	_____ Discectomy: what levels
_____ Pacemaker	_____ Spinal fusion: what levels
_____ OTHER _____	_____ Laminectomy: what levels
_____ NO SURGERY	

INJURY HISTORY:

Vehicle/Work accidents, etc: (describe, date) _____

 NO Major Injuries _____

HOSPITALIZATIONS: (explain)

CHILDHOOD DISEASES:

_____ Rheumatic fever _____
 _____ Nothing unusual _____
 _____ Other (major only) _____

CURRENT MEDICATIONS:

_____ Aspirin _____ Tylenol	_____ Pain Meds _____
_____ Sleep meds _____	_____ Heart Meds _____
_____ Anti-inflammatories _____	_____ Depression Meds _____
_____ Muscle Relaxants _____	_____ For Other Medical Problems _____
_____ High Blood Pressure _____	_____

ALLERGIES: (If so, please indicate reaction)

Penicillin	Rash	Breathing problems	Nausea/vomiting	Hospitalized
Sulfa	Rash	Breathing problems	Nausea/vomiting	Hospitalized
Keflex	Rash	Breathing problems	Nausea/vomiting	Hospitalized
Codeine	Rash	Breathing problems	Nausea/vomiting	Hospitalized
OTHER	Rash	Breathing problems	Nausea/vomiting	Hospitalized

FAMILY MEDICAL HISTORY:

MOTHER: Alive & well - age Deceased - Age at death Alive but suffers with cause

FATHER: Alive & well - age Deceased - Age at death Alive but suffers with cause

I have living brothers and sisters deceased brothers and sisters - cause

SOCIAL HISTORY:

I am single married separated divorced widow-widower

Number of children at home away from home

I live with my children or other relatives. Explain

I work as a

I am retired from

I drink beer wine hard drinks daily socially I DON'T USE ALCOHOL

I currently smoke cigarettes pipe cigars packs per day/ years

I don't use tobacco

I used to smoke cigarettes pipe cigars packs per day/ years

My recreational activities include jogging bicycling sports (list)

REVIEW OF SYSTEMS:

Do you have physical problems other than neck or back?

eyes ears nose throat Explain

skin moles, spots or sores that are unusual. Explain

unusual lumps or bumps under skin such as enlarged lymph nodes. Explain

trouble breathing shortness of breath cough pain breathing Other

chest pain/discomfort sharp aching arm discomfort along with chest discomfort

with activity after meals when under stress Other

trouble with stomach of bowels nausea/vomiting stomach pains diarrhea

constipation bleeding in bowel movements black tarry stools Other

trouble with legs fatigue with walking/relieved by rest Other

trouble with nerves

anxious/fearful I feel down/depressed

trouble with neck trouble with back Joint pain

FEMALES- MENSTRUAL HISTORY

My periods are normal for me. I am menopausal post-menopausal

I have been pregnant times stillbirths

I have had vaginal deliveries C-sections

I have had problems with deliveries and pregnancies; Describe

MALES -

problems with sexual function discharge

other problems you need to discuss with a doctor



Chief, Orthopaedic Surgery
Sound Shore Medical Center of Westchester

Chief, Joint Reconstruction Service
Westchester Medical Center

This notice describes how medical information about you may be used and disclosed by this office and how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice.
We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.
We will post a copy of the current notice in the office.

The notice will contain on all the pages, in the bottom left hand corner, the effective date.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact Sonia Farina, Privacy Officer, at 914-686-0111. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I acknowledge receipt of a copy of Specialty Orthopaedics' Notice of Privacy Practices.

Patient Name (Please print)

Parent or Authorized Representative (if applicable)

Signature

Date

Effective Date: 4/14/03