825 Northern Blvd Suite 201
Great Neck, NY 11021

10 Medical Plaza Suite 202
Glen Cove, NY 11542

Patient Name: ___________________ **DOB:**___________________

Which physician are you scheduled to see?

- ☐ **Sreevathsa Boraiah, MD**
- ☐ **Steven Erlanger, MD**
- ☐ **Barry Simonson, MD**
- ☐ **Joshua Steinvurzel, MD**
- ☐ **Baruch Toledano, MD**

Scheduled Appointment Date: ____________________________

As a reminder:
Please arrive 15-20 minutes prior to your scheduled appointment.

Please bring the following on the day of your scheduled appointment:

- Your insurance card
- Any X-Ray or MRI films, discs or results the scheduling office asked you to provide
- Lab results
- A referral if needed
- Co-pay if required
- Drivers License or Photo ID

We are happy you chose Northwell Health Physician Partners Orthopaedics, and strive to provide you with high quality medical care and customer service!

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Patient Registration Form

Is this injury: Work related? ☐Yes ☐No Due to a Motor Vehicle Accident? ☐Yes ☐No

In order to serve you better, please ***PRINT*** *and complete all information*

Age: ________ Sex:☐M ☐F Marital Status: ☐Single ☐Married ☐Widow ☐Divorced
Street Address____
City: _______________ State: _______ Zip: _________ Email: ________________________________
Phone: (Home) ____________________ (Cell) ____________________ (Work) ____________________
Employer: ______________________________________ Occupation: _______________________________

Financially Responsible Party: ☐Same as above (if not, please fill in below)

Last Name: _____________________________First Name: __________________________ MI: ________
Date of Birth: _____/_____/__________Age: ___ Sex:☐M ☐F Relationship: ☐Spouse ☐Parent
Address: ____
Phone: (Home) ____________________ (Cell) ____________________ (Work) ____________________

Emergency Contact
Name: __________________________ Phone #: _________________ Relationship to patient: ___________
Do you have a health care proxy? ☐Yes ☐No
Primary Care Physician:

Name: ______________________________Phone #: ____________________Fax #: ____________________
Address: ____

Referring Physician:
Name: ______________________________Phone #: ____________________Fax #: ____________________
Address: ____

Insurance Information:
Please be advised that if a referral is needed it must be obtained prior to seeing our providers. If you fail to obtain a referral you will be responsible for full payment for the services provided.
Primary Insurance: _________________________ Policy #: ________________ Group #: _____________
Subscriber's Name: ____ Date of Birth: ____/____/__________
Relationship to Patient: ____
Secondary Insurance: ________________________Policy #: ________________ Group #: _____________
Subscriber's Name: ____ Date of Birth: ____/____/__________
Relationship to Patient: ____

____ __________________
Patient Signature or Authorized Guardian **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and direct my physician(s), having treated me, to release to other treating physicians, government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer, and set over to my physician(s), sufficient monies and/or benefits I may be entitled from government agencies, insurance carriers, or others who are financially liable for medical costs of the care and treatment rendered to me or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

____ __________________
Patient Signature or Authorized Guardian **Date**

AUTHORIZATION TO RELEASE INFORMATION VIA EMAIL
By providing your email address, you agree to receive by email address information about your healthcare, including protected health information.

____ __________________
Patient Signature or Authorized Guardian **Date**

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Patient Name: ___________________ **DOB:**___________________

Patient Intake and History Form

Please provide the following information. This form is confidential and will be entered into your medical record.

Past Medical History *Please check any condition you have now or have had in the past* ☐**No Past Medical History**

☐Asthma	☐Cancer(type___________________)	☐Arthritis (location___________________)
☐COPD	☐Neuropathy	☐Herniated Disc
☐Diabetes	☐Parkinson's Disease	☐Lupus
☐Heart Disease	☐Prolonged Steroid Treatment	☐Osteoporosis
☐ High Cholesterol	☐Seizure/Epilepsy	☐Rheumatoid Arthritis
☐ Hypertension	☐Stroke	☐Spinal Stenosis
Other___________________________	Other___________________________	Other___________________________

Surgery and Hospitalization History ☐**No Past Surgery/Hospitalizations**

Reason for Surgery/Hospitalization	Hospital Name (if available)	Date (approximate)

