FINGER LAKES BONE & JOINT C·E·N·T·E·R

Patient Information (Confidential)

Name____ Male ☐ Female ☐ Today's Date_____________

DOB___________ Social Security #_______________ Employer____

Address____________________________________ City___________________ State_______ Zip_____________

Home Phone_____________________ Cell Phone_____________________ Work Phone____________________

Social History

Living Situation: ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Highest Grade of School Completed (Year or Degree):

☐Elementary________ ☐High School_________ ☐College_________ ☐Post Graduate________

Primary Care Physician___________________________________ Referrer________________________________

Hobbies/Interests____

Person to Contact In Case of Emergency

Name___________________________________ Relationship__________________ Phone___________________

Responsible Party (If Under 18)

Name of Person Responsible For This Account____ DOB___________

Relationship to Patient___________________________ Driver's License #________________________________

Home Phone___________________ Cell Phone_______________________ Work Phone____________________

Address_____________________________________ City___________________ State_______ Zip_____________

Insurance Information

Insurance Holder______________________________ Relationship to Patient______________________________

DOB of Insurance Holder___________ Insurance Company____

Group#______________________________________ ID#____

New York State Social Security Number Law Protections Waiver

Effective December 12, 2012, new restrictions are in place for Social Security numbers in the State of New York. The new law limits certain entities, including physician offices, from requiring individuals to disclose their Social Security numbers for any purposes.

Under the new law, the Social Security number includes not only the nine digit number issued by the Social Security Administration, but also "any number derived from such a number", unless the number is encrypted.

As a patient at the above noted office, I acknowledge that I have read and understand this information and that I am voluntarily Providing consent for the use of my Social Security number or any number derived thereof for billing purposes and or referring Physicians.

Patient Name (Print):____

Patient Signature: ____ Date: ______

Acknowledgement Form

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY

SUMMARY:

By law, we are required to provide you with our **Notice of Privacy Practices (NNP).** The notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communication;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.

If you have any questions about the Notice, the name and phone number of our contact person is listed on the last page of the ***NOTICE OF PRIVACY PRACTICE*** form.

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of this practice's **Notice of Privacy Practices.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the **Notice of Privacy Practice** form. I further understand that the practice will offer me updates should there be amendments, modifications or changes in anyway of the **Notice of Privacy Practices."**

____

Patient or Representative Name (please print)

____ __________________

Patient or Representative Signature **Date**

☐ **Patient was unable to sign because**: ______________________________

☐ **Patient refused to sign**

HEALTH HISTORY FORM

Name____ DOB__________________

Personal History

Tobacco Use: ☐ **Yes** packs per day____ # of years____ ☐ Cigarettes ☐ Cigars ☐Smokeless

☐ **No** ☐**Former Smoker,** quit smoking date_________

Alcohol Use: ☐**Yes** drinks per day/week_____ ☐**No** ☐**Rarely**

Do You Exercise Regularly? ☐**Yes** ☐**No** How Often____________ Type/Activity_____________________________

History of Injury

Date Symptoms Started/Accident Occurred_________ Body Part____________________________________ ☐**Left** ☐**Right**

Where Did Accident Occur? ☐**Work** ☐**School** ☐**Motor Vehicle** ☐**Public Facility** ☐**Private Residence**

List Any Treatments/ Tests You've Had **for This Problem**:

Medications________________________________ Physical Therapy____

X-rays/Other Tests____________________ Other Treating Physicians_______________________________________

Medical History

Medications (Please List All Medications You Are Currently Taking)

____

____

____

Allergies ☐**Yes (Please List All)** ☐**No** ***Latex Allergy** ☐**Yes** ☐**No**

____

Surgical History (Please List both the Surgery, And Date) ____

____

Please Indicate if You've Had Any of the Following:

PROBLEM	NO	YES	WHEN	DESCRIPTION
HEART DISEASE				
DIABETES				
HIGH BLOOD PRESSURE				
CANCER (TYPE?)				
LUNG/BREATHING PROBLEMS				
STOMACH/INTESTINAL PROBLEMS				
CIRCULATION PROBLEMS				
BLEEDING/CLOTTING PROBLEMS				
NEUROLOGICAL PROBLEMS (TYPE?)				
HEPATITIS/INFECTIOUS DISEASE (TYPE?)				
THYROID DISEASE				
ARTHRITIS (TYPE?)				
BROKEN BONES				
SEVERE SPRAINS				
DISLOCATIONS				
OTHER				

Next Page→

Name____ DOB______________________

Review of Systems (Check Anything That Applies to You)

Gastrointestinal:

☐Bleeding Ulcer ☐Hiatal Hernia ☐Frequent Indigestion ☐Colitis

Genitourinary (Urination):

☐Frequent ☐Burning ☐Painful ☐Bloody

Neurological:

☐Paralysis ☐Weakness ☐Numbness ☐Tingling in Arms or Legs ☐Seizures

Skin:

☐Rashes ☐Frequent Itching ☐Wounds That Do Not Heal ☐Infections

Vascular/ Hematological/ Lymphatic:

☐Vein Problems ☐Phlebitis ☐Blood Clots ☐Anemia ☐Swollen Nodes ☐Easy Bruising ☐Bleeding Problems

☐Calf Pain on Exertion

Cardiac/Pulmonary:

☐Chest Pain ☐Shortness of Breath ☐Enlarged Heart ☐Heart Murmur ☐Cough ☐Irregular Heart Beat ☐Wheezing

Endocrine:

☐Thyroid Problems ☐Weight Loss ☐Weight Gain ☐Excessive Sweating ☐Tremors

Family Health History

	AGE	LIVING	DECEASED	DESCRIBE
MOTHER				
FATHER				
BROTHERS				
SISTERS				
CHILDREN				

Patient Signature____ Date__________________

Thank You!

Workers Compensation Cases Only:

Date of Injury___________ Are You out of Work? **Yes / No** Who Took you out of Work? _________________________

First Date of Disability_________________________ Last Date That You Worked_________________________________