KENNETH R. ALLEYNE, M.D., F.A.A.O.S.
20 EAST 46TH STREET, 7TH FLOOR - NEW YORK, NY 10017

NEW PATIENT FORM

Please fill out what is relevant to you and this visit.

Date: _____ Referred by: _____

Last Name_____ First Name _____
Date of Birth _____ Age _____ Sex ☐ M ☐ F SS#_____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address_____ Apt#_____ City _____ State _____ Zip _____
Home Phone (_____) _____ Business Phone (_____) _____
Cell Phone (_____) _____ Email: _____
Employer_____ Occupation _____
Address _____ City _____ State _____ Zip _____

Primary Care Dr._____ City/State: _____Physician Ph # _____
Preferred Pharmacy Name: _____ Address: _____
Pharmacy phone number: _____

*** Reason for visit ***

_____

Type of Injury ☐ W/C ☐ Auto ☐ Other_____ Date of Injury: _____

INSURANCE INFORMATION

Primary Insurance:
Insurance Company Name:_____ Insurance ID# _____
Card Holder's Name _____ Card Holder's DOB: _____
Relationship to patient_____ Card Holder's Employer _____

Secondary Insurance:
Insurance Company Name:_____ Insurance ID# _____
Card Holder's Name _____ Card Holder's DOB: _____
Relationship to patient_____ Card Holder's Employer _____

Worker's Compensation or No Fault Information:
Carrier: _____ Case #: _____
Adjuster name: _____ Adjuster phone #: _____
Date of accident: _____

Attonrey Information:
Name: _____ Phone #: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____

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MEDICAL QUESTIONNAIRE

Patient Name:_____ Date _____

Age:_____ Sex: □ F □ M Height:_____ Weight:_____ Dominant hand: □ R □ L Did you bring X-Rays? □ Y □ N

What is the reason for this visit? □ Pain □ Numbness □ Weakness □ Swelling □ Stiffness □ Other _____

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

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
□ R □ L	□ R □ L	□ R □ L	□ R □ L	□ R □ L	□ R □ L	□ R □ L	□ R □ L	□	□

How long did it start?_____ Days _____ Weeks _____ Months _____ Years Have you had a problem like this before? □ Y □ N

In this section, check the ONE BOX which 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)
If Gradual, please indicate when most recently this condition has bothered you? _____

□ **INJURY:** □ Accident □ Sport (NOT Auto or Work)
Date: _____ please specify where and how it happened.
What Sport? _____ School? _____

□ **INJURY AT WORK** Date: _____
From a: □ lift □ twist □ fall □ bend □ pull □ reach

□ **WORK RELATED** (but NO INJURY)
Date: _____ How did your job cause the problem?

□ **AUTO ACCIDENT** Date: _____ How was your car hit?

COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____

On a scale of 0-10 (10 is the worst) how severe is your pain? _____

What is the quality of the pain? [ ] Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning
The pain is: [ ] Constant [ ] Intermittent
Does your pain wake you from your sleep? [ ] Yes [ ] No
Do you have: [ ] Swelling [ ] Bruises [ ] 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? _____
What makes your symptoms better? _____
What medications are you taking now? _____
Have you had any of these treatments? Injection: □ Y □ N Brace: □ Y □ N Physical Therapy: □ Y □ N Cane/Crutch: □ Y □ N
What test/scans have you had for this problem?
[ ] X-Rays [ ] MRI [ ] CAT Scan [ ] Bone Scan [ ] Nerve Test (EMG/NCV) Where? _____
Have you already had surgery for a problem in this same area either recently or in the past? □ Y □ N
Please list below:
Procedure #1 _____ Surgeon _____ City _____ Date_____
Procedure #2 _____ Surgeon _____ City _____ Date_____
Current work status? [ ] Regular [ ] Light Duty [ ] Not working due to this problem [ ] Disabled [ ] Student [ ] Retired
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

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

_____

_____

_____

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 these

Past Medical History:

☐ Diabetes	☐ Thyroid Problems	☐ Stomach ulcers	☐ Heart Problems
☐ Kidney	☐ High Blood Pressure	☐ Stroke	☐ Arthritis
☐ Seizures	☐ Hepatitis	☐ Cancer	☐ Bowel Problems
☐ Depression	☐ Tuberculosis	☐ Bladder	☐ HIV/AIDS
☐ Asthma	☐ Osteoporosis	☐ Other: _____	

ALLERGIES: _____

Latex Allergy? ☐ Y ☐ N

Surgical History:

_____

_____

Family History:

Please check the health issues that are in your family:

☐ Alcohol/drug abuse	☐ Diabetes	☐ High Cholesterol	☐ Osteoporosis	☐ Allergies
☐ Gall Bladder	☐ Kidney Disease	☐ Ulcers	☐ Anxiety	☐ Mental Illness
☐ Liver Disease	☐ Rheumatoid Arthritis	☐ Cancer	☐ Hypertension	☐ Migraines
☐ Stroke	☐ Thyroid Disease	☐ Heart Disease	☐ Chronic Pain	☐ Other _____

Social History:

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____ or ☐ socially
Has anyone ever told you that you should decrease your use of alcohol or drugs? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Packs/day _____ how many years? _____ Quit since: _____

PLEASE SIGN: The information on this form is accurate to the best of my knowledge.

