South Island Orthopedics, P.C.

657 Central Avenue
Cedarhurst, NY 11516
T: 516-295-0111
F: 516-295-9438

205 Froehlich Farm Blvd
Woodbury, NY 11797
T: 516-364-0070
F: 516-364-0242

PATIENT REGISTRATION FORM (Please Print)

Today's Date:	**Thank you for selecting South Island Orthopedics, P.C.**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Gender:	Age:

Patient's Birth Date: mm/dd/yyyy	Marital Status: ○ S ○ M ○ D ○ W ○ SEP	Social Security:	Preferred Language:

Street Address:	Apt #	City/Town:	State:	Zip Code:	Home Phone Number:

Mobile Phone Number:	Work Phone Number:	Email Address:	Preferred Method of Contact: ☐ Home ☐ Mobile ☐ Work ☐ Email

Name of Employer:	Address:	City/Town:	State:	Zip:

SPOUSE INFORMATION

Last Name:	First:	Contact Number:

EMERGENCY CONTACT

Name:	Relationship to Patient:
Primary Telephone Number:	Secondary Telephone Number:

REFERRAL SOURCE	**Primary Care Physician**
How did you learn about us? Internet ☐ Friend/Family ☐ Physician ☐ Attorney ☐ Other ☐	Primary Care Physician Name:
Please list the name and number of the referral source:	Street Address:
	City, State, Zip:
	Telephone Number:

PHARMACY INFORMATION

Name (Local):	Address:	Telephone #:	Fax#:
Name (Mail Away):	Address:	Telephone #:	Fax#:

HEALTH INSURANCE INFORMATION

Primary Insurance: Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Name:	Group Number:
	ID Number:
Insured's Name (if not self, spouse or parent listed above):	Birth Date:

Secondary Insurance: Patient's Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other: ☐

Secondary Insurance Name:	Group Number:
	ID Number:

Insured's Name (if not self, spouse or parent listed above):	Birth Date:

SYMPTOM SPECIFICATIONS (Give only a brief description in one to two sentences)

Please list your symptoms and complaints relating to your visit today:

PATIENT REGISTRATION FORM CONTINUED (Please Print)

MEDICAL TREATMENT HISTORY

Are these symptoms related to an accident? ☐ YES ☐ NO

Did you go to the hosptial? ☐ YES ☐ NO	If yes, list hopsital name:
Were you: ☐ Out-Patient ☐ In-Patient	Any X-Rays/MRI's or testing performed?
Have you seen any doctors for this inury and/or condition: ☐ YES ☐ NO	If yes, what type?

Medication(s) Prescribed:

NO FAULT MOTOR VEHICLE ACCIDENT

Insurance Company Name:	Insurance Phone Number:
Policy Holder Name:	Claim Representative:
Claim #:	Policy#

Was the accident reported to the insurance company? ☐ YES ☐ NO

Was the accident reported to the police? ☐ YES ☐ NO **(If yes, provider the front desk with a copy of the police report.)**

Where you the: ☐ Driver ☐ Passenger ☐ Pedestrian

# of people in the Vehicle:	Where was the vehicle hit? ☐ Front ☐ Rear ☐ Driver Side ☐ Passenger Side

Were you working at the time of accident? ☐ YES ☐ NO

WORKERS COMPENSATION-WORK ACCIDENT

Insurance Carrier:	Employer Name & Address (at the time of accident)
Claim/Carrier Case #:	
WCB #:	
Claim/Case Manager:	Telephone Number:

Was injury reported to your employer? ☐ YES ☐ NO

Name & Phone number of Supervisor Reported to:

Injury Specifications

Date of Injury:	Accident occurred in: City:	State:

Injury resulted from: ☐ Motor Vehicle Accident ☐ Work Accident ☐ Other

- If other please specify:

Do you have an attorney representing you for this injury? ☐ YES ☐ NO

Attorney Firm Name:		Telephone Number:
Did you miss any time at work as a result of the injury? ☐ YES ☐ NO	1st Date Missed:	Date of Return:

PATIENT/GUARDIAN SIGNATURE: _____DATE: _____/_____/_____

IF GUARDIAN, PRINT RELATIONISHIP TO PATIENT: _____

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Patient Permissions and Preferences Form

Patient Name:_____ **Date of Birth:** _____
Last **First** **MI**

I authorize **South Island Orthopedics, P.C.,** to discuss my health information with the following personal representative(s).

Name:	Relationship:	Telephone:
Name:	Relationship:	Telephone:

☐ I decline at this time to list a personal representative to discuss my health information.

