SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

INJURY / ACCIDENT INFORMATION

PATIENT INFORMATION

Name: ______________________________ Date of Birth: _______________ Age: _____ Sex:____________
Social Security # ________________________ Marital Status: Single Married Widowed Divorced
Address: ______________________________(Apt # _____) City: _______________ State: _____ Zip: ______
Home Phone #: ____________________ Cell Phone #__________________ Work Phone #________________
____
Primary Care Physician: ___________________ Address: __________________________Phone: __________
Employer: ____Occupation: _________________________
Employer Address: ____
Spouse or Parent's Name: ______________________________Work Phone #: __________________________
Employer: ____
Person to contact in case of an emergency: ____________________________Phone: _____________________

Pharmacy Name/Address/Phone Number:____

BODY PARTS / Complaints: ____

Describe How and Where Injury Occurred: ____
Are you out of work due to this injury: Yes No Date Returned to Work: _______________

ARE INJURIES RELATED TO:
An Auto Accident? YES NO A Work Related Injury? YES NO

IF INJURIES ARE A RESULT OF AN AUTO ACCIDENT:

Date of Accident: __________________
Name of Insurance Company: ____
Insurance Company Address: ____
Name of Insured: ______________________ Address _________________________ Telelpone # _________
Policy Number: ________________________________ File Number: _____________________________________
Claim Representative: ____ Telephone # _____________

IF INJURIES ARE A RESULT OF A WORK RELATED INJURY:

Date of Accident: __________________
Name of Employer: ____
Name of Insurance Carrier: ____
Insurance Carrier Address: ____
Was this accident reported? _____________ Did you complete an accident report? _______________________
Carrier Case # __________________________________ WCB # ___________________________________
Claim Representative: ____ Telephone # _____________
Is There, Or Will There Be A Lawsuit As A Result Of This Accident? _____________________

Name of Attorney: ____Phone: __________

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me. In the event that the provider's charges are outstanding, or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the providers charges.

____ ______________________
SIGNATURE OF PATIENT, OR PARENT (if minor) DATE

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

MEDICAL HISTORY FORM

NAME: ______________________________ DATE: ____________

Chief Complaint: ______________________________ Date of Injury: ________

History of present illness:

Location of pain/problem: ______________________

How severe is pain/problem (on a scale of 1 – 10) (10 being the worst) _______

Does this pain/problem occur at a specific time? ______________

What other signs or symptoms are you having? ______________

How long have you had this pain/problem? ______________

Where were you at the onset of this pain/problem? ______________

What makes the pain/problem better or worse? ______________

Have you had previous episodes? ______________

How did it start? ______________

Allergies to food: ______________ ☐ none

Allergies to medicine: ______________ ☐ none

What medications do you take either prescription or non-prescription:

____

Previous Surgeries (what kind, where, when?) ______________

____

Previous Hospitalizations (for what, where, when?) ______________

____

Previous Fractures: (of what, when?) ______________

Past Medical History:

(Check YES or NO for all)

Diabetes	☐ yes	☐ no
High Blood Pressure	☐ yes	☐ no
Cancer	☐ yes	☐ no
(what kind) ______________		
Stroke	☐ yes	☐ no
Heart Trouble	☐ yes	☐ no
Arthritis	☐ yes	☐ no
Convulsions/Seizures	☐yes	☐ no
Bleeding Tendency	☐ yes	☐ no
Acute Infection	☐ yes	☐ no
Venereal Disease	☐ yes	☐ no
Hereditary Defects	☐ yes	☐ no
Blood Clots	☐ yes	☐ no
Gout	☐ yes	☐ no

What other medical problems to you have? ______________

____

Review of Systems: (check if DENIED / CIRCLE items)

	DENIES	SYMPTOMS
Neurological		Headache fainting dizziness seizure numbness tingling weakness
Eyes / Ears / Nose		Vision change double vision pain hearing change ringing in ears smelling change nose bleeds congestion
Throat		Pain difficulty swallowing painful swallowing
Respiratory		Cough wheezing pain asthma short of breath blood in sputum
Cardiovascular		Chest pain palpitations irregular heartbeat swelling skin/color/tem change murmur
GI		Nausea vomiting blood in stool constipation diarrhea bleeding appetite change weight change pain
GU		Frequency hesitancy urgency blood in urine incontinence discharge pain painful urination
Musculoskeletal		Swelling range of motion change pain
Skin		Rash skin change pain itchiness
Psych / Subst Abuse		History of treatment: ______________Out-Patient In-Patient Over ________months________years

Patient Social History:

What kind of work do you do? ______________________________

Are you: ☐ right handed ☐ left handed

Marital Status ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Use of alcohol ☐ never ☐ rarely ☐ moderate ☐ daily ☐ recovering alcoholic

Use of tobacco ☐ never ☐ previously, but quit ☐ current pack/day

Use of drugs ☐ never ☐ type/frequency

Excessive exposure at home or work to ☐ fumes ☐ dust ☐ solvents ☐ noise

Family Medical History:	**Age**	**Diseases**	**if deceased, cause of death**
Father	____	______________	______________
Mother	____	______________	______________
Siblings	____	______________	______________
	____	______________	______________
Spouse	____	______________	______________
Children	____	______________	______________

Is there a family history of : ☐ diabetes ☐ cancer (what kind) ______________ ☐ heart disease, other

Inherited medical problem: ______________________________

COMPLETED BY: ______________________________

REVIEWED BY: ______________________________

M.D. Signature

SUFFOLK ORTHOPAEDIC ASSOCIATES, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ____

Signature ____

Date ____

OFFICE USE ONLY

I attempted to obtain the patient’s signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
___________	______	_____________________________________

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form is to be completed in order for this office to better serve your interests in protecting the privacy of your health information. Please complete all sections in order to ensure that your health information is released **ONLY** to the parties you are authorizing.

I, __________________________, authorize Suffolk Orthopaedic Associates to disclose my protected health information to the parties listed below for purposes other than treatment, payment or healthcare operations. I understand that I retain the right to revoke this authorization and any revocation must be done so in writing to the attention of the Privacy Officer of Suffolk Orthopaedic Associates.

Description of the information to be used or disclosed (check all that apply):
( ) Medical Date / Information as related to:
- ( ) Specific condition(s): ____
- ( ) Specific medication(s): ____
- ( ) Specific procedure(s): ____

Name of person(s) authorized to request my protected health information or to speak with Suffolk Orthopaedic Assoc. regarding my healthcare (i.e. family member or attorney)

____

____

Name of person(s) NOT authorized to request my protected health information or to speak with Suffolk Orthopaedic Associates regarding my healthcare:

____

____

Purpose(s) of the information (i.e. to assist in care, legal matters):

____

____

This authorization permits Suffolk Associates to send the protected health information ONLY to this address or fax number:

____

____

Fax Number: ________________________________

This authorization shall remain in effect from the date signed below until ____
(expiration date)

I understand that any information used or disclosed prior to this authorization may be subject to re-disclosure and may no longer be protected health information.

Patient Name: ______________________________________ ***Signature:*** ____

Relationship to Patient: ____ ***Date:*** __________________________

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

RICHARD J. TABERSHAW, M.D., F.A.A.O.S.
MICHAEL LASTIHENOS, M.D., F.A.A.O.S.
WILLIAM K. WRIGHT, R.P.A.-C.
MICHAEL POLIDORO, R.P.A.-C.
PAIN MANAGEMENT AND PHYSIATRY
MATTHEW H. KALTER, M.D.

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW

AUTHORIZATION TO PAY BENEFITS

NYS FORM NF-3

Claim Number: ________________

Date of Accident: ____________

PATIENT: Your health provider may agree to accept payment for health services performed directly from your insurer (**Authorization to Pay Benefits**) so that you are not required to make payment to the health provider at the time of service. Such agreement is optional on the part of he health provider and must he signed by both patient and health provider. You may use the optional authorization language provided below, by checking off the designated spot in item 20- of this form.

20. _____ (IF YOU HAVE CHOSEN TO AUTHORIZE THE DIRECT PAYMENT OF BENEFITS BY CHECKING THIS OPTION, <u>YOU MAY NOT ALSO ENTER INTO AN ASSIGNMENT OF BENEFITS CONTAINED IN #21</u>)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

AUTHORIZATION TO PAY BENEFITS:

I AUTHORIZE PAYMENT OF HEALTH BENEFITS TO THE UNDERSIGNED HEALTH CARE PROVIDER OR SUPPLIER OF SERVICES DESCRIBED BELOW. I RETAIN ALL RIGHT, PRIVILEGES AND REMEDIES TO WHICH I AM ENTITLED UNDER ARTICLE 51 (THE NO-FAULT PROVISION) OF THE INSURANCE LAW.

PRINT NAME ________________________ SIGNED ________________________
Patient Patient Date

PROVIDER NAME ______________________ SIGNED ______________________
Date

MEDICAL ARTS BUILDING, 375 E. MAIN STREET, SUITE 1, BAY SHORE, NY 11706
PHONE: 631-665-8790 FAX: 631-665-1581
COMPENSATION PHONE: 631-665-2467 FAX: 631-665-8170