

6/6/2022

(08338)-Jones Hellean

Date of Birth - 1/2/1964 Sex - Male Marital Status - Single

Address: 40-01 10st,Astoria,NY,11101

Phone #: (646) 373-1209

Social Security# -

Employer or Company Name:

Address:

Emergency Name:

Work Phone #:

Date of Accident - 2/12/2022

Time/Place Accident - 907M E/B GRAND CENTRAL PKWY

Policy Report - Yes

Date of Visit - 2/17/2022

Condition Related to : Auto Accident

Insurance Company : GEICO

Address: PO Box 9507

Fredericksburg,VA, 22403

Phone: Fax: 518-560-3913

Claim# - 0334617200101046

Claim Address - PO Box 9507

Fredericksburg, VA 22403-9526

NF-2 - Yes Sending Date - 02/22/2022

Policy Effective Date - 10/8/2021

Policy# - 4346-44-36-68

Policy holder - JONES,HELLEAN

WCB# -

Carrier case # -

Attorney - Greenstein & Milbauer, P.C. Firm Name - Greenstein & Milbauer, P.C.

Attorney Address - 1825 Park Ave, New York, NY 10035

Attorney Phone - (212) 685-8500 Fax - (212) 297-0504

Contact Person -

Other Insurance -

Medicare -

2-17-22

NEW YORK STATE DRIVER LICENSE

EXCELISIOR

DOB 01/02/1984

EXP 01/02/2027

SEX F

DOB 01/02/1984

LONG IS CITY NY 11101

4006 VERNON BLVD 50

JONES

HELLEN

ID 748 309 024

JAN 64

12/28/2018

RD

EXCELISIOR

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4006 VERNON BLVD 50

JONES

HELLEN

ID 748 309 024

JAN 64

12/28/2018

RD

EXCELISIOR

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418

INITIAL INTAKE SHEET

WC NF LIEN

Patient Name: Jones Hellean DOB: 1/21/64 Age: 58 Height: 5'1" Weight: 235 M / F / E
Chief Complaint: R/SH L/SH R/KN L/KN R/Elb L/Elb R/Hip L/Hip R/Ank L/Ank

Type of Injury: MVA Work-Related Working: Y / N Degree of Disability: _____ %

Asymptomatic prior to accident: Y / N History of prior trauma: Y / N

Pain in: _____
Other: _____

____ Pedestrian ____ Bicyclist ____ Motorcyclist ____ Bus pass. ____ Driver ____ Front Pass. ____ Rear Pass
Vehicle hit: Rear Front Driver-side front Driver side rear Passenger side front
Passenger side rear T-Boned Driver side T-Bone Passenger side

Airbags deployed: Y / N EMS Arrived: Y / N Police at Scene: Y / N

Went to Hospital: Y / N Hospital name: NY Presbyterian Flushing Amb. Car

PMH: None Diabetes HTN HLD Asthma Cardiac Thyroid CA just clear
PSH: None Transplant (kidney) colon cancer 6 months ago

Meds: None / Pain meds PRN

Drug Allergy: Y / N

Soc. His: Smoke Y / N ppd Alcohol Y / N Recreational Drugs Y / N

PT/Chiro: Y / N Duration: _____ Weeks / Months / Years Relief: Good Little None

Walk: Y / N 3 blocks Stand: Y / N 20 mins Sit Y / N 10 mins

Unable to: Garden Play sports Drive Lift Childcare Carry Reach overhead

Laundry Shopping Errands Kneel Squat Stairs Jog Exercise

PRESENT COMPLAINTS:

<u>R SH</u> Pain <u>5</u> /10 Constant Intermittent Stiff Weak Pop Click Reach overhead <u>Y</u> / N Reach back <u>Y</u> / N Unable to sleep at night Imp w/ Rest Med PT Ice	<u>L SH</u> Pain ____ /10 Constant Intermittent Stiff Weak Pop Click Reach overhead Y / N Reach back Y / N Unable to sleep at night Imp w/ Rest Med PT Ice	<u>R KN</u> Pain <u>5</u> /10 Constant Intermittent Stiff Weak Diff rising from chair Y / <u>N</u> Diff w/ stairs Y / <u>N</u> Click Pop Buckl Lock Imp w/ Rest Med PT Ice	<u>L KN</u> Pain <u>5</u> /10 Constant Intermittent Stiff Weak Diff rising from chair Y / <u>N</u> Diff w/ stairs Y / <u>N</u> Click Pop Buckl Lock Imp w/ Rest Med PT Ice
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<u>R HIP</u> Pain ____ /10 Constant Intermittent Lock Pain w/ stand walk climb Standing from sitting Imp w/ Rest Med PT Ice	<u>L HIP</u> Pain ____ /10 Constant Intermittent Lock Pain w/ stand walk climb Standing from sitting Imp w/ Rest Med PT Ice	<u>R ANK</u> Pain ____ /10 Constant Intermittent Pain w/ stand walk climb Imp w/ Rest Med PT Ice	<u>L ANK</u> Pain ____ /10 Constant Intermittent Pain w/ stand walk climb Imp w/ Rest Med PT Ice
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<u>R WRI</u> Pain ____ /10 Constant Intermittent Weak Numb Tingle Pain w/ lift carry drive Imp w/ Rest Med PT Ice	<u>L WRI</u> Pain ____ /10 Constant Intermittent Weak Numb Tingle Pain w/ lift carry drive Imp w/ Rest Med PT Ice	<u>R ELB</u> Pain ____ /10 Constant Intermittent Weak Numb Tingle Pain w/ lift carry drive Imp w/ Rest Med PT Ice	<u>L ELB</u> Pain ____ /10 Constant Intermittent Weak Numb Tingle Pain w/ lift carry drive Imp w/ Rest Med PT Ice
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Other Complaints: _____

ROS:**General:** Fevers chills night sweats weight gain weight loss**HEENT:** Double vision eye pain eye red. hearing loss earache ear ringing nose bleeds sore throat hoarseness**Endocrine:** Cold intolerance appetite changes hair changes**Skin:** Clear no rashes or lesions**Neuro:** Headaches dizziness vertigo tremors**Respiratory:** Wheezing coughing shortness of breath difficulty breathing**Cardiovascular:** Chest pain murmurs irregular heart rate hypertension**GI:** Nausea vomiting diarrhea constipation jaundice change in bowel habits**GU:** Blood in urine painful urination loss of bladder control urinary retention**Hematology:** Active bleeding bruising anemia blood clotting disorders**Psychiatric:** Anxiety change in sleep pattern depression suicidal thoughts**PHYSICAL EXAMINATION:****C SPINE:** Pain Sharp Shoot Burn Constant Intermit Numb Tingling Radiates to R L

Pain w/ neck bend lift carry Improves w/ Rest Med PT Ice

ROM: Flex. ___/45 Ext. ___/45 R Lat Flex. ___/45 L Lat Ext. ___/45 Rot ___/60

L SPINE: Pain Sharp Shoot Burn Constant Intermit Numb Tingling Radiates to R L

Pain w/ stand walk sit bend Improves w/ Rest Med PT Ice

ROM: Flex. ___/80 Ext. ___/25 R Lat Flex. ___/35 L Lat Ext. ___/45 Sac Hip Flex ___/45

R /SH: Swelling /Tender to palp → Supraspinatus AC joint Trap. Prox biceps Coracoid Deltoid Scapula

Heat Erythema Crepitus Deformity

Drop Arm Cross-Over Empty Can Yergason Deltoid Atrophy

O'Brien's Impingement Lift off test Hawkins

ROM: Abd. 105/180 Add. ___/45 For Flex. 115/180 Ext. 40/60 IR 35/90 ER 65/90

IR: sacrum mid back ___no motor or sensory deficit

L /SH: Swelling/Tender to palp → Supraspinatus AC joint Trap. Prox biceps Coracoid Deltoid Scapula

Heat Erythema Crepitus Deformity

Drop Arm Cross-Over Empty Can Yergason Deltoid Atrophy

O'Brien's Impingement Lift off test Hawkins

ROM: Abd. ___/180 Add. ___/45 For Flex. ___/180 Ext. ___/60 IR ___/90 ER ___/90

IR: sacrum mid back ___no motor or sensory deficit

R /KN: Swelling /Tender along → Med joint line Lat joint line Sup. patella Inf. Patella Pop. fossa

Heat Swelling Erythema Crepitus Deformity

McMurray Lachmans Pat. fem. grind Ant. draw Post. draw

ROM: Flexion 105/130 Extension 5/5 Stable varus/valgus ___no motor or sensory deficit

L /KN: Swelling /Tender along → Med joint line Lat joint line Sup. patella Inf. Patella Pop. fossa

Heat Swelling Erythema Crepitus Deformity

McMurray Lachmans Pat. fem. grind Ant. draw Post. draw

ROM: Flexion 105/130 Extension 5/5 Stable varus/valgus ___no motor or sensory deficit

R /HIP: Swelling /Hematoma / Effusion / bruise ___Trendelenburg +ve -ve

Tenderness to palpation → Great Troch Groin Medial thigh. ROM: Full Limited and painful.

