Blood Pressure: _____ Pulse: _____
(Clinical Use Only)

Patient Intake Sheet

«PatientFullName» Date: **«CurrentDate»**
Age_____Height: _____ Weight: _____ Gender_____

Birth Date «PatientDOB»

Hand Dominance: Right Left
Reason for visit (please list side if applicable): _____

Date of injury (onset of symptoms): _____

Is this a work related accident? YES NO Is this related to a motor vehicle accident? YES NO
Are you currently working ? _____ If no, date last worked: _____

Current Occupation: _____

Have you had any test for this injury? Please circle
X-rays CAT Scan MRI Nerve Studies Blood Studies
If yes, where were they performed? _____

Have you had any treatment for this injury? i.e., physical therapy, cortisone injections, etc.?
_____

Referring MD: _____ Primary Care MD: _____
Current Pharmacy: _____

Pain Scale Please rate your pain on a scale on 0-10, zero being none and 10 being unbearable

0	1	2	3	4	5	6	7	8	9	10

Past Surgical History

Date	Type of surgery and if extremity, which extremity

Current Medication, including dose and frequency

Please list all Allergies **Reaction:**

Are you allergic to latex rubber products? YES NO
Have you ever had an infection that was resistant to antibiotics, such as MRSA? YES NO

Do you smoke? YES NO If yes, how much per day? _____ Former Smoker? _____
Do you drink alcohol? YES NO If yes, how much? _____ drinks Per day Per week
Do you take addictive drugs? If yes, what? _____
Do you know that you are now, or could possibly be pregnant? YES NO Not Applicable

Name:_____ **Current/Past/Family History**

Please review the following medical conditions and note if A.) You have this condition currently B.) Have had this condition in the past or C.) Know of a family member who has had this condition. Please circle Yes or No for each.

	Current Condition		Past Condition		Present in Family	
High Blood Pressure	Yes	No	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No	Yes	No
Anemia	Yes	No	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	Yes	No
Bleeding Tendency	Yes	No	Yes	No	Yes	No
Blood Clots	Yes	No	Yes	No	Yes	No
Bronchitis/Asthma/Emphysema	Yes	No	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Yes	No
Depression	Yes	No	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Yes	No
Fibromyalgia	Yes	No	Yes	No	Yes	No
Gout	Yes	No	Yes	No	Yes	No
Hepatitis	Yes	No	Yes	No	Yes	No
Immune Deficiency Disorder/HIV	Yes	No	Yes	No	Yes	No
Kidney Disease	Yes	No	Yes	No	Yes	No
Liver Disease	Yes	No	Yes	No	Yes	No
Malignant Hyperthermia	Yes	No	Yes	No	Yes	No
Neuropathy	Yes	No	Yes	No	Yes	No
Osteoporosis	Yes	No	Yes	No	Yes	No
Peripheral Vascular Disease	Yes	No	Yes	No	Yes	No
Psoriasis	Yes	No	Yes	No	Yes	No
Reflux/GERD	Yes	No	Yes	No	Yes	No
Seizures	Yes	No	Yes	No	Yes	No
Sleep Apnea	Yes	No	Yes	No	Yes	No
Stroke/TIA	Yes	No	Yes	No	Yes	No
Thyroid Disease	Yes	No	Yes	No	Yes	No
Ulcers	Yes	No	Yes	No	Yes	No

Review of Systems

Do you have any of these symptoms? Please circle yes or no for each

Constitutional			**Hematopoietic/Lymph**			**Neurological**		
Fever or chills	yes	no	Easy Bruising/Bleeding	yes	no	Balance/Coordination	yes	no
Weight Loss/Gain	yes	no	Extremity Swelling	yes	no	Changes in Sensation	yes	no
Endocrine Function			**Immunologic**			Muscle Weakness	yes	no
Hot Flashes	yes	no	Frequent infections	yes	no	Numbness in hands/Feet	yes	no
Cold Sensitivity			Viral Infections	yes	no	Tingling in hands/feet	yes	no
Gastrointestinal	yes	no	**Musculoskeletal**			Visual Changes	yes	no
Diarrhea	yes	no	Joint Pain	yes	no	**Respiratory**		
Stomach Pain	yes	no	Joint Swelling	yes	no	Shortness of breath	yes	no
Heart			Muscle Aches	yes	no	**Skin**		
Chest Pain	yes	no				Dryness of skin	yes	no
Irregular Heartbeat	yes	no				Rashes	yes	no

-

_____«CurrentDate»_____

_____

Patient's Signature **Date** **reviewed – initial and date**

_____

Physician's Signature **Date** **reviewed – initial and date**

Acknowledgement of receipt of privacy notice

I, _____ , acknowledge that I have received a copy of the OrthoNY Notice of Privacy Practices.

Patient's signature or signature of personal representative Date

Witness Date

Note: This page is to be included in the patient's chart.

For internal use only

☐ Receipt received by on

☐ Patient refused to sign receipt (Signature of practice representative)

Financial disclosure

To be completed by all patients
Name: **DOB:**

Assignment and release

I hereby authorize my insurance benefits to be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize that physician to release any information required for billing and payment purposes.

I understand that I am financially responsible for all charges, whether or not covered by insurance.

I understand that I will be charged a $10 fee if I do not pay my co-payment(s) at the time of service.

I understand that I will be charged a collection fee if my account is turned over to a collection agency for non-payment.

Patient's signature Date

No Show Policy

The ORTHONY No Show Policy is as follows:

• A 24 hour notice is required. If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we may accommodate our other patients. You may also reschedule your appointment at this time.

• After the first no show appointment you will receive a phone call to remind you of your missed appointment and to reschedule your appointment. After the second no-show, you (not your insurance company), will be charged a fee for the time slot we were not able to fill when you were a no show. The fee is dependent on the type of visit you were scheduled for.

• On the third no-show, it will be the physician's discretion as to whether you will be discharged from the practice at which point a letter would be sent out discharging you from the practice and giving you 30 days to enroll with a new physician.

Fees:

Office Visit - $25.00
MRI - $75.00
In Office Procedure - $75.00
Surgery - $100.00

Statement to authorize payment of Medicare benefits

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct.

I authorize any holder of medical information about me to release to the Social Security Administration or its carriers, any information required to process my Medicare claims.

I request that payment under the medical insurance program be made to OrthoNY for services provided to me.

Beneficiary signature Date

Non-participation of Provider(s) in your Health Insurance Plan/Network

I understand that OrthopedicsNY, LLP does not participate in my health insurance plan/network. The amount or estimated amount that OrthopedicsNY, LLP will bill you is available upon request. I understand that I am responsible for payment of all services provided.

Beneficiary signature Date