_____ _____

Signature Date

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GENERAL CONSENT TO TREATMENT

1. GENERAL CONSENT TO TREATMENT: By signing below, I (or my authorized representative on my behalf) authorize Kenneth R. Alleyne, M.D., staff and agents to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my healthcare provider to explain to me the reason/s for any particular diagnostic examination, test or procedure, the available treatment options and the common potential risks and benefits associated with these options.

2. INFORMED CONSENT FOR INJECTION THERAPIES: By signing below, I (or my authorized representative on my behalf) authorize Kenneth R. Alleyne, M.D., staff and agents to administer injections if my healthcare provider deems necessary. I understand that all injection treatments are commonly but not always accompanied by possible risks including, but not limited to bruising, temporary increase in pain, inflammation and temporary numbness. I also understand that more serious reactions may but do not always occur, including but not limited to infection, allergic reaction, prolonged numbness, weakness, paralysis, spinal headache, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of orthopedics including, but not limited to trigger point, intramuscular, intra articular (joint), tendon, ligament or other forms of injections.

3. RIGHT TO REFUSE TREATMENT: I acknowledge that I am given the opportunity to discuss the nature and purpose; alternate methods of treatment; the risks, potential complications and associated risks associated with any treatment or procedure recommended by my healthcare provider. I also understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my healthcare provider. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment. I further acknowledge that I will ask any questions I have regarding my evaluation and treatment to my satisfaction, and I understand that I may ask any additional questions I may have at any time.

Patient Name (print): _____
Patient Signature: _____ Date: _____
Authorized Representative (if applicable): _____ Relationship: _____

CONSENT TO TREATMENT OF A MINOR UNACCOMPANIED BY PARENT/GUARDIAN:

I, the undersigned parent or legal guardian of (child's name) _____, consent to/authorize Kenneth R. Alleyne, M.D., staff and agents to provide treatment, including but not limited to diagnostic examinations, tests, medical treatment and/or therapy necessary to effectively assess and maintain my child's health and to assess, diagnose and treat illness or injury when I am not immediately available in person or by a telephone call to (Phone Number): _____.
I understand that this consent is given in advance of any specific diagnosis or treatment and allows Kenneth R. Alleyne, M.D., staff and agents to diagnose and treat my child even when I (the parent or guardian) am not present.
I have the legal right to preauthorize Kenneth R. Alleyne, M.D., staff and agents to deliver said medical treatment to my child, and I have specified any limitations/restrictions below.

Limitations
Identify any limitations/restrictions regarding the kinds of medical services for which this authorization is given. If none, state "none."

_____
Identify any limitations/restrictions regarding the time frame for which this authorization is given. If none, state "none."

_____
In the event the nature of the medical care is not routine or requires consideration due to the limitations/restrictions stated above, please try to contact
me or the designated individual/s below, whom I give authorizing authority. ONLY CONTACT PARENT.
1. Name: _____Relationship to Child: _____Phone: _____
2. Name: _____Relationship to Child: _____Phone: _____
Patient Name: _____ DOB: _____
Parent/Guardian Name and Signature: _____Date: _____

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ASSIGMENT, RELEASE OF INFORMATION, PATIENT RESPONSIBILITIES AND HIPAA FORM

Patient Name: _____ DOB: _____

Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to *Kenneth R. Alleyne, M.D.* for medical services rendered to me and/or my dependents regardless of my insurance benefits. I understand that I am financially responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize *Kenneth R. Alleyne, M.D., staff and agents* to: (1) release any information necessary to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment. (3) Allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from *Kenneth R. Alleyne, M.D., staff and agents* on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized.

General patient and patient family responsibilities

Patient acknowledges, in certain circumstances, insurance company may send a check for services provided by *Kenneth R. Alleyne, M.D.* directly to the patient/guardian.

If the above occurs, the patient shall immediately contact our billing department to get instructions on how to remit payment.

The patient acknowledges, they remain responsible for the full amount of the above-mentioned check plus any reasonable costs, co-payments or co-insurance associated with the collection of said funds until it is received by the treating physician.

Laboratories:

If you have insurance, most of the lab tests should be covered and we will do our best to provide the correct ICD code to insure that happens. However, you are ultimately responsible for the payment to the laboratory.

HIPAA release:

The attached Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

- *Uses and disclosures of Health Information:* we will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

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- *Uses and Disclosures Based on Your Authorization:* except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.
- *Uses and Disclosures Not Requiring Your Authorization*: in the following circumstances, we may disclose your health information without your written authorization:
    - To family members or close friends who are involved in your healthcare;
    - For certain limited research purposes;
    - For purposes of public health and safety;
    - To Government agencies for purposes of their audits, investigations and other oversight activities;
    - To government authorities to prevent child abuse or domestic violence;
    - To the FDA to report product defects or incidents;
    - To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
    - When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian: _____Date: _____