Welcome to Orlin & Cohen Orthopedic Associates, LLP

( ) 2 Lincoln ( ) 36 Lincoln ( ) Cedarhurst ( ) Patchogue

NYS WORKERS' COMPENSATION PATIENT REGISTRATION

Today's Date _____ Which physician are you seeing today?_____

Last Name _____ First Name _____

Address _____ Home Phone _____

City, State, Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

SS# _____ Date of Birth _____ Age _____ Sex ( )Male ( ) Female

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

Who may we thank for referring you to us? _____ Phone _____

Who is your Primary Care Physician? _____ Phone _____

Physician's Address _____

Are you currently working? ( ) Yes ( ) No Retired? ( ) Yes ( ) No Last date worked? _____

Employer _____ Office Phone _____ Occupation _____

Address _____ City _____ State ____ Zip _____

WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Carrier _____ Phone _____

Address _____

Claim No. _____ WCB No. _____

Policy Holder _____Date of Accident_____

Attorney Name _____ Phone _____

Address _____

Date _____ Patient Name _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

INJURY INFORMATION

Date of Injury _____ Time of Injury _____ ( ) AM ( ) PM

Place of Injury _____

Accident reported to employer? ( ) Yes ( ) No Who did you report to? _____

Give a full description of how accident happened. _____

_____

Have you missed time from work? ( ) Yes ( ) No If yes, how much? _____

Are you currently working? ( ) Yes ( ) No If no, last date worked? _____

Did you go to the hospital/urgent care center/physician/chiropractor? ( ) Yes ( ) No If yes, where?

_____

Were x-rays/MRIs taken? ( ) Yes ( ) No If yes, which and where?_____

Were any medications prescribed? If yes, please list _____

Have you been treated for this injury? ( ) Yes ( ) No If so, where? _____

Is this injury an exacerbation of a prior WC claim? ( ) Yes ( ) No If yes, date of prior accident?_____

HISTORY OF PRESENT ILLNESS

Chief Complaint (reason for visit): _____

Body Part: ( ) Right ( ) Left ( ) Shoulder ( ) Elbow ( ) Wrist ( ) Hand ( ) Hip ( ) Leg ( ) Knee
( ) Ankle ( ) Foot ( ) Low Back ( ) Neck ( ) Other _____

Date problem started? _____

Circle the number that best describes your **pain level**: (least severe) 1 2 3 4 5 6 7 8 9 10 (most severe).

How long does the pain last? _____Was there a prior injury to this body part? _____

Is the pain? ( ) Dull ( ) Sharp ( ) Shooting You are: ( ) Right-handed ( ) Left-handed

What treatments have you received (i.e., ice, elevation, medication, therapy)?_____

_____

Does the problem interfere with normal activities? Please explain _____

If applicable, How far can you walk with no or minimal pain?_____

Do you use any support (i.e., brace, cane, walker, other)? _____

Date _____ Patient Name _____

PAST MEDICAL, FAMILY & SOCIAL HISTORY

Allergies to medications? ( )Yes ( )No If yes, please list _____

List all medications you are currently taking _____ _____ _____
_____ _____ _____ _____ _____

Current **personal** illnesses: ( ) diabetes ( ) heart disease ( ) high blood pressure ( ) elevated cholesterol
( ) asthma ( ) thyroid disease ( ) ulcers ( ) peripheral vascular disease ( ) cancer
Other _____

List any **personal** past illnesses and/or surgeries performed and when they occurred: _____
_____

List all serious illnesses in your immediate **family**:_____

Do you smoke? ( )Yes ( )No If yes, how much? _____ Do you drink? ( )Yes ( )No If yes, how much?_____

Do you exercise regularly? ( )Yes ( )No If yes, how much? _____

REVIEW OF SYSTEMS

Have you had any problems related to the following systems in the past year? Circle Y for Yes or N for No.

Constitutional Symptoms			**Dermatologic**			**Gastrointestinal**		
Fever	Y	N	Skin Rash	Y	N	Abdominal pain	Y	N
Chills	Y	N	Boils	Y	N	Nausea/vomiting	Y	N
Headache	Y	N	Persistent Itch	Y	N	Indigestion/heartburn	Y	N
Other _____			Other _____			Other _____		
Eyes			**Musculoskeletal**			**Hematologic/Lymphatic**		
Blurred vision	Y	N	Joint pain	Y	N	Swollen glands	Y	N
Double vision	Y	N	Neck pain	Y	N	Blood clotting problem	Y	N
Pain	Y	N	Back pain	Y	N			
Other _____			Other _____			Other _____		
Allergic/Immunologic			**Ear/Nose/Throat/Mouth**			**Cardiovascular**		
Hay Fever	Y	N	Ear infection	Y	N	Chest pain	Y	N
			Sore throat	Y	N	Varicose veins	Y	N
			Sinus Problem	Y	N			
Other _____			Other _____			Other _____		
Neurologic			**Genitourinary**			**Psychologic**		
Tremors	Y	N	Urine retention	Y	N	Anxiety	Y	N
Dizzy Spells	Y	N	Painful urination	Y	N	Depression	Y	N
Numbness/Tingling	Y	N	Urinary Frequency	Y	N			
Other _____			Other _____			Other _____		
Endocrine			**Respiratory**					
Excessive thirst	Y	N	Wheezing	Y	N			
Too hot/cold	Y	N	Frequent cough	Y	N			
Tired/sluggish	Y	N	Shortness of breath	Y	N			
Other _____			Other _____					

Physician Signature _____ Date _____

Date _____ Patient Name _____

CONSENT INFORMATION

CONSENT TO TREAT

This information I have given this office is complete and true to the best of my knowledge. I authorize the doctors and staff of Orlin & Cohen Orthopedic Associates, LLP, to administer such procedures and treatment as they deem necessary. They have implied no guarantee of cure.

Patient Initials _____ Date _____

CONSENT TO TREAT A MINOR CHILD

The information I have given this office pertaining to _____ is true and complete to the best of my knowledge. I authorize the doctors and staff of Orlin & Cohen Orthopedics, LLP, to administer such procedures and treatment as they deem necessary to my child/ward in my legal custody. The doctors have implied no guarantee of cure.

Parent/Guardian Initials _____ Date _____

FOR WOMEN ONLY

The doctor or a staff member of Orlin & Cohen Orthopedic Associates, LLP, has advised me that x-rays can be hazardous to an unborn child. At this time and to the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patient Initials _____ Date _____

PAYMENT AGREEMENT

I understand that I am required to sign the attached approved *Workers' Compensation A-9* form.

Patient Initials _____ Date _____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have been provided with a copy of Orlin & Cohen Orthopedic Associates, LLP's HIPAA Privacy Notice. I would like to authorize the following parties to have access to my protected health information _____

_____

Signature _____ Date _____