ROM: Abd. ___/45 Add. ___/35 Flex. ___/120 Ext. ___/30 IR ___/45 ER ___/45

L /HIP: Swelling /Hematoma / Effusion / bruise ___Trendelenburg +ve -ve

Tenderness to palpation → Great Troch Groin Medial thigh. ROM: Full Limited and painful.

ROM: Abd. ____/45 Add. ____/35 Flex. ____/120 Ext. ____/30 IR ____/45 ER ____/45

R/ANK: Swell /Hemato/ bruise → Ant. Post. Lat. Malleo Ant Draw +ve -ve Inv Stress +ve -ve
Tenderness to palpation → Med. aspect Lat. aspect. ROM: Full Limited and painful.

ROM: Dorsi flexion ____/20 Plantar flex. ____/50 Inversion ____/15 Eversion ____/15

L/ANK: Swell /Hemato/ bruise → Ant. Post. Lat. Malleo Ant Draw +ve -ve Inv Stress +ve -ve
Tenderness to palpation → Med. aspect Lat. aspect. ROM: Full Limited and painful.

ROM: Dorsi flexion ____/20 Plantar flex. ____/50 Inversion ____/15 Eversion ____/15

R/WRI: Pain to palp. → Ulnar styl. Distal rad. Scaphoid ____/5 grip strength Swell Erythema Bruise
Tinel +ve -ve Phalen +ve -ve

ROM: Flexion ____/80 Extension ____/70 Radial dev. ____/20 Ulnar dev. ____/30

L/WRI: Pain to palp. → Ulnar styl. Distal rad. Scaphoid ____/5 grip strength Swell Erythema Bruise
Tinel +ve -ve Phalen +ve -ve

ROM: Flexion ____/80 Extension ____/70 Radial dev. ____/20 Ulnar dev. ____/30

R/ELB: Swell Erythema Bruise Deltoid atrophy ____/5 musc stren Tender → Med Epi Lat Epi Ole Pro
Varus +ve -ve Valgus +ve -ve Tinel +ve -ve

ROM: Flexion ____/150 Extension ____/150 Supin. ____/90 Pron. ____/90

L/ELB: Swell Erythema Bruise Deltoid atrophy ____/5 musc stren Tender → Med Epi Lat Epi Ole Pro
Varus +ve -ve Valgus +ve -ve Tinel +ve -ve

ROM: Flexion ____/150 Extension ____/150 Supin. ____/90 Pron. ____/90

Dx:

