Orlin & Cohen Medical Specialists Group

Patient Label

NYS WORKERS' COMPENSATION 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 Orthopedic 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? _____

Current Employer _____ Office Phone _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer at time of injury_____

Who is your Primary Care Physician? _____ Phone _____

Physician's Address _____

WORKERS' COMPENSATION INSURANCE INFORMATION (if minor, list guardian)

Insurance Carrier _____ Phone _____

Address _____

Claim No. _____ WCB No. _____

Policy Holder _____Date of Accident_____

Attorney Name _____ Phone _____

Address _____

PLEASE LIST THE PATIENTS PRIVATE INSURANCE INFORMATION BELOW

Name of Insured _____ Date of Birth _____ SS# _____

Address _____ City _____ State ____ Zip _____

Employer _____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:_____

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 <u>how your problem started</u> 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?_____

☐ WERE YOU INJURED BY AN OBJECT: ☐Y ☐N If yes what type of object?_____

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? _____

Have you attended PT for your WC injury? ☐ Y ☐ N If so, when was your first visit? _____ last visit_____ don't know_____

If you are attending PT, what is the name of the physical therapy facility? _____

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/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_____

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_____ 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.

Employee Claim

C-3

State of New York - Workers' Compensation Board

Fill out this form to apply for workers' compensation benefits because of a work injury or work-related illness. Type or print neatly. This form may also be filled out on-line at www.wcb.state.ny.us.

WCB Case Number (if you know it): _____

A. YOUR INFORMATION (Employee)

1. Name: _____ (First / MI / Last) 2. Date of Birth: ____/____/____

3. Mailing address: _____ (Number and Street/PO Box / City / State / Zip Code)

4. Social Security Number: ___ - ___ - ____ 5. Phone Number: (___) _____ 6. Gender: ☐ Male ☐ Female

7. Do you speak English? ☐ Yes ☐ No If no, what language do you speak? _____

B. YOUR EMPLOYER(S)

1. Employer when injured: _____ 2. Phone Number: (___) _____

3. Your work address: _____ (Number and Street / City / State / Zip Code)

4. Date you were hired: ____/____/____ 5. Your supervisor's name: _____

6. List names/addresses of any other employer(s) at the time of your injury/illness: _____

7. Did you lose time from work at the other employment(s) as a result of your injury/illness? ☐ Yes ☐ No

C. YOUR JOB on the date of the injury or illness

1. What was your job title or description? _____

2. What types of activities did you normally perform at work? _____

3. Was your job? (check one) ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Volunteer ☐ Other: _____

4. What was your gross pay (before taxes) per pay period? _____ 5. How often were you paid? _____

6. Did you receive lodging or tips in addition to your pay? ☐ Yes ☐ No If yes, describe: _____

D. YOUR INJURY OR ILLNESS

1. Date of injury or date of onset of illness: ____/____/____ 2. Time of injury: _____ ☐ AM ☐ PM

3. Where did the injury/illness happen? (e.g., 1 Main Street, Pottersville, at the front door) _____

4. Was this your usual work location? ☐ Yes ☐ No If no, why were you at this location? _____

5. What were you doing when you were injured or became ill? (e.g., unloading a truck, typing a report) _____

6. How did the injury/illness happen? (e.g., I tripped over a pipe and fell on the floor) _____

7. Explain fully the nature of your injury/illness; list body parts affected (e.g., twisted left ankle and cut to forehead): _____

YOUR NAME: _____ (First / MI / Last) DATE OF INJURY/ILLNESS: ____/____/____

D. YOUR INJURY OR ILLNESS *continued*

8. Was an object (e.g., forklift, hammer, acid) involved in the injury/illness? ☐ Yes ☐ No If yes, what? _____

9. Was the injury the result of the use or operation of a licensed motor vehicle? ☐ Yes ☐ No
   If yes, ☐ your vehicle ☐ employer's vehicle ☐ other vehicle License plate number (if known): _____
   If your vehicle was involved, give name and address of your motor vehicle insurance carrier: _____
   _____

10. Have you given your employer (or supervisor) notice of injury/illness? ☐ Yes ☐ No
    If yes, notice was given to: _____ ☐ orally ☐ in writing Date notice given: ____/____/____

11. Did anyone see your injury happen? ☐ Yes ☐ No ☐ Unknown If yes, list names: _____
    _____

E. RETURN TO WORK

1. Did you stop work because of your injury/illness? ☐ Yes, on what date? ____/____/____ ☐ No, skip to Section F.
2. Have you returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ regular duty ☐ limited duty
3. If you have returned to work, who are you working for now? ☐ Same employer ☐ New employer ☐ Self employed
4. What is your gross pay (before taxes) per pay period? _____ How often are you paid? _____

F. MEDICAL TREATMENT FOR THIS INJURY OR ILLNESS

1. What was the date of your first treatment? ____/____/____ ☐ None received (skip to question F-5)
2. Were you treated on site? ☐ Yes ☐ No
3. Where did you receive your first off site medical treatment for your injury/illness? ☐ none received ☐ Emergency Room
   ☐ Doctor's office ☐ Clinic/Hospital/Urgent Care ☐ Hospital Stay over 24 hours
   Name and address where you were first treated: _____
   _____ Phone Number: (____)_____
4. Are you still being treated for this injury/illness? ☐ Yes ☐ No
   Give the name and address of the doctor(s) treating you for this injury/illness: _____
   _____ Phone Number: (____)_____
5. Do you remember having another injury to the same body part or a similar illness? ☐ Yes ☐ No
   If yes, were you treated by a doctor? ☐ Yes ☐ No If yes, provide the names and addresses of the doctor(s) who treated you and **COMPLETE AND FILE FORM C-3.3 TOGETHER WITH THIS FORM:**
   _____
   _____
   _____
6. Was the previous injury/illness work related? ☐ Yes ☐ No
   If yes, were you working for the same employer that you work for now? ☐ Yes ☐ No

I am hereby making a claim for benefits under the Workers' Compensation Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief.

Any person who knowingly and with INTENT TO DEFRAUD presents, causes to be presented, or prepares with knowledge or belief that it will be presented to, or by an insurer, or self-insurer, any information containing any FALSE MATERIAL STATEMENT or conceals any material fact, SHALL BE GUILTY OF A CRIME and subject to substantial FINES AND IMPRISONMENT.

Employee's Signature: _____ Print Name: _____ Date: ____/____/____

On behalf of Employee: _____ Print Name: _____ Date: ____/____/____

An individual may sign on behalf of the employee only if he or she is legally authorized to do so and the employee is a minor, mentally incompetent or incapacitated.

I certify to the best of my knowledge, information and belief, formed after an inquiry reasonable under the circumstances, that the allegations and other factual matters asserted above have evidentiary support, or are likely to have evidentiary support after a reasonable opportunity for further investigations or discovery.

Signature of Attorney/Representative (if any): _____ Date: ____/____/____

Print Name: _____ Title: _____

ID No., if any: R _____ If Licensed Representative, License No.: _____ Expiration 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_____