

**Welcome to Orlin & Cohen Orthopedic Associates, LLP**

( ) 2 Lincoln ( ) 36 Lincoln ( ) Cedarhurst ( ) Bohemia ( ) Merrick ( ) 64 N. Long Beach

**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

Were you referred here for a consultation by another Physician, Physical Therapist or Lawyer? ( ) Yes ( ) No  
If yes, who is requesting this?

\_\_\_\_\_  
Name / Address / Phone/Fax

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

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

Primary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Address \_\_\_\_\_

Patient Relationship to Insured ( ) Self ( ) Spouse ( ) Child ( ) Other \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Policy No. \_\_\_\_\_ Address \_\_\_\_\_

IF YOU ARE COVERED UNDER ANOTHER PERSON'S INSURANCE, PLEASE COMPLETE:

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Appointment Date \_\_\_\_\_ What Dr. are you seeing today? \_\_\_\_\_

CC: Chief complaint: What is the reason for this visit? \_\_\_\_\_

Did you bring films/disc? X-Ray  Y  N MRI  Y  N CD/DVD  Y  N

Location: What is the location of your injury? *Check all that apply*

Spine/Back  Neck  R Shoulder  L Shoulder  R Arm  L Arm  R Elbow  L Elbow  L Wrist  R Wrist  
 R Hand  L Hand  R Hip  L Hip  Toes  Finger  Pelvis  Chest  Ribs  Clavicle  
 R Leg  L Leg  R Knee  L Knee  R Ankle  L Ankle  R Foot  L Foot Other: \_\_\_\_\_

**State of NY – Workers Compensation: If this injury was WORK RELATED, Please answer all of the questions below.**

Check the ONE box which best describes how your problem started and answer the questions asked.

NO INJURY or onset was:  Gradual  Sudden

INJURY AT WORK From a:  lift  twist  fall  bend  pull  reach Date: \_\_\_\_\_ Time: \_\_\_\_\_ Where? \_\_\_\_\_

WORK RELATED (BUT NO INJURY) Date: \_\_\_\_\_ How did your job cause the problem? \_\_\_\_\_

Have you missed time from work?  Y  N If yes, how much? \_\_\_\_\_ days/weeks/months/years

When is the last date you worked at your regular job? Date: \_\_\_\_\_

If you are NOT currently working, is your goal to return to work?  Y  N

Current Work Status?  Regular  Light Duty  Not working due to this injury  Disabled  Retired  Student

Are you currently receiving or plan to apply for: Disability:  Y  N Worker's Comp:  Y  N Unemployment:  Y  N

Was your injury reported to your employer?  Y  N If so, who did you report it to? \_\_\_\_\_

Were you hospitalized for this injury?  Y  N On date of injury what was your job title/description? \_\_\_\_\_

On date of the injury what were your work activities? \_\_\_\_\_

Please write specific details of your problem (if accident/injury, list details):  
\_\_\_\_\_  
\_\_\_\_\_

Are you being treated by another physician for this condition/injury?  Y  N If yes: Dr. \_\_\_\_\_

What tests/scans have you had for this problem?  X-Ray  MRI  CT Scan  Bone Scan  Nerve Test (EMG)

If yes, what location? (Name of office, hospital, radiology cite) \_\_\_\_\_

Dominant Hand  L  R  Ambidextrous (both)

**If this injury was due to a MOTOR VEHICLE ACCIDENT, please answer the questions below**

Were you wearing a seat belt at the time of the accident?  Y  N Did your airbag deploy?  Y  N

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  T collision  You were a Pedestrian

Date of Accident: \_\_\_\_\_

Did you go to the hospital for this problem?  Y  N If yes, which hospital? \_\_\_\_\_

What type of pain do you have?  Burning  Diffuse  Dull/Aching  Localized  Radiating  Sharp  
 Shooting  Stabbing  Throbbing  Tightness  Tingling

What is your level of pain when active? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your level of pain at rest? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your severity of pain? Please Circle 0 1 2 3 4 5 6 7 8 9 10 most severe

\_\_\_\_\_  
 Last Name                      First Name                      Date

Duration: How long have you had your pain? 1 2 3 4 5 6 7 8 9 10 11 12 Hours / Days / Weeks / Months / Years

Have you had a problem like this before?  Y  N Date original problem/condition started? \_\_\_\_\_

Is your pain with activity?  Constant or  Intermittent (comes and goes)  Frequent  Occasional

When do you have the worst pain?  Morning  Afternoon  Night  with Activity

Does your pain affect your ability to asleep?  Y  N

Does your pain get better with? *Please Circle* Warmth or Cold Does it get worse with? Warmth / Cold / Dampness

What makes your symptoms/pain worse?  Stretching  Sitting  Standing  Twisting  Walking  Bending  Squatting  
 Kneeling  Warmth  Cold  Lifting  Exercise  Stairs  Lying in bed  Coughing  Other: \_\_\_\_\_

Context: Which make your symptoms/pain better?  Rest  Rx Meds  Elevation  Ice  Heat  Massage

What are you treating your pain with? \_\_\_\_\_

Have you had any of these treatments?  Injections  Brace/s  Physical Therapy

Associated signs and symptoms: Do you have any of the following? *check all that apply*  None (denies any symptoms)

