Orlin & Cohen Medical Specialists Group

Patient Label

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

Preferred Method of Communication: Please choose from the following: Email ( ) Phone-home ( ) Phone-cell ( ) Phone-work ( ) Mail ( ) Other _____

☐ By checking this box, I certify that I am 18years of age or older, the email address provided is my personal email address, and I also consent to receiving on going communication from Orlin & Cohen Medical Specialists group including company news, information and announcements.

Provider may send me email messages such as appointment reminders, statements, or other material. ( ) Yes ( ) No

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 THE PATIENT IS A MINOR OR UNDER THE SUPERVISION OF A LEGAL GUARDIAN, THEN THE RESPONSIBLE PARTY MUST COMPLETE THE FOLLOWING SECTION

Guardian/Guarantor _____ Date of Birth _____ SS# _____

Address _____ City _____ State ____ Zip _____

Employer/Name/Address_____ Office Phone _____

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:_____

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. _____

Where were you when this happend? _____

What was your activity at the time of the injury? (Ex: Walking down stair, jogging, etc.) _____

If you fell, what was the height of your fall? _____

Were you injured by a object? ☐ Y ☐ N

If yes, Type of object? (Be specific) _____

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

If yes, where? _____

Dominant Hand ☐ L ☐ R ☐ Ambidextrous (both)

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

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

_____/_____

Last Name **First Name** **Date**

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

Does your pain affect your ability to asleep? ☐ Y ☐ N

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

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***

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

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:	

_____/_____

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) ☐ Plavix/Clopidogrel ☐ Coumadin/Warfarin ☐ Fragmin ☐Lovenox ☐ Platal
check all that apply

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 □
Smoking Status: □ Never Smoked □ Former Smoker □ Current every day Smoker □ Current someday Smoker
If you smoke, how many packs a day? _____

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_____

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 Medical Specialists Group 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 Medical Specialists Group 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 Medical Specialists Group 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. Patients Initials_____ Date_____

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 Medical Specialists Group
PO Box 412013
Boston, MA 02241-2013

Patient/Guardian Signature _____ Date_____

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

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

Signature_____ Date_____

HIPAA AUTHORIZATION TO RELEASE

I authorize/give permission to the following people to receive my protected health information. List school, office etc…
_____Signature_____ Expiration Date: _____

CONSENT TO ACCESS THE NATIONAL RXHUB

I have agreed to allow Orlin & Cohen Medical Specialists Group to access my current list of medications via the National RxHub.

Signature_____ Date_____