WELCOME

ANDREW FELDMAN, MD
University Place Orthopaedics
95 University Place, 8th Floor, New York, NY 10003
(212) 604-1340 (212) 604-1338 FAX

1 PATIENT INFORMATION

Date: _____

Patient: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthday: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Spouse's Phone: _____

Referring Physician Name: _____

Ref Physician Address: _____

_____

Ref Physician Phone: _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Birthday: _____ SS #: _____

Insurance Co. _____

Group #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name: _____

Birthday: _____ SS #: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Andrew Feldman, MD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

Relationship: _____ Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Andrew Feldman, MD for any services furnished to me by Andrew Feldman, MD. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

3 PHONE NUMBERS

Home: _____ Work: _____ Ext: _____

Cell/Pager: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Phone: Home: _____ Work: _____

4 REASON FOR TODAY'S VISIT

What injury/problem? Knee ☐ Left ☐ Right ☐ Bilateral/Both

Shoulder ☐ Left ☐ Right ☐ Bilateral/Both

Other _____ ☐ Left ☐ Right ☐ Bilateral/Both

When did the injury occur? _____

Were you injured ☐ on the job ☐ in a vehicular accident ☐ Sports injury ☐ at the gym?
☐ Other _____

Patient's Signature _____ Date _____

5 MEDICAL HISTORY (All information is strictly confidential)

Check symptoms **YOU** *currently have or have had in the past year.*

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Arthritis
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Cardiovascular

- ☐ Cardiovascular disease
- ☐ Chest pain
- ☐ High/low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Pacemaker
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

General

- ☐ Chills ☐ Sweats
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Forgetfulness
- ☐ Headache ☐ Migraine
- ☐ Loss of Sleep
- ☐ Numbness

Gastrointestinal

- ☐ Appetite poor
- ☐ Bowel changes
- ☐ Constipation ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas ☐ Bloating
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Vomiting
- ☐ Vomiting blood

Pulmonary/Lung

- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis

Skin

- ☐ Bruise easily
- ☐ Hives ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sores that won't heal
- ☐ Other skin problems

Ear, Eye, Nose &Throat

- ☐ Glaucoma ☐ Cataracts
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

Genital-Urinary

- ☐ Herpes
- ☐ Venereal Disease
- ☐ Bladder problems

Women Only

Date of last menstrual period _____

Are you pregnant? _____

Your Age: _____

Height: _____

Weight: _____

Sex: Male or Female

Family History Checklist

Check illnesses which have occurred in any of your **BLOOD RELATIVES**:

- ☐ Diabetes
- ☐ Cancer
- ☐ Bleeding Tendency
- ☐ Kidney Disease
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Nervous Illness
- ☐ Allergy
- ☐ Other

_____

_____

_____

Father ☐ Alive ☐ Deceased

Mother ☐ Alive ☐ Deceased

Check symptoms/illnesses you have or have had in the past:

- ☐ AIDS ☐ HIV positive
- ☐ Appendicitis
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Drug Use (Marijuana, etc.)
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles ☐ Mumps
- ☐ Multiple Sclerosis
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems

Surgeries/Operations you had:

_____

_____

_____

_____

_____

_____

_____

Have you ever been under the care of a psychiatrist/psychologist? ☐ Yes ☐ No

Have you ever been under the care of a neurologist? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No Do you drink caffeinated beverages? ☐ Yes ☐ No

6 MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

List **allergies** to medications or substances _____

_____

7 OFFICE USE ONLY

PRESCRIPTIONS: ☐ Voltaren ☐ Other _____

- ☐ Physical Therapy
- ☐ Brace: _____ ☐ Action Patch ☐ Lidoderm Patch
- ☐ Foot Orthotics ☐ Glucosamine
- ☐ Synvisc Injections _____
- ☐ MRI/CT Scan _____
- ☐ Referred To _____

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Feldman or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ **Date** _____

OFFICEUSE: BODYPART _____ **PRINT PT. NAME** _____

Dr. Andrew J. Feldman

Patient Name: _____

Race:

- Alaskan Native
- American Indian
- Asian
- Black/African American
- Caucasian
- Hispanic/Latino
- Prefer not to answer

Have you had a flu shot? Yes ___ No ___

Are you diabetic? Yes ___ No ___

Do you have any Drug Allergies? If so please list them.

_____

Please list current medications.

_____

_____

_____

Pharmacy: _____

Address: _____

Phone Number: _____

Email: _____

Patient Signature: _____ Date: _____

University Place Orthopaedics

95 UNIVERSITY PLACE / 8TH FLOOR / NEW YORK, N.Y. 10003
Phone (212) 604-1340 Fax: (212) 604 1338

Consent to the Use and Disclosure of Health Information

Name: _____

Birthday: _____ Social Security: _____

I understand that as part of my orthopaedic care under the auspices of Dr. Andrew J. Feldman and his affiliate staffs (administrative, billing, phone service etc.) the office generates and maintains original medical records inclusive of my medical history, examination (s), test results and all pertinent data relating to my care. I understand that this information serves as:

- ☐ A basis for planning my care and treatment
- ☐ A means of communication amongst the various healthcare professionals who are involved in my care and treatment
- ☐ A source of information for billing purposes/claim submissions
- ☐ A source of proof for third-party payers that services billed were actually provided
- ☐ A point of reference for routine healthcare operations to monitor quality of care

I understand and consent to the use of my medical/billing information being used in connection with any other providers of service directly/indirectly involved with my care knowing that this will be done with prudence under mandatory parameters.

I understand that there is no expiration on this document, as it will be used for the duration of my orthopaedic care.

X_____ Date: _____
(Signature of patient or legal guardian)

UNIVERSITY PLACE ORTHOPAEDICS

95 UNIVERSITY PLACE / 8TH FLOOR / NEW YORK, N.Y. 10003

PHONE: (212) 604-1340 FAX: (212) 604-1379

FRANCO P. CERABONA, M.D. *Spinal Surgery* (212) 604-1350

BASIL DALAVAGAS, M.D. *General Orthopaedics* (212) 604-1361

DENNIS F. FABIAN, D.O. *Reconstructive Surgery* of the Hip and Knee (212) 604-1350

ANDREW J. FELDMAN, M.D. *Sports Medicine* Arthroscopic Surgery (212) 945-2274

JOEL B. GRAD, M.D. *Hand/Upper Extremity* Surgery (212) 604-1362

STEVEN C. SHESKIER, M.D. *Orthopaedic Surgeon* Sports/Dance Medicine Fracture Care/Foot and Ankle (212) 604-1366

We value you as a patient and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect are determined by your health plan benefits. As you may be financially responsible for a portion of the medical services provided to you, it is our policy to obtain your credit number and authorization to process payments. The credit card information you provide will be entered into a system which is PCI Level One Compliant, this is the highest level of security. You can be assured that your information is encrypted and safe.

In providing credit card information below, you authorize payment for co-payments, co-insurance, deductibles, non-covered services or absence of coverage by your health plan. If you wish a maximum payment restriction to be imposed, payments will not exceed _____.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS, AND CHECK CARDS.

I authorize Andrew J. Feldman, M.D. to maintain my credit card on file and process payments when appropriate.

Cardholder Signature: _____

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____ State: _____ Zip: _____

Card Type: _____ Card Number: _____

Expiration Date: _____ V Code: _____