Northwell Health℠
Physician Partners
Orthopaedic Institute

Patient Name:_____ DOB:_____/____/_____

Select the office where your visit is located:

Please Select a Location...

What is the date of your appointment?

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
- A referral if needed
- Co-pay if required
- Drivers License or Photo ID
- Any X-Ray or MRI films, discs or results the scheduling office asked you to provide
- Lab results
- Medication List
- Pharmacy Name and Phone #

Note: **This packet can be submitted online by clicking the submit form button on the last page or can be printed and emailed to**
Orthofastrac@northwell.edu

If you would like to receive text appointment reminders, text Northwell to 622622

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

Patient Name:_____ DOB:_____/_____/_____

Patient Intake Form

Current Height: _____ft. _____in. Current Weight: _____lbs.

Dominant Hand: ◯ Right ◯ Left

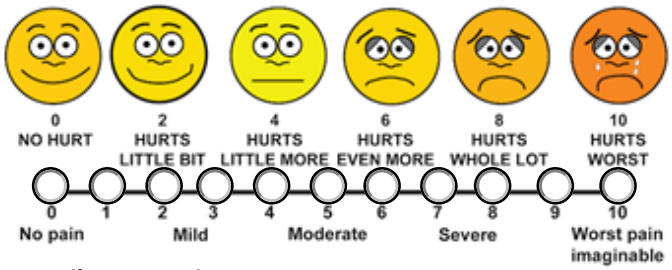
Reason For Visit

Reason for your visit today:_____

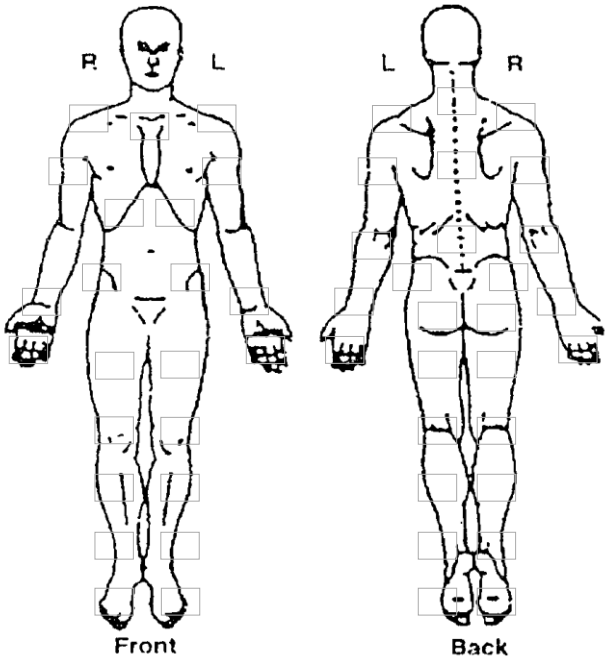
Date of Injury/Onset of Pain: ___/____/_____ **Was injury/onset related to:** Work? ◯ Y ◯ N Auto Accident? ◯ Y ◯ N

Pain Assessment

*Please circle the picture/number to describe the severity of your pain **right now***



*On the drawing below, please shade the area where you currently experience your **chief complaint***



Describe your pain

☐ Intermittent ☐ Constant ☐ Localized ☐ Radiating

How would you characterize your pain?
(e.g. Dull, Sharp, Achy, Burning, Throbbing, Cramping, Shooting, Stabbing)

_____

What makes your symptoms better? (e.g. Rest, Heat, Ice, Medication)

_____

What makes your symptoms worse? (e.g. Walking, Bending, Lying down)

_____

Previous Treatment

Have you been to another physician for this issue?

◯ Yes ◯ No If yes, name & date

_____ _____

Have you had any alternative treatment(s) for this issue?
(i.e. acupuncture, injections)

◯ Yes ◯ No If yes, date_____

Have you had Physical Therapy for this issue?

◯ Yes ◯ No If yes, date_____

Have you seen a chiropractor for this issue?

◯ Yes ◯ No If yes, date_____

Review of Systems

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

☐ Arthralgia	☐ Decrease Hearing	☐ Heartburn	☐ Convulsions
☐ Joint Pain	☐ Nasal Discharge	☐ Urinary Frequency	☐ Anxiety
☐ Joint Stiffness	☐ Nosebleeds	☐ Urinary Urgency	☐ Depression
☐ Joint Swelling	☐ Sore Throat	☐ Incontinence	☐ Sleep Disturbances
☐ Chills	☐ SOB at Rest	☐ Abnormal Vaginal Bleeding	☐ Suicidal
☐ Feeling Tired	☐ Cough	☐ Breast Pain	☐ Feeling Weak
☐ Fever	☐ SOB on Exertion	☐ Breast Lump	☐ Muscle Weakness
☐ Recent Weight Gain	☐ Wheezing	☐ Skin Lesions	☐ Hot Flashes
☐ Discharge	☐ Lower Extremity Edema	☐ Change in a Mole	☐ Deepening of Voice
☐ Eye Pain	☐ Abdominal Pain	☐ Headache	☐ Easy Bleeding
☐ Sight Problems	☐ Constipation	☐ Dizziness	☐ Easy Bruising
☐ Redness	☐ Diarrhea	☐ Fainting	☐ Swollen Glands

When did these symptoms start?

