Neil F. Watnik, M.D.
Orthopaedic Surgery

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

PATIENT INFORMATION

Patient Name:		**Date:**
DOB:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? ____

II. Which side is affected? O Right O Left O Bilateral

III. Date of Injury or start of pain: ____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV: Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: ___________

Have you had physical therapy? O Yes O No

Are you taking any pain medications?

Anti-inflammatory agent O Yes O No Drug Name: _________________

Pain Medication O Yes O No Drug Name: _________________

Tylenol O Yes O No

Have you been putting ice on the area? O Yes O No

Have you had any testing? O Yes O No

Which tests? O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan

Medical History

Osteoporosis	O Yes	O No	Cancer	O Yes	O No
Hypertension	O Yes	O No	Prolonged Steroid Treatment	O Yes	O No
Diabetes	O Yes	O No	Degenerative Joint Disease	O Yes	O No
Arthritis	O Yes	O No	Degenerative Disk Disease	O Yes	O No

Social History

Do you smoke cigarettes? O Yes O No

How long have you smoked? O >1 year O 1-10 years O 10+ years

How many packs per day? O >1 pack O 1-2 packs O 3+ packs

Have you ever smoked cigarettes in the past? O Yes O No

Do you drink alcohol regularly? O Yes O No

How many drinks per day? O 1 drink O 2-3 drinks O 4+ drinks

Do you have a history of substance abuse? O Yes O No

Have you ever had a blood transfusion? O Yes O No

Do you participate in sports/recreational activities? O Yes O No

If yes, please list ____

Family History

Mother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis

Review of Systems: *Are you experiencing any of these issues now?*

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No
Back Pain	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Other

Sexually Transmitted Diseases	O	Yes	O	N

Allergies

Are you allergic to any medications?	O	Yes	O	No	If yes, please list:________________________
Are you allergic to food or environmental substances?	O	Yes	O	No	If yes, please list:________________________
Do you have any known Metal allergies?	O	Yes	O	No	

Medications (Please list name of medication and dosage) a copied updated list is acceptable for this section	

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

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Last Name: ______________________________ First Name: ______________________________ MI: ________

Sex: __________ DOB: __________________ SSN: ______________________ Marital Status: M S W D

Home Address: ____

City/State/Zip: ____

Home Phone: ____________________ Work Phone: ________________ Cell Phone: ____________________

Email: ___________________________________ Pharmacy: ____________________ #: ______________

Emergency Contact Name_____________________ Telephone#___________________ Relation____________

Who referred you to the doctor? ____

Primary Care Physician: ____

PCP Phone, Address: ____

Are you currently working? ______________ Retired? _____________ Last date worked? ____________________

Employer: _______________________________ Employer Address: _______________________________

Telephone: ______________________________ Occupation: ____________________________________

The following information is now required by Medicare:

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: (check one) ☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Other Race: ______________

Primary Language: (check one) ☐ English ☐ Spanish ☐ French ☐ Italian ☐ Polish ☐ Greek ☐ Portuguese

☐ Russian ☐ Chinese ☐ Japanese ☐ German ☐ Other ______________

INSURANCE INFORMATION

Primary Insurance: ____ Phone #: ________________________

Primary Insurance Address: ____

Policy #: ____________________ Group #: ____________________ Group Name: ____________________

Name of Insured: ____

Insured Address (if different from patient): ____

Insured's DOB: _______________ Insured's SSN: _________________ Relation to Patient: _________________

Insured's Employer: ____

Secondary Insurance: ______________________________________ Phone #: ________________________

Secondary Insurance Address: ____

Policy #: ____________________ Group #: ____________________ Group Name: ____________________

Name of Insured: ____

Insured Address (if different from patient): ____

Insured's DOB: _______________ Insured's SSN: _________________ Relation to Patient: _________________

I hereby give my permission to Dr. Frank R. DiMaio to release medical information to insurance companies. I understand that charges incurred by me that are rendered by Dr. DiMaio that not covered by medical insurance are my responsibility.

