Patient Appointment Information						
Attending Physician:	**Sched Resource:**	**Appt Date:**	**Appt Time:**	**Encounter #:**	**MGMRN#:**	**Activity Type:**

REGISTRATION FORM

Instructions: Fill in the blanks. Please replace any incorrect or outdated information.

Patient Information					
Patient Name:	**Gender:**	**DOB:**	**Race:**	**Ethnicity:**	**Preferred Language:**
Address:			**City State Zip:**		
Home Phone:	**Cell Phone:**	**Email Address:**		**Appointment Reminder:**	
Employer Name:		**Employer Address:**			
HIPAA Statement Provided:		**Date Provided:**		**HIPAA Statement Signed:**	

Contact Information			
Contact Name and Relationship: (Patient is:)	**Contact Type:** Emergency	**Preferred Phone:**	**Alternate Phone:**
Contact Name and Relationship: (Patient is:)	**Contact Type:** Next Of Kin	**Preferred Phone:**	**Alternate Phone:**

Guarantor Information		
Guarantor Name:	**Guarantor Address:**	**City State Zip:**
Relationship of Patient:	**Home Phone:**	**Guarantor DOB:**

Physician Information	
Referring Physician's Name:	**Phone:**
Primary Care Physician Name:	**Phone:**

Insurance Information			
Primary Insurance Name:	**Subscriber's Name:**	**Subscriber's DOB:**	**Subscriber's Relation to Patient:**
Address:		**Group #:**	**Phone:**
Secondary Insurance Name:	**Subscriber's Name:**	**Subscriber's DOB:**	**Subscriber's Relation to Patient:** Subscriber is:
Address:		**Group #:**	**Phone:**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Northwell Health Physician Partners, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to Northwell Health Physician Partners sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

(Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare for payment to me.

_______________________________ _______________________________

Signature of Patient or Authorized Guardian ***Date***

(User ID/Dt: ,)

Northwell Health
Physician Partners

Patient Name: ________________ **DOB:** ________________

In order to serve you better please answer the following questions.

**Note: Definitions are available below for reference.*

Did your injury occur at work? ◯ Yes ◯ No
***If yes,* do you have an ACTIVE Workers Compensation case?** ◯ Yes ◯ No

Did your injury occur due to a Motor Vehicle Accident ◯ Yes ◯ No
***If yes,* do you have an ACTIVE No Fault case?** ◯ Yes ◯ No

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Workers Compensation:

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The Workers' Compensation Board is a state agency that processes the claims. If Board intervention is necessary, it will determine whether that insurer will reimburse for cash benefits and/or medical care, and the amounts payable.

Your injury should be covered under Workers Compensation if:

- You were injured on the job.
- You were injured while traveling on business.
- You were doing a work-related errand.
- You were attending a required business-related social function.
- If your job requires you to drive a motor vehicle and you were hurt in an accident.

No Fault

A no fault insurance claim, sometimes called a Personal Injury Protection claim (or PIP claim), is one you make against your own automobile insurer for payment of medical bills and lost earnings under New York's no fault laws. Your insurer will pay your medical bills and will reimburse you for some of all of your lost earnings up to the amount of your claim or New York's no fault limit, whichever is lower. Once your medical bills exceed New York's no fault limit, you are responsible for paying them. If you have health insurance, your health insurer will pay your medical bills from that point on. If you are on Medicare or a state run health insurance program through Medicaid, those entities will pay the bills. If you do not have health insurance, Medicare, or Medicaid, then you are responsible for working out payment arrangements with your health care providers.

Your injury should be covered under No Fault if:

- The accident occurred in New York.
- The injured party was the driver or passenger of the insured vehicle or a cyclist or pedestrian struck by or in contact with the motor vehicle.
- The vehicle caused the injury, for example: a motor vehicle accident, a parked car causes bodily harm, etc.
- The vehicle must be a car, truck, bus, taxi (not a motorcycle) or other vehicle covered by New York No-Fault law.
- The vehicle is registered in New York.
- The vehicle has an insurance policy sold in New York or issued by a company licensed to do business in the State of New York.