_____

Patient Name:_____ DOB:_____/_____/_____

Past Medical History

☐ No Past Medical History

☐ Asthma
☐ COPD
☐ Diabetes
☐ Heart Disease
☐ High Cholesterol
☐ Hypertension
☐ Blood Clots
☐ Cancer (type:_____)
☐ Neuropathy
☐ Parkinson's Disease
☐ Prolonged Steroid Treatment
☐ Seizure/Epilepsy
☐ Stroke
☐ Pulmonary Embolism
☐ Arthritis (location:_____)
☐ Herniated Disc
☐ Lupus
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Spinal Stenosis
☐ Other:_____

Surgery and Hospitalization History

☐ No Past Surgical History

Reason for Surgery	Hospital Name	Date (approx.)	Infection?
			◯Y ◯N
			◯Y ◯N
			◯Y ◯N

Family History

☐ No Pertinent Family History

	Yes	Who?	Type	Location
Arthritis/DJD	☐			
Cancer	☐			
Genetic Disease	☐			
Osteoporosis	☐			

Allergies

☐ No Known Allergies
☐ Shellfish
☐ Contrast Dye
☐ General/Local Anesthetic
☐ Medications
☐ Other

Seasonal
Latex

_____

_____

Social History

Living Situation

☐ Alone ☐ Family ☐ House ☐ Apartment ☐ Stairs

Currently Working? ◯Yes ◯No

Current Smoker ◯Yes ◯No

# of years _____ # packs/day _____

Do you drink alcohol? ◯Yes ◯No

drinks/week _____

Do you use recreational drugs? ◯Yes ◯No

Types?_____ #times/week____

Do you exercise? ◯Yes ◯No

times/week _____

Activities:_____

Current Medications

☐ No Current Medications

Please list all medications including vitamins and supplements

Name	Dosage	Frequency

Have you recently taken or used…

☐ NSAIDS (Aleve, Ibuprofen, Aspirin) ☐ Tylenol ☐ Ice/Compression ☐ Other OTC

_____
Print Name

_____ _____
Signature Date

Northwell Health℠ Physician Partners

Orthopaedic Institute

Northwell Health℠
Physician Partners
Orthopaedic Institute

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

Northwell Health℠
Physician Partners

Patient Name: _____ DOB:_____

In order to serve you better please answer the following questions.

**Note: Definitions are available below for reference.*

Did your injury occur at work? ◯ **Yes** ◯ **No**

***If yes*, do you have an ACTIVE Workers Compensation case?** ◯ **Yes** ◯ **No**

Did your injury occur due to a Motor Vehicle Accident ◯ **Yes** ◯ **No**

***If yes*, do you have an ACTIVE No Fault case?** ◯ **Yes** ◯ **No**

Workers Compensation:

Workers' compensation is insurance that provides cash benefits and/or medical care for workers who are injured or become ill as a direct result of their job. Employers pay for this insurance, and shall not require the employee to contribute to the cost of compensation. Weekly cash benefits and medical care are paid by the employer's insurance carrier, as directed by the Workers' Compensation Board. The Workers' Compensation Board is a state agency that processes the claims. If Board intervention is necessary, it will determine whether that insurer will reimburse for cash benefits and/or medical care, and the amounts payable.

Your injury should be covered under Workers Compensation if:

- You were injured on the job.
- You were injured while traveling on business.
- You were doing a work-related errand.
- You were attending a required business-related social function.
- If your job requires you to drive a motor vehicle and you were hurt in an accident.

No Fault

A no fault insurance claim, sometimes called a Personal Injury Protection claim (or PIP claim), is one you make against your own automobile insurer for payment of medical bills and lost earnings under New York's no fault laws. Your insurer will pay your medical bills and will reimburse you for some of all of your lost earnings up to the amount of your claim or New York's no fault limit, whichever is lower. Once your medical bills exceed New York's no fault limit, you are responsible for paying them. If you have health insurance, your health insurer will pay your medical bills from that point on. If you are on Medicare or a state run health insurance program through Medicaid, those entities will pay the bills. If you do not have health insurance, Medicare, or Medicaid, then you are responsible for working out payment arrangements with your health care providers.

Your injury should be covered under No Fault if:

- The accident occurred in New York.
- The injured party was the driver or passenger of the insured vehicle or a cyclist or pedestrian struck by or in contact with the motor vehicle.
- The vehicle caused the injury, for example: a motor vehicle accident, a parked car causes bodily harm, etc.
- The vehicle must be a car, truck, bus, taxi (not a motorcycle) or other vehicle covered by New York No-Fault law.
- The vehicle is registered in New York.
- The vehicle has an insurance policy sold in New York or issued by a company licensed to do business in the State of New York.

Northwell Health℠

Physician Partners

Orthopaedic Institute

Patient Name: _____ DOB:_____/_____/_____

Consent to Provide Information

I, _____, (☐do / ☐do not) give permission for any staff member at the office of _____, to speak with a family member or individual regarding appointments, prescriptions, test results or pick up films on your behalf. Please list the individuals that we may speak with:

Name _____Relationship _____

Name _____Relationship _____

Name _____Relationship _____

May we leave a voicemail recording regarding your appointment or message to call us back?

☐Yes ☐ No

_____ _____

Patient Signature Date

Northwell Health℠

Physician Partners

Orthopaedic Institute

You have now completed all required forms.

Once you have reviewed all documents, this packet can be submitted electronically by clicking the box below:

Submit Form

If using Google Chrome, DO NOT SUBMIT ONLINE. Please print. Submission of forms not compatible with web browser!

Please print a copy for your records as well:

PRINT

CLEAR FORM