825 Northern Blvd Suite 201
Great Neck, NY 11021

10 Medical Plaza Suite 202
Glen Cove, NY 11542

Northwell Health℠
Physician Partners

Patient Name: _____ DOB:_____

Which physician are you scheduled to see?

-

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 Name: _____ **DOB:**_____

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**

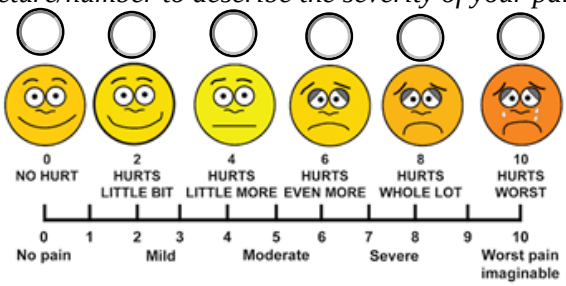
1.	2.	3.
4.	5.	6.

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	☐Feeling Tired	☐Fever	☐Recent Weight Gain
☐Discharge	☐Eye Pain	☐Sight Problems	☐Redness
☐Dec Hearing	☐Nasal Discharge	☐Nosebleeds	☐Sore Throat
☐SOB at rest	☐Cough	☐SOB w/exertion	☐Leg Swelling
☐Abdominal Pain	☐Constipation	☐Diarrhea	☐Heartburn
☐Urinary Frequency	☐Urinary Urgency	☐Incontinence	☐Abnormal. Vaginal Bleeding
☐Arthralgias	☐Joint Pain	☐Joint Stiffness	☐Joint Swelling
☐Breast Pain	☐Breast Lump	☐Skin Lesions	☐Change in a mole
☐Headache	☐Dizziness	☐Fainting	☐Convulsions
☐Anxiety	☐Depression	☐Sleep Disturbances	☐Muscle Weakness
☐Deepening Voice	☐Feeling Weak	☐Hot Flashes	
☐Easy Bleeding	☐Easy Bruising	☐Swollen Glands	

_____
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

Clear Form

Submit Form