Welcome to Orlin & Cohen Orthopedic Associates, LLP

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

NYS NO FAULT 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 _____________

AUTO INSURANCE INFORMATION

Insurance Company ____ Phone __________________

Address ____

Policy No. __________________________________ Claim No. ____________________________________

Policy Holder ____ Phone ___________________

Attorney Name __________ ____ Phone __________________

Address ____

Have you submitted your *Application for Benefits* to your insurance company? ( ) Yes ( ) No

Name of Examiner ____ Phone ___________________

Date __________ Patient Name ____

Height ___________ Weight _____________ Blood Pressure ____________ Pulse __________

ACCIDENT/INJURY INFORMATION

Date of Accident _________________________ Which seat were you in? _________________________

Your car: ( ) Hit another car ( ) Was hit in the: ( ) Right ( ) Left ( ) Rear ( ) Front

Type of Accident: ( ) Head on collision ( ) Broad side collision ( ) Rear end collision
( ) Front impact (rear ended car in front) ( ) T collision ( ) Pedestrian (you were struck)

Were you wearing a seatbelt at the time of accident? ( ) Yes ( ) No

Did the airbag deploy? ( ) Yes ( ) No ( ) No airbag

Did you go to the hospital? ( ) Yes ( ) No If yes, which hospital? ___________________________________

Were x-rays taken? ( ) Yes ( ) No If yes, where? ____

Were any medications prescribed? If yes, please list ____

Were you in the course of your employment at the time of accident? ( ) Yes ( ) No

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 ___________________________

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? _________

If yes, was the injury from a prior motor vehicle accident? ____

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

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

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

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other ________________		

Dermatologic

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other ________________		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other ________________		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other ________________		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other ________________		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other ________________		

Allergic/Immunologic

Hay Fever	Y	N
Other ________________		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus Problem	Y	N
Other ________________		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
Other ________________		

Neurologic

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Other ________________		

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary Frequency	Y	N
Other ________________		

Psychologic

Anxiety	Y	N
Depression	Y	N
Other ________________		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other ________________		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
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 *New York Motor Vehicle Insurance Law Assignment of Benefits Form* to authorize direct payment to my provider. **Orlin & Cohen Orthopedic Associates, LLP**
165 North Village Ave., Suite 128
Rockville Centre, NY 11570

I further understand that if my claim is denied in whole or in part due to non-compliance with current NYS No Fault Insurance Law requirements, I shall become responsible for my balance.

Signature ____ 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 ______________________