Right Shoulder	Left Shoulder	Right Knee	Left Knee
S46.011A Partial rot cuff tear	S46.012A Partial rot cuff tear	S83.241A Med. Men. tear	S83.242A Med. Men. tear
M75.121 Complete rot cuff tear	M75.122 Complete rot cuff tear	S83.281A Lat. Men. tear	S83.282A Lat. Men. tear
M24.811 Internal derangement	M24.812 Internal derangement	M23.91 Internal derangement	M23.92 Internal derangement
M75.01 Adhesive Capsulitis	M75.02 Adhesive Capsulitis	S83.519A ACL tear	S83.519A ACL tear
M75.81 Shoulder tendinitis	M75.82 Shoulder tendinitis	S83.511A ACL sprain	S83.512A ACL sprain
S43.431A Labral tear	S43.432A Labral tear	S83.411 MCL sprain	S83.412A MCL sprain
S43.431A SLAP tear	S43.432A SLAP tear	M94.261 Chondromalacia	M94.262 Chondromalacia
M75.41 Impingement	M75.42 Impingement	S83.31XA Tear artic. cartilage	S83.32XA Tear artic. cartilage
M65.811 Tenosynovitis	M 65.812 Tenosynovitis	M22.2X1 PF chondral injury	M22.2X2 PF chondral injury
M75.51 Bursitis	M75.52 Bursitis	M25.461 Joint effusion	M25.462 Joint effusion
M75.21 Bicipital tendinitis	M 75.22 Bicipital Tendinitis	M12.569 Trauma. arthropathy	M12.569 Trauma. arthropathy
M25.511 Pain	M25.512 Pain	S80.911A Injury	S80.912A Injury
S49.91XA Injury	S49.92XA Injury	M25.561 Pain	M25.562 Pain
S46.101A Biceps tendon tear	S46.102A Biceps tendon tear	M65.161 Synovitis	M65.162 Synovitis
M24.10 Glenoid chondr defect	M24.10 Glenoid chondr defect	M23.40 Loose body in knee	M23.40 Loose body in knee
M94.211 Chondromal, glen/HH	M94.212 Chondromal, glen/HH	M24.10 Chondral lesion	M24.10 Chondral lesion
M67.211 Hypertroph. synovitis	M67.212 Hypertroph. synovitis	M93.261 Osteochondral lesion	M93.262 Osteochondral lesion
M89.311 AC joint hypertrophy	M89.312 AC joint hypertrophy	M17.11 Osteoarthritis	M17.12 Osteoarthritis
M24.011 Loose Bodies	M24.012 Loose Bodies	M24.661 Adhesions	M24.662 Adhesions
M25.311 Shoulder instability	M25.312 Shoulder instability	M67.51 Medial plica	M67.52 Medial plica
M19.011 Primary osteoarthritis	M19.012 Primary osteoarthritis	M25.761 Osteophyte	M25.762 Osteophyte
M25.411 Joint Effusion	M25.412 Joint Effusion	M70.41 Prepatellar bursitis	M70.42 Prepatellar bursitis

____ Recommend steroid inj. for pain mgmt.

R/SH	L/SH	R/KN	L/KN	R/HIP	L/HIP	R/ANK	L/ANK
R/WRI	L/WRI	R/ELB	L/ELB	C Spine	L Spine		

____	Brace ordered	R /SH	L /SH	R /KN	L /KN	R /HIP	L /HIP	R /ANK	L /ANK	R /WRI	L /WRI
		R /ELB	L /ELB								

____MRI ordered R/SH L/SH R/KN L/KN R/HIP L/HIP R/ANK L/ANK R/WRI L/WRI
 B/ELB L/ELB C Spine L Spine

Follow up in 9 (Weeks / Months / PRN).

Discussed R/SH L/SH R/KN L/KN R/HIP L/HIP R/ANK L/ANK R/WRI L/WRI
R/ELB L/ELB C Spine L Spine

Proceed w/ Sx / Wants to think about it Proceed with _____ Sx after rehab on _____

____ Med Clearance needed prior to Sx. ____ W/C authorization needed prior to Sx

_____ Patient consents to _____ Sx.

Patient scheduled for **R/SH** **L/SH** **R/KN** **L/KN** **Surgery on** _____

Richard
Trenns.

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132
usinhaorthopedics@gmail.com

Date: 06/08/22

NF Forms

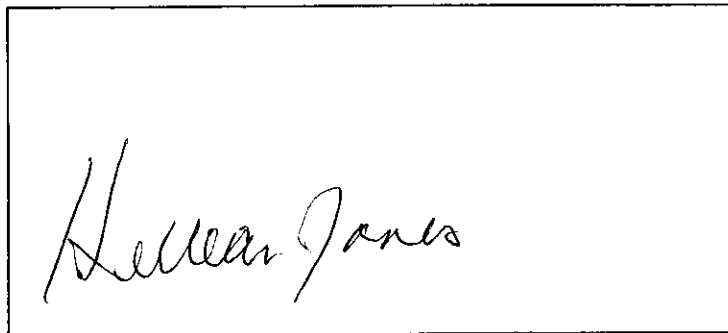
I, Hellean Jones hereby authorize **UK Sinha Physician, P.C.**

to use my signature as signed below for the following documents:

1. NY Motor Vehicle No-Fault AOB Form
2. NYS Form NF-2
3. NYS Form NF-3
4. Attorney Lien document
5. HIPAA (OCA official Form N0.: 960)

WC Forms

1. Workers Compensation Insurance form
2. HIPAA (OCA official Form N0.: 960)



(Please sign within the box with black ink)