SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.
INJURY / ACCIDENT INFORMATION

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____ Sex:_____
Social Security # _____ Marital Status: Single Married Widowed Divorced
Address: _____(Apt # _____) City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #_____ Work Phone #_____
_____
Primary Care Physician: _____ Address: _____Phone: _____
Employer: _____Occupation: _____
Employer Address: _____
Spouse or Parent's Name: _____Work Phone #: _____
Employer: _____
Person to contact in case of an emergency: _____Phone: _____

Pharmacy Name/Address/Phone Number:_____

BODY PARTS / Complaints: _____

Describe How and Where Injury Occurred: _____
Are you out of work due to this injury: Yes No Date Returned to Work: _____

ARE INJURIES RELATED TO:
An Auto Accident? YES NO A Work Related Injury? YES NO

IF INJURIES ARE A RESULT OF AN AUTO ACCIDENT:
Date of Accident: _____
Name of Insurance Company: _____
Insurance Company Address: _____
Name of Insured: _____ Address _____ Telelpone # _____
Policy Number: _____ File Number: _____
Claim Representative: _____ Telephone # _____

IF INJURIES ARE A RESULT OF A WORK RELATED INJURY:
Date of Accident: _____
Name of Employer: _____
Name of Insurance Carrier: _____
Insurance Carrier Address: _____
Was this accident reported? _____ Did you complete an accident report? _____
Carrier Case # _____ WCB # _____
Claim Representative: _____ Telephone # _____
Is There, Or Will There Be A Lawsuit As A Result Of This Accident? _____

Name of Attorney: _____Phone: _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me. In the event that the provider's charges are outstanding, or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the providers charges.

_____ _____
SIGNATURE OF PATIENT, OR PARENT (if minor) DATE

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

MEDICAL HISTORY FORM

NAME: _____ DATE: _____

Chief Complaint: _____ Date of Injury: _____

History of present illness:

Location of pain/problem: _____

How severe is pain/problem (on a scale of 1 – 10) (10 being the worst) _____

Does this pain/problem occur at a specific time? _____

What other signs or symptoms are you having? _____

How long have you had this pain/problem? _____

Where were you at the onset of this pain/problem? _____

What makes the pain/problem better or worse? _____

Have you had previous episodes? _____

How did it start? _____

Allergies to food: _____ □ none

Allergies to medicine: _____ □ none

What medications do you take either prescription or non-prescription:

_____

Previous Surgeries (what kind, where, when?) _____

_____

Previous Hospitalizations (for what, where, when?) _____

_____

Previous Fractures: (of what, when?) _____

Past Medical History:

(Check YES or NO for all)

Diabetes	□ yes	□ no
High Blood Pressure	□ yes	□ no
Cancer	□ yes	□ no
(what kind) _____		
Stroke	□ yes	□ no
Heart Trouble	□ yes	□ no
Arthritis	□ yes	□ no
Convulsions/Seizures	□yes	□ no
Bleeding Tendency	□ yes	□ no
Acute Infection	□ yes	□ no
Venereal Disease	□ yes	□ no
Hereditary Defects	□ yes	□ no
Blood Clots	□ yes	□ no
Gout	□ yes	□ no

What other medical problems to you have? _____

_____

Review of Systems: (check if DENIED / CIRCLE items)

	DENIES	**SYMPTOMS**
Neurological		Headache fainting dizziness seizure numbness tingling weakness
Eyes / Ears / Nose		Vision change double vision pain hearing change ringing in ears smelling change nose bleeds congestion
Throat		Pain difficulty swallowing painful swallowing
Respiratory		Cough wheezing pain asthma short of breath blood in sputum
Cardiovascular		Chest pain palpitations irregular heartbeat swelling skin/color/tem change murmur
GI		Nausea vomiting blood in stool constipation diarrhea bleeding appetite change weight change pain
GU		Frequency hesitancy urgency blood in urine incontinence discharge pain painful urination
Musculoskeletal		Swelling range of motion change pain
Skin		Rash skin change pain itchiness
Psych / Subst Abuse		History of treatment: _____Out-Patient In-Patient Over _____months_____years

Patient Social History:

What kind of work do you do? _____

Are you: □ right handed □ left handed

Marital Status □ single □ married □ separated □ divorced □ widowed

Use of alcohol □ never □ rarely □ moderate □ daily □ recovering alcoholic

Use of tobacco □ never □ previously, but quit □ current pack/day

Use of drugs □ never □ type/frequency

Excessive exposure at home or work to □ fumes □ dust □ solvents □ noise

Family Medical History:	**Age**	**Diseases**	**if deceased, cause of death**
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____

Is there a family history of : □ diabetes □ cancer (what kind) _____ □ heart disease, other

Inherited medical problem: _____

COMPLETED BY: _____

REVIEWED BY: _____

M.D. Signature

SUFFOLK ORTHOPAEDIC ASSOCIATES, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
_____	_____	_____

SUFFOLK ORTHOPAEDIC ASSOCIATES, P.C.

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This form is to be completed in order for this office to better serve your interests in protecting the privacy of your health information. Please complete all sections in order to ensure that your health information is released **ONLY** to the parties you are authorizing.

I, _____, authorize Suffolk Orthopaedic Associates to disclose my protected health information to the parties listed below for purposes other than treatment, payment or healthcare operations. I understand that I retain the right to revoke this authorization and any revocation must be done so in writing to the attention of the Privacy Officer of Suffolk Orthopaedic Associates.

Description of the information to be used or disclosed (check all that apply):

( ) Medical Date / Information as related to:
- ( ) Specific condition(s): _____
- ( ) Specific medication(s): _____
- ( ) Specific procedure(s): _____

Name of person(s) authorized to request my protected health information or to speak with Suffolk Orthopaedic Assoc. regarding my healthcare (i.e. family member or attorney)

_____
_____

Name of person(s) NOT authorized to request my protected health information or to speak with Suffolk Orthopaedic Associates regarding my healthcare:

_____
_____

Purpose(s) of the information (i.e. to assist in care, legal matters):

_____
_____

This authorization permits Suffolk Associates to send the protected health information ONLY to this address or fax number:

_____
_____

Fax Number: _____

This authorization shall remain in effect from the date signed below until _____
(expiration date)

I understand that any information used or disclosed prior to this authorization may be subject to re-disclosure and may no longer be protected health information.

Patient Name: _____ ***Signature:*** _____

Relationship to Patient: _____ ***Date:*** _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS	APT. NO.
EMPLOYER			
INSURANCE CARRIER			

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature X _____ Date _____

Provider's Name and Address _____

_____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.