Signature: ______________________________________ Date: ______________________________

Long Island Orthopaedics & Joint Replacement Services

Long Island Orthopaedics and Joint Replacement Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

____ ____
Signature of Patient or Personal Representative — Print Name of Patient or Personal Representative

____ ____
Description of Personal Reprentative's Authority — Date

____ ____
Signature of Facility Representative — Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. Long Island Orthopaedic & Joint Replacement Services may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit long Island Orthopaedic & Joint Replacement Services to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

____ ____
(Relationship to me)

____ ____
(Relationship to me)

I expressly permit Long Island Orthopaedic & Joint Replacement Services to disclose my protected health information for the purposes of appointment/test/ procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel. # ________________________________

Office voicemail: Tel. # ________________________________

Other (specify):________________________ Tel. # ________________________________

____ ____
Signature of Patient — Date

Understanding and Acknowledgment of Office Policies and Procedures

Referrals

If your insurance plan requires a referral, it is your responsibility to visit or call your primary care physician prior to your appointment to ensure that you have a referral on file with us (either paper or electronic). Please be advised that some insurance companies may take up to 48 hours to provide a referral. Failure to produce your referral at the time of your visit may result in the cancellation of your appointment.

Disability Paperwork, Injection & MRI Authorization

Disability paperwork and injection authorizations require one week for processing and you may be charged a fee for completion of disability forms. If you have not had an office visit within the past 30 days, you may need to make an appointment to review the status of your disability. You will be contacted if an appointment is necessary.

Medical Records

If you need to obtain copies of your medical records, a signed release is necessary. If you need to obtain copies of medical records for someone other than yourself, a signed release from the patient or his/her guardian is necessary. The medical records department requires at least five business days to process requests and there is a fee associated with copying records and films.

Prescription Refills

If you require a refill on your prescription you can call our office during business hours on weekdays at least one- to three days before you'll need your medication. Pain medications will not be prescribed unless you have been seen by Dr. DiMaio within the past 60 days.

By signing this you are acknowledging that you read and understand the policies and procedures of this office. A copy will be given to you and one will be kept in our files as well.

____ ______________________________

Print Name Date

____

Signature

Workers' Compensation Insurance Information

Insurance Carrier: ____Phone:____________________

Address: ____

Claim #:____________________________________WCB#:_____________________________________

Policy Holder: _____________________________________Date of Accident: ________________________

Attorney Name: ______________________________________Phone:______________________________

Address: ____

Were you referred here for a consultation by another Physician, Physical Therapist or Lawyer? ☐ Y ☐ N
If yes, who is requesting this? ____
Name Phone Fax
Chief complaint: What is the reason for this visit____

Did you bring films/disc? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

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 ☐ R Wrist ☐ L Wrist
☐ R Hand ☐ L Hand ☐ R Hip ☐ L Hip ☐ R Knee ☐ L Knee ☐ R Ankle ☐ L Ankle ☐ Pelvis ☐ Ribs ☐ Clavicle
☐ R Leg ☐ L Leg ☐ 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 <u>how your problem started</u>.
☐ **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? ____
Have you attended PT for your WC injury? ☐ Y ☐ N If so, when was your first visit? ______ last visit_____don't know_____
If you are attending PT, where are you going? ____
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. ___________________________
Dominant Hand ☐ R ☐ L ☐ Ambidextrous (both)

Signature: ______________________________________ Date: ____________________________________

AUTO INSURANCE INFORMATION

Insurance Company: ____ Phone: ______________________________
Address: ____
Policy#: _____________________________ Claim#:____
PolicyHolder: ____ Phone: ______________________________
Name of Examiner: _______________________________________ Phone: _______________________________

Attorney Name: ____ Phone: _______________________________

Address: ____

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? ______________________________

Chief complaint: What is the reason for this visit? ____

Did you bring films/disc? ☐ X-Ray ☐ MRI ☐ CT scan ☐ Bone scan ☐ Nerve Test (EMG/NCV)

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 ☐ R Wrist ☐ L Wrist ☐ R Hand ☐ L Hand ☐ R Hip ☐ L Hip ☐ R Knee ☐ L Knee ☐ R Ankle ☐ L Ankle ☐ Pelvis ☐ Ribs ☐ Clavicle ☐ R Leg ☐ L Leg ☐ R Foot ☐ L Foot ☐ Other: ____

Were you hospitalized for this injury? ☐ Y ☐ N On date of injury what was your job title/description? ____

Have you attended PT for your MV injury? ☐ Y ☐ N If so, when was your first visit? ____________________
Last visit: ________________ don't know: ___________________________

If you are attending PT, where are you going? ____

Please write specific details of your problem (of accident/injury, list details): _____________________________
____
____

Are you being treated by another physician for this condition/injury? ☐ Y ☐ N
If yes: Dr. ____

Dominant Hand ☐ R ☐ L ☐ Ambidextrous (both)

Signature: ______________________________________ Date: ____