

THE CENTRAL ORTHOPEDIC GROUP PHYSICAL THERAPY

**CONFIDENTIAL NEW PATIENT QUESTIONNAIRE
PLEASE ANSWER ALL QUESTIONS**

PATIENT INFORMATION

EMAIL _____

First Name: _____ Last Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Birth Date / / Age: _____ Male Female S.S.# _____ Marital Status _____

Home Phone: _____ Alternate Phone(s): _____

Chose facility because/Referred to facility by Dr: Insurance Plan Family _____

Friend _____ Former Patient Close to Work/Home Street Sign Yellowbook

Website _____ Other _____

WORK INFORMATION

Employer: _____ Work Phone () _____ Ext _____

Occupation: _____ Employment Status Full Time Part Time Retired Not Employed

CARE PROVIDER INFORMATION

Referring Dr: _____ Referring Dr. Phone: () _____

Medical Dr./PCP: _____ Medical Dr./PCP Phone: () _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Carrier:

Subscriber Name: _____ Birth Date: / /

I.D.#: _____ Group/Policy #: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

Secondary Insurance Carrier:

Subscriber Name: _____ Birth Date: / /

I.D.#: _____ Group/Policy #: _____

Patient's Relationship to Subscriber: Self Spouse Child Other

AUTO OR WORK INJURY CLAIM (PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)

Insurance Name: Auto: Work/Labor: Claim # _____

Adjuster/Claim Rep: _____ Phone: () _____ Ext _____

Address: _____ City: _____ State: _____ Zip: _____

ATTORNEY INFORMATION

Name: _____ Law Firm: _____ Phone: () _____

Address: _____ City: _____ State: _____ Zip: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative: _____

Relationship to Patient: _____ Home Phone: () _____ Alt. Phone: () _____

PAST MEDICAL HISTORY FORM			Patient Name _____		
MUSCLE CONDITION	<input type="checkbox"/> YES	<input type="checkbox"/> NO	OTHER CONDITIONS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Carpel Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
JOINT CONDITION	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes/Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eye Sight	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking Packs/Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol Drinks a wk ____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda Cups a wk ____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor		

What types of exercise do you perform? _____
 Stress causing conditions? _____

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy? YES NO If yes list name(s): _____

List all medications you are currently taking: _____

List all surgeries in the past(including dates): _____

Are you pregnant? YES NO If yes, what week? _____

Have you had any injuries related to work or any auto accidents? YES NO If yes list body part & date: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where? _____

Signature of Patient, Parent, Guardian, Personal Representative

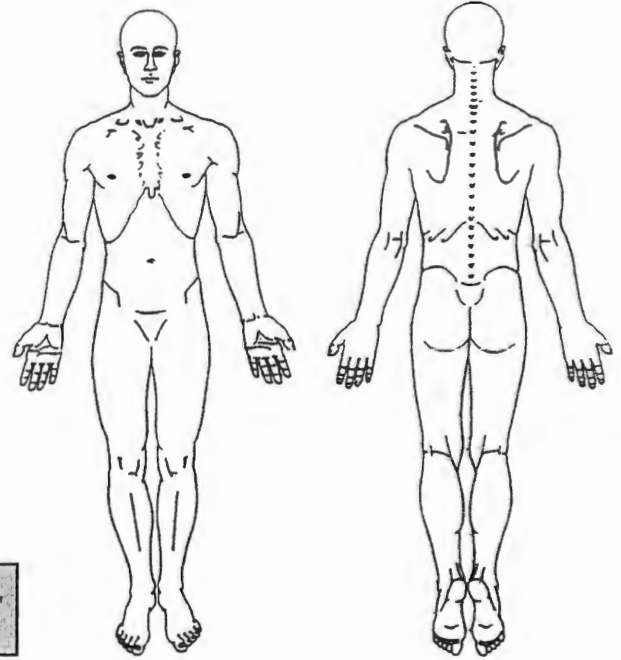
Date

PAIN AND SYMPTOM STATUS REPORT

Name: _____ Date _____

Using the symbols below, please draw at the location the type of pain you are experiencing.

Ache	Burning	Numbness
MMM	-----	OOOO
M	---	OOO
Pins and Needles	Stabbing	Other
□□□□□□	////////	x x x x
□□□□	////	x x x



CHIEF COMPLAINT AND VISUAL ANALOG SCALE

My Chief Complaint is: _____

Date First Symptom of your problem occurred on _____

2nd Complaint _____

3rd Complaint _____

Please Circle on the scale below to indicate your CURRENT level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Please Circle on the scale below to indicate your AVERAGE level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Please Circle on the scale below to indicate your WORST level of pain:

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 HIGHEST LEVEL OF PAIN

Additional Comments _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Central Orthopedic Group Physical Therapy to furnish medical care and treatment necessary in diagnosing or treating his/her physical condition.

Signature of Patient/ Guardian

Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Central Orthopedic Group Physical Therapy. A photocopy of this assignment is information necessary including Medical records, to secure payment.

Signature of Patient/ Guardian

Date

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I, hereby authorize Central Orthopedic Group Physical Therapy to obtain any and all medical records concerning my care from any physician, hospital or health care professional that has provided medical care to me in the past.

I also authorize Central Orthopedic Group Physical Therapy practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to myself/and or any child at anytime.

Signature of Patient/ Guardian

Date

ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how the Practice may use and disclose my health information for treatment, payment and health care options. I know that I have the right to review the Practice's HIPAA Privacy Notice and to ask any questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information for treatment, payment and health care operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's uses and disclosures of my health information for treatment, payment or health care operations. _____ (Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and health care operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

Signature of Patient/ Guardian

Date

Patient chose not to sign acknowledgement

Reason: _____

Office staff acknowledging patients refusal to sign consent

THE CENTRAL ORTHOPEDIC GROUP, LLP

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DATE OF EXAM: _____ Account number# _____

PATIENT NAME: _____

Responsible Party/ Policy Holder : _____

Insurance Company name: _____ Member Id# _____

How did the occurrence happen?

What part of the body was injured/hurt?

Date of Onset: _____

Address of Onset: _____

Was this related to a Motor Vehicle accident yes / no

Was this a Work related accident yes / no

I affirm that the above statement is true and request the release of any monies from my insurance company to the Central Orthopedic Group, LLC.

I also give permission to the Central Orthopedic Group to release any information necessary to pay this claim to my health insurance company.

PATIENT SIGNATURE: _____ Date: _____

Responsible party Signature: _____ Date: _____