MANHATTAN ORTHOPEDIC & SPORTS MEDICINE GROUP, P.C.

## New Patient/Update Intake Forms

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Last Name:_____ First Name:_____ DOB:___/___/____

Social Sec#:_____ Sex: _____ Marital Status: ☐ S ☐ M ☐ D ☐ Sep

Address:_____ Apt#:____ City/State/Zip:_____

Home Phone (____)_____ Cell Phone:(__)_____ Work Phone: (___)_____

Email Address: _____ Please enter your email address to allow us to contact you

Primary Care Physician: (Name, Address, Tel)_____ Age:_____

Pharmacy: (Name, Address, Tel)_____

## EMPLOYER INFORMATION:

Employer:_____ Job Title:_____ Phone: (____)_____

Address:_____

## EMERGENCY CONTACT:

Last Name:_____ First Name:_____ DOB: ___/___/____

Relationship: _____ Address:_____

Home Phone (____)_____ Cell Phone (_)_____ Work Phone (____)_____

***Is the injury work related or a car accident? ____ Yes ___ No***

***If yes, please circle one of the following: Work Related Car Accident***

## INSURANCE INFORMATION

Health Insurance Carrier: _____ (Receptionist will copy your card)

Insured's Information if not the same as the patient:

Name: _____ D.O.B: _____ SS#: _____

Secondary Insurance Carrier: _____ (Receptionist will copy your card)

Insured's Information if not the same as the

patient: Name: _____ D.O.B: _____ SS#: _____

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## Please tell us how you heard about us:

☐ I am a Previous Patient

☐ Referring Physician

Please Specify _____

☐ Primary Physician

Please Specify _____

☐ Internet

Please Specify _____

☐ Family/Friend

Please Specify _____

☐ Insurance

Please Specify _____

☐ Other

Please Specify _____

☐ NYC Triathlon Expo

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What is the reason for today's visit? (Include Right or Left)_____

## REVIEW OF SYMPTOMS:

| Please circle all that apply: | Circle | If Yes Date | Please circle all that apply: | Circle | If Yes Date |
|---|---|---|---|---|---|
| **Constitutional** e.g. Fever, weight loss, malaise | ☐YES ☐NO | | **Musculoskeletal** e.g. fracture, sprains, stiffness | ☐YES ☐NO | |
| **Eyes** e.g. Blurring, double vision, glasses | ☐YES ☐NO | | **Skin/Breast** e.g. Rashes, lesions, scars, masses | ☐YES ☐NO | |
| **Ear, Nose, Throat** e.g. Deafness, sinusitis, vertigo | ☐YES ☐NO | | **Neurological** e.g. Seizures, balance, memory, stroke | ☐YES ☐NO | |
| **Cardiovascular** e.g. chest pain, palpitations, high blood pressure | ☐YES ☐NO | | **Psychiatric** e.g. Depression, sleep disturbance, hallucination | ☐YES ☐NO | |
| **Respiratory** e.g. Shortness of breath, cough, asthma | ☐YES ☐NO | | **Endocrine** e.g. increased urinat ion, obesity, growth or hair changes | ☐YES ☐NO | |
| **Gastrointestinal** e.g. appetite, abdominal pain, constipation, weight change | ☐YES ☐NO | | **Hematologic/Lymphatic** e.g. Bleeding tendency, anemia, lymph node pain or enlargement | ☐YES ☐NO | |
| **Genitourinary** e.g. Hesitancy, incontinence, pregnancies, menstrual problems | ☐YES ☐NO | | **Allergic/Immunologic** e.g. Allergies, dermatitis, eczema | ☐YES ☐NO | |

**Pt. Height:** _____ **Pt. Weight:** _____ **Lbs.**

Medical Conditions: _____

Previous Surgeries: _____

Current Medications: _____

Drug Allergies: _____

Family Medical History: _____

I certify that the above is correct and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

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Name: _____ Date: _____

If you would please take a moment to answer the following questions that we are now required by law to retrieve from you.

**Language:** ☐ English ☐ Other: _____

**Ethnicity:**
☐ Hispanic or Latino Not
☐ Hispanic
☐ Unknown

**Race:**
☐ American Indian
☐ Asian
☐ African American
☐ White
☐ Pacific Islander
☐ Other: _____

**Smoker:**
☐ Current Every Day
☐ Current Some Day
☐ Current Status Unknown
☐ Former Smoker
☐ Never Smoker
☐ Unknown if ever smoked

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Did you have a drink containing alcohol in the past year?

☐ Yes ☐ No

If 'Yes': How often did you have a drink containing alcohol in the past year?

☐ Never ☐ 2 to 4 times a month ☐ 4 or more times a week
☐ Monthly or less ☐ 2 to 3 times a week

If 'Yes': How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 to 2 drinks ☐ 5 to 6 drinks ☐ 10 or more drinks
☐ 3 to 4 drinks ☐ 7 to 9 drinks

'If 'Yes': How often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Weekly
☐ Less than monthly ☐ Daily or Almost Daily
☐ Monthly

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In the past year have you had :

☐ No falls ☐ Two or more falls with injury
☐ One fall without injury ☐ Two or more falls without injury ☐ One
fall with injury

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# Financial Policy

Thank you for choosing MOSM as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

We must emphasize that as medical care providers; our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date of service is rendered are your responsibility. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract .

If the physician participates with your managed care medical insurance, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment . If you insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we well bill surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is pain in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account.

## ***Canceled Appointments***

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged $50.00.

## ***Dependent Children***

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of the practice.

## ***Workers Compensation / No Fault***

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim. We realize that temporary financial problems may affect timely payment of your account . If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (212) 289-0700.

## ***Payment***

I hereby authorize and instruct the insurance company(s) noted to pay authorized benefits on my behalf to MOSM. This payment will not exceed my current indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. I also authorize the release of any medical information required to process payment claims.

I have read and understand the above financial policy:

Patient Name (Print): _____ Parent/Guardian Name (Print): _____

Signature: _____ Date: _____

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## Use and Disclosure of Your Protected Health Information

Your protected health information will be used by MOSM or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

## Notice of Privacy Practices

You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

## Requesting a restriction on the Use or Disclosure of Your Information

You may request a restriction on the use of disclosure of your protected health information. MOSM may or may not agree to restrict the use or disclosure of your protected health information . If MOSM agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal policy standards.

## Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing, any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

## Reservation of Rights to Change Privacy Practices

MOSM reserves the right to modify the privacy practices outlined in the notice.

## Signature

I have reviewed this consent form and received a copy of Notice of Privacy Practices. I give my permission to MOSM to use and disclose my health information in accordance with it. Additionally, I agree that MOSM may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient's Name {Print):_____ Signature: _____

Signature of Patient Representative:_____ Relationship:_____

Date:_____

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& SPORTS MEDICINE
GROUP, P.C.

## Patient Request for Confidential Communication

Patient Name: _____ DOB:___/___/____

Patient Address: _____

Phone: (___)_____ Social Sec#: _____

MOSM may contact you by telephone at your home, work or cell unless you instruct us otherwise.

**Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obliged to honor it, except if any emergency arises.**

I wish to be contacted as follows {check all that apply)

☐ via Email: _____ **We may use your email to contact you.**

☐ At my home telephone number (___)_____

☐ Leave me a message with a call back number only

☐ At my work telephone number (___)_____

☐ Leave me a message with a call back number only

☐ At my cellphone number (___)_____

☐ Leave me a message with a call back number only

☐ Send a message reminder via text message

☐ Other: Please specify any other person {s) allowed to contact our office on your behalf:

_____ _____

_____ _____

Patient Name: _____ Date: _____

Signature: _____