PATIENT AUTHORIZATION -AUTHORIZATION TO CALL

It is the policy of **South Island Orthopedics, P.C.,** to confirm appointments via telephone or in some cases with an automated appointment confirmation service.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:_____

☐ OK to leave message with detailed information*
☐ OK Leave message with call back number only

Cell Phone: _____

☐ OK to leave message with detailed information*
☐ Leave message with call back number only

Written Communication

☐ OK to mail home address
☐ OK to mail to my work/office address (provide address)
☐ OK to fax to this number _____

Work Telephone: _____

☐ OK to leave message with detailed information *
☐ Leave message with call back number only

Other:
☐ OK to text (text messaging fees may apply)

Patient/Patient Representative signature: _____ Date: _____
Print Name (if other than patient): _____
Relationship to Patient: _____

*detailed information may include but is not limited to: lab results, diagnosis, treatment instructions

PLEASE NOTE, THE ABOVE INFORMATION WILL BE IN EFFECT UNTIL YOU REVOKE IT IN WRITING TO THE PRACTICE

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Medical History Questionnaire

Name: **Age:** **Date of Birth:**

Hand Dominant ☐ **Right** ☐ **Left** **Date of Injury:** _____ **Height:** _____ **Weight:** _____

Chief Complaint: please describe, in detail, your current injury or complaint (which limb, initial symptoms, aggravating activities)

Past Medical History: (i.e., diabetes, high blood pressure, kidney, liver, heart problems)

Present Medication: please list all the medications and supplements you are taking or have taken in the last month

Allergies: please list allergies to food or medication

Past Surgeries/Illness/Accidents and Hospitalizations:

Family History:

Father: AGE _____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

Mother: AGE ____ ☐ Living ☐ Deceased ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Stroke
Other:

Review of Systems: Have you ever been diagnosed by a physician with any of the following?

Head and Neck
☐ Severe Headaches ☐ Double Vision ☐ Swelling in Neck ☐ Dizzy Spells ☐ Difficulty Hearing
☐ Fainting ☐ Failing Vision ☐ Prolonged Hoarseness ☐ Stroke

Heart and Lungs
☐ Chest Pain ☐ High Blood Pressure ☐ Pneumonia ☐ Heart Attack ☐ Difficulty Breathing
☐ Skipping Heart Beats ☐ Chronic Cough/TB ☐ Ankles Swell ☐ Heart Defects/Murmurs

Stomach and Intestines
☐ Persistent Nausea ☐ Diabetes ☐ Stomach Ulcers ☐ Heartburn Regularly ☐ Hepatitis/Jaundice
☐ Black or Blood in stool ☐ Appetite Loss ☐ Hemorrhoids ☐ Chronic Diarrhea/Constipation

Urinary Tract-etc.
☐ Excess Urination ☐ Urinary Problems ☐ Painful/Excess Menstruation ☐ Difficulty Urination
☐ Passes any Stone ☐ Bleed Between Periods ☐ Blood in Urine ☐ Retention of Urine ☐ Pregnancies # _____

Muscle Joints Nerves
☐ Tingling Sensations ☐ Memory Loss ☐ Seizures ☐ Numbness ☐ Personality Changes
☐ Depression ☐ Disturbance in Walking ☐ Paralysis ☐ Varicose Veins ☐ Muscle Jerking
☐ Speech Disturbance

Other:
☐ Skin Disorders ☐ Bleeding Disorders ☐ EBV ☐ CMV ☐ HIV
☐ Thyroid Disorder ☐ ALL OTHER NEGATIVE

Occupation/Position:

Do you smoke or have you been a smoker? _____ _____ packs per day x _____ years
Do you drink alcohol? _____ How Much? _____ Non-Prescribing drug use _____

Date Reviewed _____ Physician's Signature _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
South island Orthopedics, P.C. 205 Froehlich Farm Blvd, Woodbury, NY 11797

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ☐ At request of individual ☐ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

ASSIGNMENT OF BENEFITS AND PATIENT FINANICAL RESPONSIBILITY ACKNOWLEDGEMENT

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- I will assume the responsibility to respond to any financial correspondence furnished by South Island Orthopedics, P.C. and the billing service, and I also agree to pay any outstanding/remaining difference(s), if my initial out-of-pocket payment is not sufficient to satisfy my account once my insurance company has been billed, I understand that my insurance carrier may pay for services rendered I must submit the check to South Island Orthopedics, P.C. upon receipt.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to South Island Orthopedics, P.C. on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize South Island Orthopedics, P.C. to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical providers.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in South Island Orthopedics, P.C. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

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657 Central Avenue Cedarhurst NY 11516

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the HIPAA Notice of Privacy Practices.

_____

Signature

_____

Printed Name

_____

Date

If representative's signature appears above please list patient name and relationship to patient:

_____

Patient Name

_____

Relationship to Patient