Orlin & Cohen Medical Specialists Group

Patient Label

PATIENT REGISTRATION

Today's Date _____ Date of Accident _____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 _____

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

Ethnicity: (check one) ( ) Hispanic or Latino ( ) Not Hispanic or Latino ( ) Unknown

Race: (circle one) American Indian / Asian / Black or African American / Native Hawaiian / White / Other Race

Primary Language: (circle one) English / Spanish / French / Italian / German / Portuguese / Japanese / Chinese / Russian / Other

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 _____

PAIN MANAGEMENT E H R NEW PATIENT INTAKE FORM

Patient Name: _____ What doctor are you seeing today? Dr._____ Date: _____

Please write specific details of your problem/pain:

_____

_____

Where is your pain today? □ Low Back □ Neck □ Right Leg □Left Leg □ Right Arm □ Left Arm □ Mid Back □ Upper Back □Buttock □ Head OTHER_____

Duration: How long have you had your pain? 1 2 3 4 5 6 7 8 9 10 11 12 □ days □ weeks □ months □years
Please Circle

Timing: Is your pain? □ Constant or □ Intermittent (comes and goes) □ Frequent □ Occasional

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

Does your pain radiate? □Yes □ No **If yes, Where to;** □ Right Leg/Above Knee □ Right Leg/Below Knee □ Left Leg/Above Knee
□Left Leg/Below Knee □ Right Arm/Above Elbow □ Right Arm/Below Elbow □ Left Arm/Below Elbow □ Left Arm/Above Elbow
□ Upper Back □ Head □ Buttock Other _____

Associated signs and symptoms: Do you have any of the following? ***check all that apply***

□ Numbness/Tingling □ Weakness □ Pins & Needles □ Loss of control of bladder or bowel □ Headaches □ Muscle Spasms
Other _____

Severity: On a scale of 0 – 10 What is your pain today? *Please Circle* 0 1 2 3 4 5 6 7 8 9 10 most severe

What is your level of pain with activity? *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

How is your condition changing? ***check all that apply*** □ Getting Better □ Not Changing □ Getting Worse

Context: Which make your symptoms/pain better?

□ Rest □ Meds □ Bending/Leaning Forward □ extending back □ Ice □ Heat
□ Sitting □ Standing □Walking/Activity □ Massage □ Physical Therapy □Chiropractor □ Injection Therapy □ Acupuncture □Yoga
□ Nothing Helps □ Other _____

What makes your symptoms/pain worse?

□ Stretching □ Sitting □ Standing □ Twisting □Walking □ Bending forward □ Extending back □ Warmth □ Cold □Lifting
□ Exercise □ Stairs □ Lying in bed □ Coughing □ Physical Therapy □ Other _____

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

Does the pain affect your activity in these different areas? ***check all that apply***

□ Household Chores □ Leisure □ Work □ Sleep □ Sexual Activity □ Social Interactions □ Other: _____

Do you need support to help you ambulate? ***Please Circle*** Brace / Cane / Walker/ Prosthesis / Other _____

What tests/scans have you had for this problem?

□ X-Ray □MRI □ CT Scan □Bone Scan □ Nerve Test (EMG/NCV)

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

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?_____
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 □ **On date of injury what was your job title/description?** _____
On date of the injury what were your work activities? _____

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 is the name and specialty of ALL previous physicians you have seen for your pain?
Example: orthopedic surgeon, neurologist

Physician	Specialty	Treatment & Dates	Address & Telephone

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

Vitals: **What is your height and weight? Height:** _____ Ft _____ Inches **Weight:** _____ lbs _____ oz

PAST MEDICAL HISTORY (PHX)

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) _____,_____,_____

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 (ALL Medications): please list current medications and doses □ No Medications

Please circle medications that you need refilled today.

_____/_____/_____

_____/_____/_____

Do you have any *SIDE EFFECTS* from the medications? □ Y □ N **If yes, which ones?** □ Drowsiness □ Constipation □ Nausea
□ Itchiness OTHER_____

Do you take anti coagulants? (blood thinners) □ Plavix/Clopidogrel □ Coumadin/Warfarin □ Fragmin □Lovenox
□Aspirin/Ecotrin □ Anti-Inflammatory medications

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

Drug Allergy □ Yes □ No If yes; Drug Name _____Type of Reaction & Date _____

Shell fish/ Contrast dye Allergy □ Yes □ No If yes; Type of Reaction & Date _____

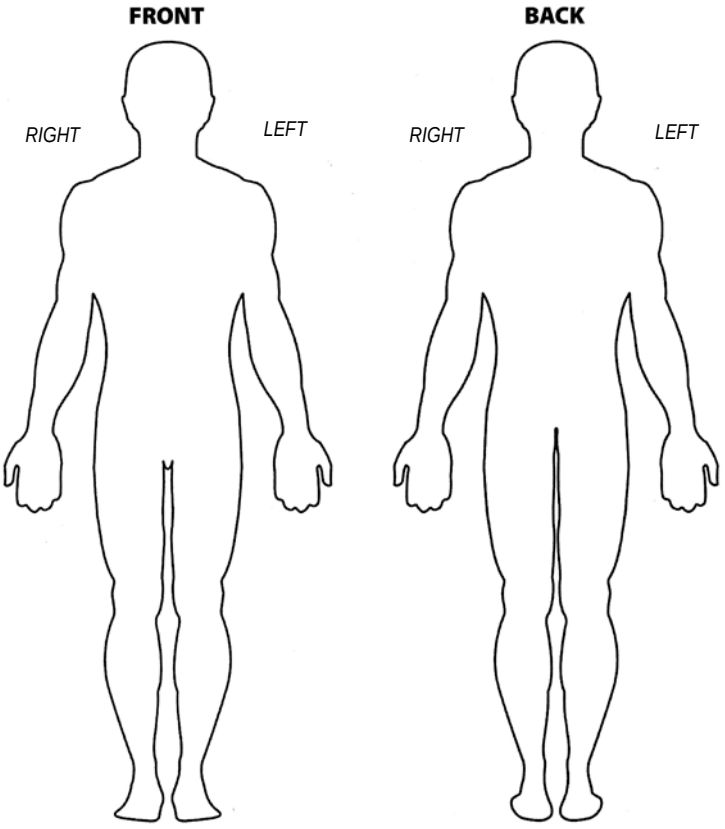
Environmental Allergy (example; latex, dust, pet dander, grass) □ Yes □ No

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:	



Please use the appropriate symbols to describe your symptoms and mark the location as accurately as possible on the body drawing to the left:

- **ACHING - AAAAA**
- **STABBING - ///////**
- **TINGLING - _____**
- **BURNING - XXXXX**
- **NUMBNESS - 00000**

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_____