Family History *Have any family members had the following?* ☐**No Pertinent Family History**

	Yes	No	If Yes, who?	Type	Location
Arthritis/DJD	☐	☐			
Cancer	☐	☐			
	☐	☐			
Genetic Disease	☐	☐			
Osteoporosis	☐	☐			

Social History

Living Situation	☐ Alone ☐ Family	☐ House ☐ Apartment ☐ Stairs
Occupation		Currently Working? ☐ Yes ☐No
Smoking Hx	☐ Current Smoker:	*packs per day*? ☐ <1 ☐ 1-2 ☐ 3+
		how long? ☐ < 1 year ☐ 1-10 years ☐ 10+years
	☐ Former Smoker	☐ Never a Smoker
Do you drink alcohol?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never *If Yes, have you ever been treated* ☐ Yes ☐No
Do you use recreational drugs?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never *If Yes, have you ever been treated* ☐ Yes ☐No
Do you exercise?	☐Regularly ☐Occasionally	☐ Rarely ☐ Never Intensity ☐ High ☐ Low
List Activities	____________________________	

Patient Name: __________________ **DOB:**__________________

Allergies *Please check all that apply* ☐**No Known Allergies**

☐ Shellfish ☐ Contrast Dye ☐ Latex ☐Medications ______________________________

☐ Seasonal ☐ Latex ☐ General/Local Anesthetic ☐ Other ______________________________

Current Medications *Please list all medications including vitamins and supplements* ☐**No Current Medications**

1. 2. 3.

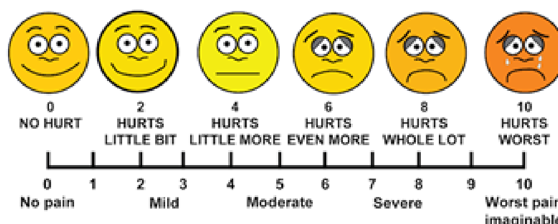
4. 5. 6.

Have you recently taken or used? ☐ NSAIDS (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC

Reason for you visit today: ____

Current Height: ______ft ______in Current Weight: ______lbs

Pain Assessment *Please circle the picture/number to describe the severity of your pain at this time.*



Location of Pain: ____

Describe Your Pain ☐ intermittent ☐ constant ☐ localized ☐ radiating ☐ other ________________________

How long have you had pain? ___Days ____Weeks ____Months ____Years

Review of Systems *Please check any of the following symptoms you have experienced recently or are experiencing now*

☐Chills
☐Discharge
☐Dec Hearing
☐SOB at rest
☐Abdominal Pain
☐Urinary Frequency
☐Arthralgias
☐Breast Pain
☐Headache
☐Anxiety
☐Deepening Voice
☐Easy Bleeding

☐Feeling Tired
☐Eye Pain
☐Nasal Discharge
☐Cough
☐Constipation
☐Urinary Urgency
☐Joint Pain
☐Breast Lump
☐Dizziness
☐Depression
☐Feeling Weak
☐Easy Bruising

☐Fever
☐Sight Problems
☐Nosebleeds
☐SOB w/exertion
☐Diarrhea
☐Incontinence
☐Joint Stiffness
☐Skin Lesions
☐Fainting
☐Sleep Disturbances
☐Hot Flashes
☐Swollen Glands

☐Recent Weight Gain
☐Redness
☐Sore Throat
☐Leg Swelling
☐Heartburn
☐Abnormal. Vaginal Bleeding
☐Joint Swelling
☐Change in a mole
☐Convulsions
☐Muscle Weakness

____

Signature of Patient Date

____

Patient Representative Name Signature Date

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Patient Name: __________________ DOB:__________________

Pharmacy Update

In order to serve you better, please ***PRINT*** *and complete all applicable information*

Pharmacy Information:

Name:__________________________________ Phone: _______________________ Fax: _______________________

Address:____

Mail Order Pharmacy Information:

Name:__________________________________ Phone: _______________________ Fax: _______________________

Address:____

Prescription Benefit Plan

Name:__________________________________ Phone: _______________________ Fax: _______________________

Address:____

Member #: ____ Group #____

Please provide the front desk with a copy of your prescription benefit plan card if applicable