Name:______________________________ Date:________________

1. **What Is Your Marital Status?**

☐ Single ☐ Widowed ☐ Civil Union ☐ Divorced ☐ Separated ☐ Married

2. **How Would You Like To Receive Your Reminder Call?**

☐ Home Phone ☐ Cell Phone ☐ No Reminder Call

☐ Text – If Yes, Please Text NORTHWELL To 622622 Preferred Language: ____________________

3. **Are You A Northwell Health System Employee?**

☐ Yes ☐ No

4. **In Compliance With New Government Regulations, We Are Required To Collect Certain Demographic Information From All Of Our Patients. Through The Collection Of This Data, There Will Be An Attempt To Improve Your Quality Of Care.**

Race:

☐ American Indian ☐ Native Hawaiian ☐ White

☐ Asian ☐ African American ☐ Declined

Ethnicity

☐ Hispanic Origin ☐ Non-Hispanic Origin

☐ Declined

5. **I Agree That The Email Address I Have Provided May Be Used To Generate A Patient Portal Account With Northwell Health. The Patient Portal Will Give You Access To A Clinical Summary From Your Last Visit.**

Email Address: ____________________ Email Belongs To: ____________________

☐ No Email ☐ Declined

6. **Pharmacy Information:**

Is This A Mail Order Pharmacy? ☐ **Yes** ☐ **No**

Pharmacy Name: ____________________

Pharmacy Address ____________________

____

Pharmacy Phone # ____________________

Is This A Mail Order Pharmacy? ☐ **Yes** ☐ **No**

Pharmacy Name: ____________________

Pharmacy Address ____________________

____

Pharmacy Phone # ____________________

- If you have a separate RX Benefit card, please hand it to the receptionist to copy.
- If you wish to change your pharmacy preference, please let the staff know so that your prescriptions will continue to be directed to your pharmacy of choice.

Northwell Health Physician Partners

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PATIENT NAME:	DATE OF BIRTH:	PATIENT IDENTIFICATION NUMBER:
PATIENT ADDRESS:		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow Northwell Health (including their agents) to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #3, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ 1. **I GIVE CONSENT** for Northwell Health to access ALL of my electronic health information through Healthix to provide health care services (including emergency care).

☐ 2. **I DENY CONSENT EXCEPT IN A MEDICAL EMERGENCY** for Northwell Health to access my electronic health information through Healthix.

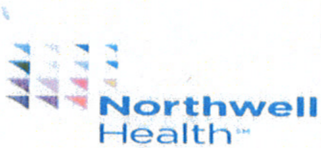
☐ 3. **I DENY CONSENT** for Northwell Health to access my electronic health information through Healthix for any purpose, ***even** in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

SIGNATURE OF PATIENT OR PATIENT'S LEGAL REPRESENTATIVE	DATE

PRINT NAME OF LEGAL REPRESENTATIVE (IF APPLICABLE)	RELATIONSHIP OF LEGAL REPRESENTATIVE TO PATIENT (IF APPLICABLE)



Patient Name:
DOB:

Acknowledgement of Receipt

I have received a copy of the Providers Notice of Privacy Practices.

Patient/Agent/Relative Guardian* (Signature) Date/Time | Print Name | Relationship if other than patient

Telephonic Interpreter's ID#

OR

Signature: Interpreter | Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) | Date/Time | Print Name

Provider Use Only

☐ Patient or patient representative refused to sign/accept Notice of Privacy Practices

☐ Patient unable to sign

Signature | Date/Time

*The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable .

Patient Name:________________________ DOB:_____/_____/______

Patient Intake Form

Current Height: _____ft. ______in. Current Weight: ________lbs.

Dominant Hand: ◯ Right ◯ Left

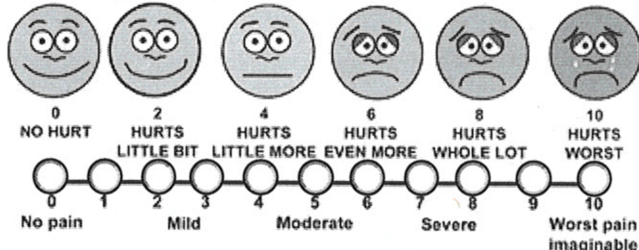
Reason For Visit

Reason for your visit today:____

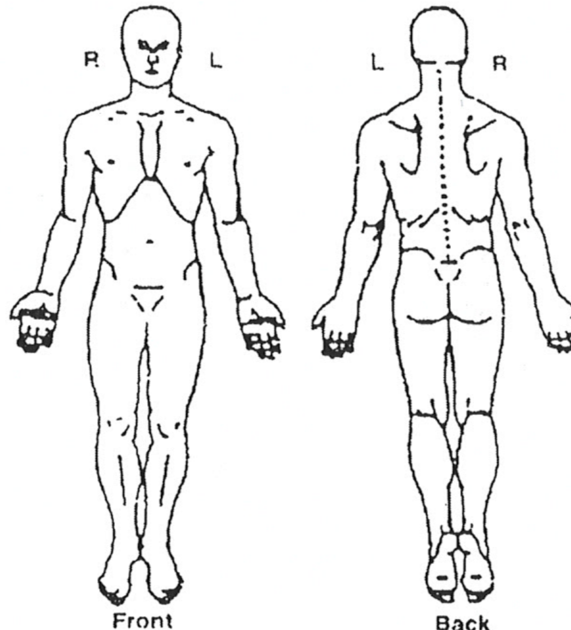
Date of Injury/Onset of Pain: ___/___/_____ **Was injury/onset related to:** Work? ◯Y ◯N Auto Accident? ◯Y ◯N

