

Welcome to Orlin & Cohen Orthopedic Associates, LLP

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

NYS NO FAULT 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

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 _____

AUTO INSURANCE INFORMATION

Insurance Company _____ Phone _____

Address _____

Policy No. _____ Claim No. _____

Policy Holder _____ Phone _____

Attorney Name _____ Phone _____

Address _____

Have you submitted your *Application for Benefits* to your insurance company? () Yes () No

Name of Examiner _____ 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 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 _____

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

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*

If "No" mark NONE / If "Yes" write Details or Comments below

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	Palpations	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

_____/_____
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 _____

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM**

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, (Assignor) hereby assign to Orlin and Cohen Orthopedic Associates, LLP, (Assignee) all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement to the contrary.
(Print Accident Date)

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS, OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDELENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of Signature)

(Address of Patient)

Orlin and Cohen Orthopedic Associates
(Print Name of Provider)

(Signature of Provider)

1728 Sunrise Highway

(Date of Signature)

Merrick, New York 11566

(Address of Provider)

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS**

NAME AND ADDRESS OF INSURER *

NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*
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DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER
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TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

- IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME BUSINESS
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3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.
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6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE
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8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: A BUS OR SCHOOL BUS, A TRUCK, AN AUTOMOBILE,
 OR A MOTORCYCLE

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS -- PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES NO

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOU WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? IN-PATIENT?

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:

\$ _____

15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?

YES NO

16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?

YES NO

17. DID YOU LOSE TIME FROM WORK?

YES NO

DATE ABSENCE FROM WORK BEGAN:

HAVE YOU RETURNED TO WORK?

YES NO

IF YES, DATE RETURNED TO WORK: _____

AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?

NUMBER OF DAYS YOU WORK PER WEEK:

NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES NO

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES NO

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

NEW YORK STATE DISABILITY? YES NO

WORKERS' COMPENSATION?

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS -- PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE

DATE

.....
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE)

SOCIAL SECURITY NO.

SIGNATURE

DATE

.....
DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE)

SIGNATURE

DATE

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3

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:		

List any additional pharmacies below.

Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

Pharmacy Name:		
Address:		
City:	State:	Zip:
Pharmacy Phone #:	Pharmacy Fax:	

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.

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 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 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.

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
1728 Sunrise Highway
Merrick, NY 11566**

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 _____