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 _______________

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? _______________

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 ________________________

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 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?__________________________

□ **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 □ **On date of injury what was your job title/description?** ____________________

On date of the injury what were your work activities? ____

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 _____________________

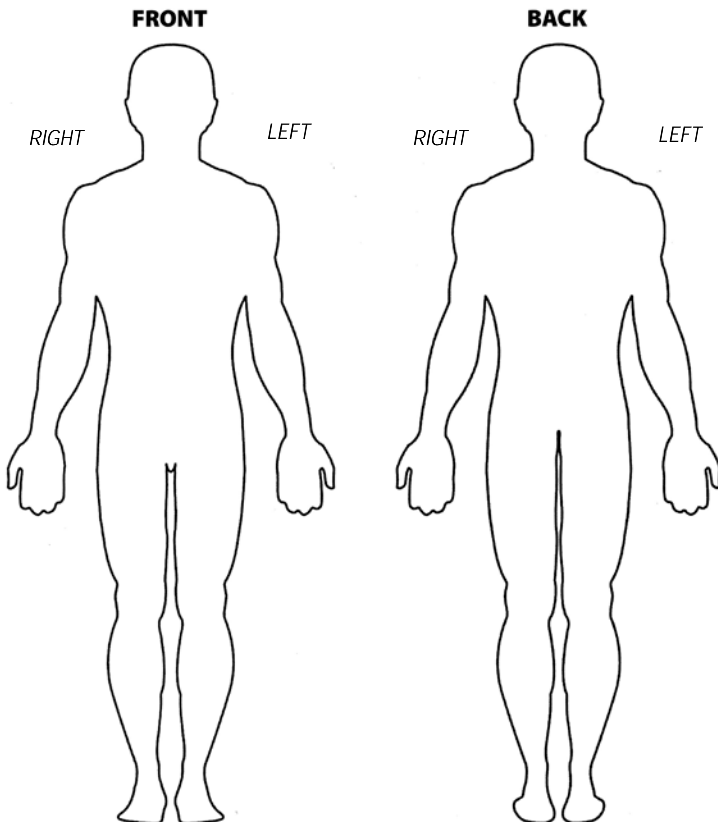
Environmental Allergy (example; latex, dust, pet dander, grass) □ Yes □ No

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**

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.

	NAME	ADDRESS APT. NO.
CLAIMANT		
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.

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________________________