Pain Assessment

Please circle the picture/number to describe the severity of your pain ***right now***



On the drawing below, please shade the area where you currently experience your ***chief complaint***



Describe your pain

☐ Intermittent ☐ Constant ☐ Localized ☐ Radiating

How would you characterize your pain?
(e.g. Dull, Sharp, Achy, Burning, Throbbing, Cramping, Shooting, Stabbing)

____

What makes your symptoms better? (e.g. Rest, Heat, Ice, Medication)

____

What makes your symptoms worse? (e.g. Walking, Bending, Lying down)

____

Previous Treatment

Have you been to another physician for this issue?

◯Yes ◯No If yes, name & date

______________________ __________

Have you had any alternative treatment(s) for this issue?
(i.e. acupuncture, injections)

◯Yes ◯No If yes, date_______________

Have you had Physical Therapy for this issue?

◯Yes ◯No If yes, date_______________

Have you seen a chiropractor for this issue?

◯Yes ◯No If yes, date_______________

Review of Systems

Please check any of the following symptoms you have experienced recently or are experiencing now

☐ Arthralgia	☐ Decrease Hearing	☐ Heartburn	☐ Convulsions
☐ Joint Pain	☐ Nasal Discharge	☐ Urinary Frequency	☐ Anxiety
☐ Joint Stiffness	☐ Nosebleeds	☐ Urinary Urgency	☐ Depression
☐ Joint Swelling	☐ Sore Throat	☐ Incontinence	☐ Sleep Disturbances
☐ Chills	☐ SOB at Rest	☐ Abnormal Vaginal Bleeding	☐ Suicidal
☐ Feeling Tired	☐ Cough	☐ Breast Pain	☐ Feeling Weak
☐ Fever	☐ SOB on Exertion	☐ Breast Lump	☐ Muscle Weakness
☐ Recent Weight Gain	☐ Wheezing	☐ Skin Lesions	☐ Hot Flashes
☐ Discharge	☐ Lower Extremity Edema	☐ Change in a Mole	☐ Deepening of Voice
☐ Eye Pain	☐ Abdominal Pain	☐ Headache	☐ Easy Bleeding
☐ Sight Problems	☐ Constipation	☐ Dizziness	☐ Easy Bruising
☐ Redness	☐ Diarrhea	☐ Fainting	☐ Swollen Glands

When did these symptoms start?

____

Orthopaedic Institute

Patient Name:________________________ DOB:____/_____/______

Past Medical History

☐ Asthma
☐ COPD
☐ Diabetes
☐ Heart Disease
☐ High Cholesterol
☐ Hypertension
☐ Blood Clots

☐ No Past Medical History
☐ Cancer (type:______________)
☐ Neuropathy
☐ Parkinson's Disease
☐ Prolonged Steroid Treatment
☐ Seizure/Epilepsy
☐ Stroke
☐ Pulmonary Embolism

☐ Arthritis (location:____________)
☐ Herniated Disc
☐ Lupus
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Spinal Stenosis
☐ Other:____________________

Surgery and Hospitalization History

☐ No Past Surgical History

Reason for Surgery	Hospital Name	Date (approx.)	Infection?
			◯Y ◯N
			◯Y ◯N
			◯Y ◯N

Family History

☐ No Pertinent Family History

	Yes	Who?	Type	Location
Arthritis/DJD	☐			
Cancer	☐			
Genetic Disease	☐			
Osteoporosis	☐			

Allergies

☐ No Known Allergies
☐ Shellfish
☐ Contrast Dye
☐ General/Local Anesthetic
☐ Medications

Seasonal
Latex

____

☐ Other

____

Social History

Living Situation

☐ Alone ☐ Family ☐ House ☐ Apartment ☐ Stairs

Currently Working? ◯ Yes ◯ No

Current Smoker ◯ Yes ◯ No

# of years __________ # packs/day _________

Do you drink alcohol? ◯ Yes ◯ No

drinks/week ___________

Do you use recreational drugs? ◯ Yes ◯ No

Types?_____________ #times/week____

Do you exercise? ◯ Yes ◯ No

times/week ___________

Activities:______________________________

Current Medications

☐ No Current Medications

Please list all medications including vitamins and supplements

Name	Dosage	Frequency

Have you recently taken or used...

☐ NSAIDS (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC

____
Print Name

______________________________________ ______________
Signature Date

Orthopaedic Institute