- Blurred Vision  Depression  Irritability/Mood Swings  Localized Tingling  Nausea  Ringing in Ears
- Stiffness  Headaches  Weakness  Aches  Burning  Cold Limb(s)  Difficulty Walking  Sleep Disturbance
- Dizziness  Ecchymosis  Chronic Fatigue  Fever  Heartburn  Joint Stiffness  Muscle Spasm
- Muscle Weakness  Numbness  Pale Bluish Skin  Pins & Needles  Rhinorrhea  Shortness of Breath  Sweating
- Swelling  Locking/Catching  Loss of control of bladder or bowel  Bruises

REVIEW OF SYSTEMS                      Have you had any problems related to the following systems?                      *Circle all that apply*

<b>Constitutional Systems</b>	Chills	Fever	Headache	None
<b>Eyes</b>	Blurred	Double Vision	Vision Change	None
<b>Ear/Nose/Throat</b>	Earache	Sore Throat	Sinus Congestion	None
<b>Cardiovascular</b>	Chest Pain	Shortness of Breath	Palpations	None
<b>Respiratory</b>	Chronic Cough	Wheezes	Asthma	None
<b>Gastrointestinal</b>	Abdominal Pain	Nausea	Bowel Habit Changes	None
<b>Genitourinary</b>	Frequent Urination	Urine Retention	Kidney Problems	None
<b>Musculoskeletal</b>	Neck Pain	Back Pain	Joint Pain	None
<b>Skin</b>	Rash	Skin Discolor	Persistent Itch	None
<b>Neurologic</b>	Stroke	Weakness	Vertigo	None
<b>Psychiatric</b>	Anxiety	Depression	Sleep Disorders	None
<b>Endocrine</b>	Thirst Increase	Sweats	Thyroid Disease	None
<b>Hematologic/Lymphatic</b>	Swollen Glands	Blood Clotting Problem	Anemia	None
<b>Allergic/Immunologic</b>	Hay Fever			None

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name First Name Date

Vitals: What is your height and weight? Height: \_\_\_\_\_ Ft \_\_\_\_\_ Inches Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Do you take anti coagulants? (blood thinners) *check all that apply*

Plavix/Clopidogrel  Coumadin/Warfarin  Fragmin  Lovenox  Platal

**PAST MEDICAL HISTORY (PHX)**

Have you had any prior Orthopedic Surgery?  Yes  No If yes: Procedure & Date \_\_\_\_\_

Please list any other Surgery you have had by operation (type) and date: \_\_\_\_\_

**CURRENT PERSONAL ILLNESSES: *Check all that apply***

None (denies any personal illnesses)  
 Diabetes  Heart Disease  High Blood Pressure  Elevated Cholesterol  Lung Disease  Thyroid Disease  Ulcers  
 Peripheral Vascular Disease  Cancer  Pacemaker  Kidney Disease  Liver Disease  Seizures  Psychiatric Disorders  
 Serious Infection  HIV  Hepatitis  Other \_\_\_\_\_, \_\_\_\_\_

**FAMILY HISTORY (FHX)**

Is there a family history of medical or orthopedic conditions?  Yes  No

If yes; please list \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Which family member: (Mother, Father, Sister) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Have you or any family member had a blood clot (Deep Vein Thrombosis)?  Yes  No

**SOCIAL HISTORY (SHX) *Check all that apply***

Marital Status:  Single  Married  Divorced/Separated  Widowed  Child

Tobacco usage:  Yes  No If yes; How many packs per year/day/month? \_\_\_\_\_

Alcohol usage:  Non-Drinker  Social Drinker  Alcoholic Have you been treated for alcohol addiction?  Yes  No

Drug usage:  Yes  No If yes; (check off type used)  Marijuana  Cocaine  Amphetamines  Other \_\_\_\_\_

Have you been treated for drug addiction?  Yes  No

Do you now or have you ever used illicit or intravenous drugs?  Yes  No

**MEDICATIONS:** please list current medications and doses  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**ALLERGIES:** Do you have any allergies?  Yes  No

Drug Allergy  Yes  No If yes; Drug Name \_\_\_\_\_ Type of Reaction & Date \_\_\_\_\_

Food Allergy  Yes  No If yes; Food \_\_\_\_\_ Type of Reaction & Date \_\_\_\_\_

Environmental Allergy (example; latex, dust, pet dander, grass)  Yes  No

If yes, what are you allergic to? \_\_\_\_\_ Type of Reaction & Date \_\_\_\_\_

### Pharmacy Information Sheet

We can send your prescriptions directly to your pharmacy so that there is less waiting time for you. If you know your pharmacy, please complete the below form. Please be aware that the easiest way for us to find your pharmacy is to know the zip code.

Your Name:		Date of Birth:	
Pharmacy Name:			
Address:			
City:	State:	Zip:	
Pharmacy Phone #:	Pharmacy Fax:		

List any additional pharmacies below.

Pharmacy Name:			
Address:			
City:	State:	Zip:	
Pharmacy Phone #:	Pharmacy Fax:		

Pharmacy Name:			
Address:			
City:	State:	Zip:	
Pharmacy Phone #:	Pharmacy Fax:		

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.

Patients 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 the best of my knowledge, I am not pregnant. I consent to having x-rays taken.

Patients Initials \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT AGREEMENT/ASSIGNMENT OF BENEFITS**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse the issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of information pertinent to my case to my insurance company, claims adjuster or attorney involved in this case.

I hereby instruct and direct my insurance company to directly reimburse my provider for charges incurred on my behalf. Please remit payment directly to:

**Orlin & Cohen Orthopedic Associates, LLP  
1728 Sunrise Highway  
Merrick, NY 11566**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian's 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 \_\_\_\_\_