NEW YORK SPORTS & JOINTS ORTHOPAEDIC SPECIALISTS

WC

Today's Date: _____

Last Name: _____ First Name: _____ M.I. _____
Address: _____ Apt _____
City: _____ State: _____ Zip: _____
Home (____)_____ Cell (_____)_____ Work (____)_____
Email: _____
Date of Birth: _____ Sex: F / M Social Security # _____- ____ - _____
Marital Status: S M D W

Who Referred You? _____ Phone (____)_____
Address: _____ City: _____ State: ____ Zip: _____

Family Doctor: _____ Phone (____)_____
Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Occupation: _____
Address: _____ City: _____ State: ____ Zip:_____
Employer Phone(____)_____ Are you still working? YES / NO
If NO, when was your last day? _____ If YES, part time or full time? _____

Emergency Contact Name: _____ Relation to patient: _____
Home (____)_____ Cell (_____)_____ Work (____)_____

Worker's Compensation Carrier: _____ Date of Injury: _____
Did you report this accident to your employer? YES / NO
WCC Number: _____ WCB Number: _____
Adjuster Name: _____ Adjuster Number: _____
Established Body Parts: _____
History of Injury (Please describe how the injury occurred): _____
_____
_____

Attorney Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone (_____)_____ Fax (_____)_____

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Authorization, Assignment and Fee Agreement

In considering the amount of medical expenses to be incurred, I, the undersigned, hereby assign and convey directly to McCulloch Orthopaedic Surgical Services, PLLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor.
If I have, and do not pursue a Worker's Compensation claim, or if payment and benefits(s) under this type of claim is denied for any reason other than providers fees not meeting the applicable schedule, I understand that I am responsible for any amount not covered by insurance benefits, and all reasonable legal fees spent by providers to collect the amount I owe. I am responsible to provide insurance information and referrals, if needed to the provider. Providers can submit any dispute there may be under this authorization, assignment under the American Association New York office.

_____

(Patient Signature / Date)

Notice of Privacy Practice Policies

McCulloch Orthopaedic Surgical Services, PLLC is committed to protecting the privacy of its patients. It is the intent of the above entity to comply with the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable New York State Law. The office of McCulloch Orthopaedic Surgical Services, PLLC.

1. Makes its Notice of Privacy Practice's available upon request to any person.
2. Provides the Notice in person no later than the date of the first service delivery after October 9, 2008.
3. Makes the Notice available at the office, for individuals to take with them upon request.
4. Posts the Notice in a clear and prominent location where it is reasonable to expect the individual receiving service to read the notice.

By signing below, I hereby acknowledge that the full privacy policy has been made available to me and will continue to be upon my request.

_____

(Patient Signature / Date)

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Authorization to Use or Disclose Health Information

Patient Name: _____

Patient Address: _____ City, State, Zip: _____

Patient Phone Number: _____ Patient Email: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual and organization are authorized to make the disclosure: McCulloch Orthopaedic Surgical Services PLLC, as well as any health care provider which I am referred to by the above.

3. The type of information to be used or disclosed is as follows:
   Problem list
   Medication list
   All history and discharge summaries
   All lab results
   All x-ray and imaging reports
   All consultation reports and films
   The entire record relating to my treatment

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. The information identified above may be used by or disclosed to:

   Name: _____ Address: _____

6. This information for which I'm authorizing disclosure will be used for liability claim.

7. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health management department. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. This authorization will expire five years from the date on which it was signed.

9. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

10. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____

Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship to Patient _____

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Medical Questionnaire

FAMILY HISTORY

Illness	Self	Family	Illness	Self	Family
Diabetes			Heart Problems		
High Cholesterol			Cancer		
Hypertension			Asthma		
Strokes			Seizures		

If other please specify: _____

SURGICAL HISTORY

Year	Procedure

Height (In): _____ Weight (Lbs): _____

Please list any allergies you may have:

_____

_____

Are you currently taking non-prescription drugs? YES / NO
If yes please specify: _____

_____

Are you currently taking prescription drugs? YES / NO
If yes please specify: _____

