

NYOS New Patient Registration.

Date: _____

 Dr. Scott V Haig Dr. Eric M. Gordon**This form must be completed to its entirety; optional fields have been marked for your convenience.*

Patient's Last Name: _____ First Name: _____ MI: _____

Maiden Name/ Other Name (if Applicable): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Marital Status: _____ Email Address (optional): _____

Date of Birth: ____/____/____ Age: ____ Gender: F M Social Security # _____

Primary Care Physician Name (Please provide first and last name): _____

Primary Care Physician Phone: _____

You were referred to our office by: _____

Emergency Contact Information

Name: _____ Phone: _____

Relationship: _____

Employer Information

Occupation: _____ Company Name: _____

Address: _____

Phone: _____ Fax(if available): _____

Insurance InformationPrimary Insurance Carrier: _____ Policy Holder: Self Spouse Parent Other (Please specify relationship): _____

Policy Holder (if other than self) Name: _____

Date Of Birth: ____/____/____ Social Security #: _____

Secondary Insurance Carrier (if applicable): _____ Policy Holder: Self Spouse Parent Other (Please specify relationship): _____

Policy Holder (if other than self) Name: _____

Date Of Birth: ____/____/____ Social Security #: _____

To Our Patients:

- If this is an Auto Accident or Work related, injury please inform the reception desk immediately. If you fail to provide New York Orthopedic Specialists with this information and you later on decide you have a No Fault or Workers Compensation case, all payment made by you are non-refundable. It is your responsibility, as a patient, to provide this information at the time of your visit.
- Your current Insurance Card(s) is/are required at each visit along with a picture id.
- Co-Payments are required by your Insurance plan and must be paid at each visit.
- Your patient information may be used to contact you by telephone/mail/email for the purpose of treatment, payment or health care operations.
- I understand that my insurance carrier may deny payment for certain screenings, labs, tests, DMEs, supplies, or injections in the doctor's office. It is my right to refuse these and my responsibility to pay for them if I accept to receive them.
- I also understand that any DME and/or supplies that are purchased are non-refundable.
- Your signature is required for us to protect any Insurance claims and to ensure payment of services rendered at New York Orthopedic Specialists.
- For your convenience we DO NOT charge for any visit cancellation.

I, _____ (print name), clearly understand the above information, I authorize payment of medical benefits to the undersigned physician for services provided and accept responsibility for my bill, and all policies described.

I am the legal guardian for the patient. My name is _____ and I am fully responsible for his/her account.

Responsible Individual Signature _____ Date _____ on
behalf of (Please print patient's name if not self) _____

NYOS Orthopedic History

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

What are you being seen for today? _____

Which side is affected? Left Right Bilateral

Date of injury or start of pain: _____

How did the injury / pain occur?: _____

Is this work related? Yes No

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

Pain description

Quality of your pain? Mild Moderate Severe

Type of pain? Sharp Dull Other: _____

Location(s) of the pain? _____

Does it radiate? Yes No If so, where? _____

Treatment

Are you taking any pain medications? Yes No

Tylenol Yes No

Anti-inflammatory Yes No Drug name: _____

Other Yes No Drug name: _____

Have you applied ice to the area? Yes No If so, was it helpful? Yes No

Have you had physical therapy? Yes No If so, was it helpful? Yes No

Have you had any other treatment in the past for this problem? Yes No

If so, please describe? _____

If so, was it helpful? Yes No

Have you had any tests for this problem? Yes No

X-Ray MRI Bone Scan CT Scan EMG/Nerve Study

Have you seen another doctor previously for this problem? Yes No If so, who?

NYOS Medical History

Patient Information		
Name:	Date:	
DOB:	Height:	Weight:

Who is your primary care doctor? _____
 Approximate date of last visit: _____

Past Medical & Surgical History

Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Attack (Date: _____) | <input type="checkbox"/> Peptic Ulcer disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Stroke / TIA (Date: _____) | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer: (please describe: _____) | | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Other: _____ | | |

Past Surgical History

Have you had surgeries in the past? If so, please list and give approximate dates:

Procedure _____	Date _____
Procedure _____	Date _____
Procedure _____	Date _____
Procedure _____	Date _____

Medications and Allergies

Do you have any allergies to medications? If so please list & describe the allergic reaction:

Medication: _____ Reaction: _____
 Medication: _____ Reaction: _____

Please list any medications that you take regularly:

Name:	Dose:	Name:	Dose:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History / Social History

Please check all that apply:

- Heart disease Stroke
 Cancer Diabetes
 Osteoarthritis

Do you smoke cigarettes? Yes No

If so, how many packs per day? _____

Do you drink alcohol? Yes No

If so, how many drinks per week? _____

Recent Health Review of Systems

- | | | |
|--|---|---|
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Tooth or Gum Disease | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Malaise | <input type="checkbox"/> Skin Changes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Steroid Use |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Enlarged Glands | <input type="checkbox"/> Personal Loss |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Seizures | | |

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose my protected health information to carry out:

- Treatment including direct or indirect treatment by other healthcare providers involved in my treatment;
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20____

Print Patient Name: _____

Address: _____

Signature: _____

NEW YORK ORTHOPEDIC SPECIALISTS
700 White Plains Road
Scarsdale, New York 10583

NY ORTHOPEDIC SPECIALISTS P.C.

SCOTT V HAIG M.D. ERIC GORDON M.D.
700 WHITE PLAINS RD SCARSDALE NY 10583
TELEPHONE (914) 723-4244
FAX (914) 725-3291

OUR FINANCIAL POLICY

REFERRAL: If your insurance plan requires a referral from your primary physician it is **YOUR** responsibility to obtain it prior to your appointment, and have it with you at the time of visit. If you do not have your referral, and it is required, you will be responsible for your bill or your appointment will have to be rescheduled.

WAVIER: I agree that it is my responsibility to make payments directly to NYOS should I fail to provide my insurance company's **REQUIRED** referral from my primary physician.

- If you are completely certain that you **DO NOT REQUIRE** a referral from your insurance company, however if after submitting the claim your insurance company **DOES** require a referral for your visit **YOU** will be responsible for the cost of the visit.

If your insurance is terminated or invalid at the time of your visit you will also be responsible for the cost of your visit.

Print Patient's full name: _____

- I am the legal guardian for the patient. My name is _____ and I am fully responsible for his/her account.

SIGNATURE _____ DATE _____