Orlin & Cohen Medical Specialists Group

Sports Medicine, Joint Replacement, Arthroscopy & Reconstructive Surgery, Foot & Ankle Surgery,
Knee & Shoulder Reconstruction, Spinal Surgery & Pain Management, Hand & Elbow Surgery, Trauma

Patient Label

NEW PATIENT INFORMATION FORM

LAST _____ M.I. _____ FIRST _____

STREET # & NAME OR P.O. BOX _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SS # _____ DOB _____ SEX _____ E-MAIL _____

NAME OF SPOUSE/PARTNER/GUARDIAN (EMERGENCY CONTACT) _____ PHONE _____

REFERRING PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

PRIMARY CARE PHYSICIAN NAME _____ ADDRESS _____ PHONE _____

INSURANCE: PRIMARY _____ SECONDARY _____

INSURED _____ EMPLOYER _____ ADDRESS _____ INSURED DOB _____

CURRENT SCHOOL INCLUDES GRADE LEVEL _____ SPORTS/OCCUPATION INCLUDE POSITIONS _____

Work/Sports Status: Full Time / Part Time / Injured / Disabled / Student / Retired / Playing Sports / Light Duty / Not working due to the Injury

Does this visit involve a workman's Compensation issue? YES / NO Hand Dominance: ❑ LEFT ❑ RIGHT

Was your injury reported to your employer ❑ Yes ❑ No

Chief Complaint / History of Present Illness: Height_____ Weight_____

Body Part Injured: LEFT / RIGHT_____ Cause: Sports/Work/Auto/Other

Date of Injury/Accident/Onset: _____ Time & Place _____

How did the Injury Occur?_____

_____ Was Injury ❑ Gradual ❑ Sudden ❑ Repetitive Motion

How does it affect / bother you?_____

Pain at Rest: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Pain at Activity: (No Pain) **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** (Worst Pain Imaginable)

Does anything make your pain better or worse? (Please list) _____

Have you been treated for this problem before? YES / NO Date(s):_____

By whom? _____

Prior surgery for this problem? YES / NO Date(s): _____

Physical therapy for this problem? YES / NO Date(s):_____

If you were/are unable to work/play, list dates of disability:_____ to _____

Have you had any prior tests or imaging studies for this problem? YES / NO

If yes, list facility, type & date: _____

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Past Medical History: (PHX) *Please list none if the question does not apply.*

Medical Problems: _____

_____

Previous Hospitalizations & Surgical Procedures: (Provide Dates) _____

_____

_____

Please list all allergies (drug, food, environmental): _____

_____

Current Medications: (Include Doses and Frequency) _____

_____

_____

Family Medical History: (Include Medical Illness Affecting Patient's Immediate Family)_____

_____

Social History: (Check Boxes and Fill Blanks)

❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other:_____

Alcohol Use: ❑ Occasional ❑ Daily ❑ Heavy ❑ None

Tobacco Use: ❑ Yes ❑ No (Type:_____Packs Per Day_____Years Used:_____)

Recreational Drug Use: ❑ Yes ❑ No (Types):_____ _____)

REVIEW OF SYSTEMS: (Check All That Apply)

GENERAL
❑ Weight Change
❑ Fever or Chills
❑ AIDS/HIV
❑ Night Sweats
❑ Bleeding
❑ Lumps or Masses
❑ Dizziness or Fainting
❑ Diabetes Mellitus
❑ Thyroid Problem
❑ Cancer

EAR-EYES-NOSE-THROAT
❑ Visual Change
❑ Hearing Change
❑ Tinnitus
❑ Bleeding Gums

MUSCULOSKELETAL
❑ Back Pain
❑ Joint Pain
❑ Joint Swelling
❑ Neck Pain

GASTROINTESTINAL
❑ Difficulty Swallowing
❑ Jaundice
❑ Hepatitis
❑ Reflux
❑ Ulcer

CARDIOVASCULAR
❑ Chest Pain
❑ Heart Disease
❑ High Blood Pressure
❑ Mitral Valve Prolapse
❑ Thrombophlebitis/DVT/PE

RESPIRATORY
❑ Cough/Sputum
❑ Tuberculosis
❑ Shortness of Breath
❑ Asthma
❑ Emphysema

❑ All Systems Reviewed & Negative

GENITOURINARY
❑ Urinary Infections
❑ Incontinence
❑ Urinary Frequency
❑ Venereal Disease
❑ Menopause

NEUROLOGIC
❑ Seizures
❑ Numbness
❑ Weakness

PSYCHOLOGICAL
❑ Depression
❑ Bipolar
❑ ADD/ADHD
❑ Other

SKIN
❑ Itching or Rash
❑ Wound Discharge

Providers Notes Section:

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:	

_____ _____ _____ _____

Patient/Guardian Signature | Date | Physician's Signature | Date

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_____