NYU Hospital for Joint Diseases
NYU LANGONE MEDICAL CENTER

Dr. Alan Dayan, MD, PC, FAAOS

Workers Compensation Information

Insurance Carrier: _____

Carrier Case #: _____ WCB # _____

Were you injured on the job? ☐ Yes ☐ No Date of Injury:_____ Time:_____

Are you working? ☐ Part-time ☐ Full time (If not last date worked) _____

Claims Address: _____ City: _____State _____ Zip _____

Claim Representative Name: _____

Insurance Phone Number _____ Fax Number: _____

Job Duties:_____

State how injury occurred? _____

_____

_____

Established body part(s)? _____

I, _____ hereby authorize payment of Workers Compensation benefits directly to Dr. Alan J. Dayan. In the event that I fail to file a claim for the worker's compensation benefits for this illness or condition, or if is determined by worker's compensation carrier that this illness or condition is not result of compensable workers compensation case, I hereby agree to pay Dr. Alan J. Dayan his usual and customary fee for all service rendered.

Signature: _____ **Date:**_____

1715 Avenue T # 1F, Brooklyn, NY 11229
Tel: (718) 232-6348 Fax: (718)

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New Patient Registration Form

PLEASE PRINT **DATE:**_____

How did you learn about our practice? ☐ Physician:_____

☐ Relative ☐ Friend ☐ Website ☐ Phone book ☐ Newspaper ☐ Other:_____

Patient Information

Name: _____ M.I: ____ Last Name:_____

Date of Birth: _____ Age:_____ Social Security Number: _____

Home Address:_____

City _____ State _____ Zip _____

Home Phone Number _____ Mobile Number:_____

Email Address _____ Sex: ☐ M ☐ F

Marital Status (check one) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race (optional): ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other_____

Employment Information

Employer: _____

Address: _____ City: _____State _____ Zip _____

Employer Phone Number _____ Extension _____

If not employed, is patient… ☐ Retired? ☐ Student? ☐ Homemaker? ☐ Unemployed?

Attorney Information

Attorney: _____

Address: _____ City: _____State _____ Zip _____

Attorney Phone Number _____ Extension _____

Emergency Contact

Contact Person _____ Emergency Phone Number _____

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Patient Signature Date _____ Date:_____
(Parent/Guardian if minor)

Patient Name(Print) _____

Patient Information and Medical History

Patient Name: _____ Date: _____

Family Physician: _____ Phone #:

_____

My Problem is: _____ Work Related _____ Accident Related _____ Other:

_____

My specific orthopaedic complaint is:

_____

Body Area (specify Right or Left):

_____

Description of problem/accident including

duration:_____

Date of accident: _____

Were you treated by any other physician for this problem: ____ Yes ____ No

If yes, name of physician: _____ Phone Number: _____

Treatment: _____

Symptoms: ___ pain ___ swelling ___ weakness ___ instability ___ other: _____

Past Tests: ___ x-ray ___ MRI ___ CT Scan ___ None ___ Other _____

Tests were performed at _____

Please list all active medications you currently take and the medical reason for taking the medication

MEDICATION / REASON MEDICATION / REASON

1. _____ / _____ 5. _____ / _____

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2. _____ / _____ 6. _____ / _____

3. _____ / _____ 7. _____ / _____

4. _____ / _____ 8. _____ / _____

□ See attached list of medications

Are you allergic to any medications: _____ □ No Allergies

List past surgeries and the year they occurred: □ No Past Surgeries

1. _____ 3. _____

2. _____ 4. _____

(Please complete other side) Do you have a history of any of the following medical conditions

(please check yes or no): High Blood Pressure □ **yes** □ **no** Diabetes □ **yes** □ **no** Thyroid Disease □ **yes** □ **no**

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ALAN J. DAYAN, M.D.

ORTHOPAEDIC SURGEON

Review of Symptoms

PLEASE CIRCLE OR LIST ALL THAT APPLY OR WRITE N/A IF IT DOESN'T.

REVIEW OF SYSTEMS: Please CIRCLE if you have any of the following symptoms and give brief description.

Constitutional: fever, recent weight gain/loss, appetite problems _____

Eyes: double vision, blurring, difficulty seeing _____

Head, Ears, Nose, Throat: deafness, sinusitis, hoarseness, dizziness, headaches _____

Cardiovascular: chest pain, palpations, murmur, extra beats _____

Respiratory: shortness of breath, wheezing, cough, bloody cough _____

Digestive: abdominal pain, constipation, diarrhea, rectal bleeding, nausea, vomiting _____

Urologic: pain when urinating, hesitant urination, bleeding, incontinence _____

Gynecologic: breast masses, pain, discharge _____

Are you sexually active? YES □ NO □ Birth Control used if any? _____ Pregnant Yes □ No □ Maybe □

Skin: persistent rashes, or legions, changes in moles _____

Neurologic: seizures, loss of balance / coordination, weakness, memory loss, numbness in hands, numbness in feet _____

Psychiatric: depression, anxiety, hallucinations, sleep disturbances _____

Endocrine: excessive thirst, excessive urination, heat / cold intolerance _____

Blood and Lymph: anemia, bleeding tendencies, swollen nodes _____

Allergic and Immunologic: hives, eczema, persistent itching _____

Musculoskeletal: stiffness, joint pain/ deformity, muscle wasting, spine pain radiating to arms/legs, numbness/tingling _____

Other problems not mentioned above: _____

FAMILY HISTORY: Please list age and health of parents, (if deceased, how) and any medical problems that run in your family.

Mother: _____ Father: _____

Family Health Problems: _____

Patient Signature: _____ Date: _____

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ALAN J. DAYAN, M.D.

ORTHOPAEDIC SURGEON

Health Assessment Questionnaire

Name _____ D.O.B._____ Sex: ☐M ☐F Height _____ Weight _____
Referring Doctor (Name, Address, Ph # _____.
_____
Past Surgeries: _____ _____ _____
None ☐
Medications: _____ _____ _____
None☐ _____ _____ _____
Allergies to Meds _____
None☐

Active Medical Conditions And/or Past Medical History:

	YES	NO		YES	NO
Anxiety			Irregular Heart Beat		
Asthma			Kidney Disease		
Bleeding/Hematological Disorder			Liver Disease		
Blood Clots			Lung Disease		
Bronchitis			Mental Illness		
Cholesterol			Migraines		
Depression			Neurological		
Endocrine			Osteoarthritis		
Emphysema			Pneumonia		
Esophageal Reflux			Prior Problems with Anesthesia		
Gall Bladder			Rheumatoid Arthritis		
Hay fever/Sinus			Seizures		
Heart Attack			Sleep Apnea		
Heart Disease			Stomach Problems		
Heart Failure			Stroke		
Hepatitis			Thyroid		
High Blood Pressure			Tuberculosis		
HIV/AIDS			Ulcer Disease		
Adult Disease ☐ Check Box if you use Insulin			Childhood Diabetes ☐ Check Box if you use Insulin		
Cancer*					
If yes: What type? Treatment:			When Discovered: When last Treated:		

List any medical conditions not listed above: _____
Social History: Education (years/degree) _____
Alcohol Use (type,amount) _____ Tobacco Use (type, amount) _____
Employment: Occupation _____ Date last work (if out of work) _____