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_____

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CONSENT TO LEAVE MESSAGES /SHARE INFORMATION WITH FAMILY & FRIENDS

I understand that my healthcare information is protected. I understand that, in order for Orlin & Cohen to leave detailed messages containing specific health information on my voice mail or answering machine, I need to give permission for Orlin & Cohen to do so.

Consent for Leaving Messages

I give my permission for messages regarding the following to be left on my phone number(s) below:

Enter "Y" or "N".

____ Appointment Reminders/Changes ____ Account Payments/Balances ____ Cost Estimates ____ Needed Treatment/Completed Treatment ____ Test Results

Cell # _____ Home # _____ Work #_____

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law, we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form. The name(s) listed below are family members or friends to whom I grant permission for Orlin & Cohen to verbally discuss my care using their best judgment and grant them permission to disclose information regarding the following (Enter Y or N):

_____ Appointment Reminders/Changes _____ Account Payments/Balances _____ Cost Estimates _____ Needed Treatment/Completed Treatment

_____ Test Results

	NAME	RELATIONSHIP	PHONE NUMBER
1.	_____	_____	_____
2.	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ Printed Name (Patient/Parent)

_____ Signature (Patient/Parent)

_____ Date

CONSENT TO E-MAIL AND TEXT COMMUNICATIONS

I consent to communicate with Orlin & Cohen through e-mail and/or text messaging. If I am signing this document for another person, I agree that I am consenting for this patient and I will provide the relationship (parent, relative, health care agent, guardian, surrogate) where indicated below. I agree that:

Text messaging will be used only for the purpose of providing me with appointment-related information. Text messaging may not be used to communicate with my healthcare provider. I understand that text messages will be sent unencrypted which means that they will not be protected and others may be able to access the information as it is sent.

I understand that e-mail communication should not be used for emergencies or for communicating time-sensitive information. E-mail communication will be processed during routine business hours.

In the event of a medical emergency, I should call 911 or go to the nearest Emergency Department. E-mail should be used only for non-urgent issues. It should not contain sensitive information such as information regarding sexually transmitted diseases, HIV/AIDS, mental health, developmental disabilities or substance abuse. I understand that any e-mail communication between my provider and me regarding my care may become part of my medical records.

By providing my e-mail address, I am agreeing to receive e-mails. Emails that are sent from Orlin & Cohen will be encrypted to keep them secure, unless I request to receive unencrypted e-mails. I understand that most personal e-mail services do not encrypt or otherwise protect e-mails. Therefore, there is a risk that e-mails I send from my e-mail account to my provider may be accessed by others not affiliated with my provider. As a result, I understand that if I communicate with my provider using my personal e-mail account, it may not be secure and there is a risk that my health information may be obtained by others not affiliated with my provider. Despite this risk, I authorize my provider to send my personal health information via e-mail.
I further acknowledge that e-mails and text messages may be subject to technical malfunctions. Therefore, I understand that e-mail and text message delivery is not guaranteed and potentially subject to unauthorized disclosure to third parties.

I accept that my healthcare provider or I can terminate e-mail communication and/or text messaging at any time.

I understand that I am responsible for notifying the healthcare provider if I choose to discontinue e-mail communications or text appointment reminders or if my contact information has changed. The contact information is used for the purposes of this form will be the most current information on file with Orlin & Cohen.

Request for Email Communication via Unencrypted Email Only
Orlin & Cohen strongly discourages communication sent without encryption. In addition to the risks identified above, sending e-mail unencrypted means others may be able to access the information and read it once it is transmitted over the internet. By signing below and authorizing unencrypted email, I acknowledge the risks to which my information may be exposed.

_____ Patient (Signature) Date/time _____ Print name

_____ Agent/Relative/Guardian (Signature) Date/time _____ Print name Relationship if other than patient