_____

SOCIAL HISTORY

Do you smoke? YES / NO
If yes, how many packs per day? _____

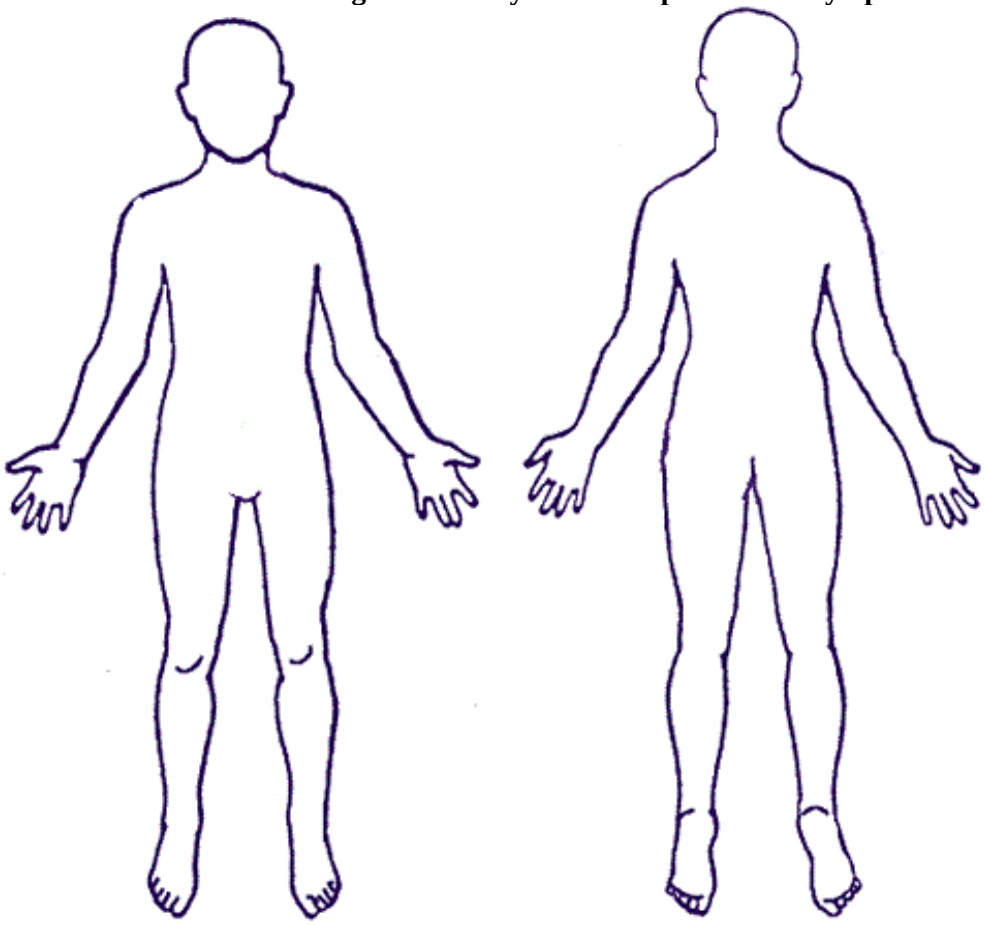
Do you drink? YES / NO
If yes, how often? _____

HISTORY AND SYMPTOMS

Chief Complaint:
1. How long have you had this problem? _____
2. Was this a result of a fall or accident? YES / NO
If yes, please give date ____/____/____
3. Can you work or perform normal activities? YES / NO
If yes, are there any restrictions? _____
4. Check the symptom (s) associated with your chief complaint:
_____Pain _____Numbness _____Tingling _____Weakness _____Muscle Spasm

If other please specify: _____

Please indicate on the diagram where you feel the pain and/or symptoms:



FRONT **BACK**

1. On a scale from 0 to 5 (5 being the worst) how severe is your pain at the onset? _____
2. On a scale from 0 to 5 how severe is your pain today? _____
3. Circle how bad your pain is based on the pictures below:

4. What is the quality of the pain?

Sharp Shooting Stabbing Dull Aching Intermittent Constant

If other, please specify: _____

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5. What makes your problem worse? (Circle all that apply)

Standing	Sitting	Walking	Lifting	Exercise	Twisting
Lying Down	Squatting	Kneeling	Bending	Coughing	Sneezing

If other, please specify: _____

6. What treatments have you had for this problem? (Circle all that apply)

Epidural Injections	Physical Therapy	Massage	Stimulation (TEN)
Acupuncture	Trigger Point Injections	Brace	

If other, please specify: _____

7. Do you have: (Circle all that apply)

MRI Report/Films	X-Ray Films	EMG (Nerve Conduction Studies)
CT Scans	Disco gram	Bone Scan

If other, please specify: _____

8. What medications have you tried for this condition? _____

All information must be filled out before seeing the Doctor

I assign directly to McCulloch Orthopaedic Surgical Services, PLLC all medical insurance and health benefits. I understand that in the event that the services rendered are not covered, or if invalid, that I am responsible for any amount not covered by the insurance carrier.

I authorize the holder of medical information about me, to be released to the NY State Worker's Compensation Board, or any information needed to determine these benefits payable for related services.

_____
Print Name

_____
Signature

_____
Date