

Welcome to Orlin & Cohen Orthopedic Associates, LLP

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

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

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
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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 _____

WORKERS' COMPENSATION INSURANCE INFORMATION

Insurance Carrier _____ Phone _____

Address _____

Claim No. _____ WCB No. _____

Policy Holder _____ Date of Accident _____

Attorney Name _____ Phone _____

Address _____

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/NCV)
If yes, where? _____

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

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

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 _____

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.

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.

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

Patient 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
165 North Village Ave., Suite 128
Rockville Centre, NY 11570**

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 _____