New Patient Intake Sheet

Effective 03/19/18

Patient Name: ______________________________

Account Number: ______________ **DOB:** ______________

**For any sections that do not apply, please write N/A

Your Current Problem:

Briefly describe the problem which brings you to us.

____

____

____

Date of onset: ______________

On a scale of 0-10, (0 = no pain 10 = severe pain), what is your pain level today? ________

Quality of pain?

Sharp Dull Aching Stabbing Throbbing Burning

Timing of Pain?

Constant Intermittent Improving Stable Worsening

What makes your pain better? ______________________________

What makes your pain worse? ______________________________

Occupation: ______________________________

Job Duties: ______________________________

Height: ______________ **Weight:** ______________

Right handed **Left handed** (please circle)

Have you been treated elsewhere for this problem? Yes No (Please circle)

If yes, when and by whom? ______________________________

Have you had any of the following diagnostic tests for the body part you are being seen for today? (Please circle)

X-ray MRI EMG/NCS CT Scan CT Myelogram Ultrasound None

When and where did you have the above test performed? ______________________________

____

Which of the following treatments have you tried for this problem? (please circle)

Physical Therapy Brace Anti-Inflammatories Injections

If you circled any of the above, please explain: ______________________________

____

Current Medications: Please list any medications you are currently taking, including dosage and frequency. Please include any over-the-counter medications.

____

____

____

____

____

____

Allergies: Are you allergic to any medication/drug? Yes No

If yes, please specify

____

____

Past Medical History: Please describe your past orthopaedic probems

____

____

Illnesses: Please circle any that you have been diagnosed with

Arthritis	Cancer	Gout	High Blood Pressure	Stroke
Asthma/Hay Fever	Diabetes	Heart Disease	Immunological Disease	Thyroid
Bleeding Disorder	Emotional Problems	Hepatitis	Liver Disease	Tuberculosis

Past Surgery: Please list any major surgical procedures you have had

____ Date: ______________

____ Date: ______________

____ Date: ______________

____ Date: ______________

Have you ever had any complications from anesthesia? Yes No

Do you have any metal in your body? Yes No (please circle) If yes, where? ____________________

Family History: Has anybody in your family ever suffered from any of the following (please circle)

Cardiac History Joint Problems Major Anesthesia Problems

Social History

Do you smoke? Yes No Daily usage: __________ **Do you drink alcohol?** Yes No Daily usage: __________

Do you use street drugs? Yes No Type: __________ **Are you pregnant?** Yes No

Marital Status: Married Separated Single Divorced Widowed (Please circle)

ORTHOPAEDIC REVIEW OF SYSTEMS

Effective 03/20/18

Name: ______________________________

DOB: ____________________ Account Number: ______________

REVIEW OF SYSTEMS: Please check all symptoms you have experienced within the past three months.

Constitutional/General

- ☐ Fever
- ☐ Chills
- ☐ Heavy Sweating/Night Sweats
- ☐ Loss of Appetite
- ☐ Sleep Disturbances
- ☐ Unexplained Weight Loss/Gain
- ☐ None of the Above

Respiratory

- ☐ Cough
- ☐ COPD
- ☐ Wheezing
- ☐ Recurrent Upper Respiratory Infections
- ☐ Shortness of Breath
- ☐ None of the Above

Endocrine

- ☐ Excessive Thirst or Fluid Intake
- ☐ Temperature Intolerance
- ☐ Feeling Tired (Fatigue)
- ☐ Hot Flashes
- ☐ None of the Above

Cardiovascular

- ☐ Chest Pain or Discomfort
- ☐ Swelling of Feet, Ankles or Legs
- ☐ Irregular Heart Beat
- ☐ Heart Failure
- ☐ Palpitations
- ☐ Varicose Veins
- ☐ None of the Above

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion/Heartburn
- ☐ Blood in Stools
- ☐ Change in Bowel Habits
- ☐ Rectal Bleeding
- ☐ Diarrhea
- ☐ Constipation
- ☐ Swallowing Difficulties
- ☐ None of the Above

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ None of the Above

Genitourinary

- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Loss of Urinary Control
- ☐ Enlarged Prostate
- ☐ Difficulty Urinating
- ☐ None of the Above

Skin

- ☐ Skin Rash
- ☐ Itching
- ☐ Discoloration of the Skin
- ☐ Lumps or Masses
- ☐ None of the Above

Musculoskeletal

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Limitation of Motion
- ☐ Neck Pain
- ☐ Pain with Walking
- ☐ None of the Above

Neurological

- ☐ Tremors
- ☐ Numbness or Tingling
- ☐ Headache
- ☐ Unsteady Gait
- ☐ Feeling Weak
- ☐ Seizure Disorder
- ☐ None of the Above

______________________________ ______________

Patient/Parent Signature Date

______________________________ ______________

Provider Signature Date

Our office locations

Linden Oaks Medical Campus
30 Hagen Drive
Suite 220
Rochester
NY 14625-2658

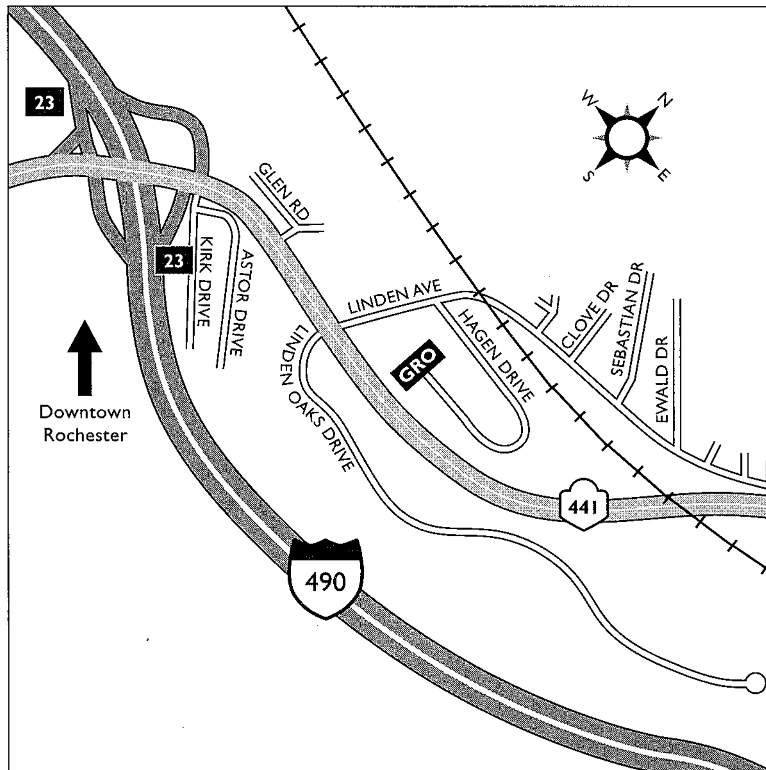
Directions (585) 295-5352

Appointment Details

Date:__________________

Time:__________________

Provider:________________



2621 Culver Road
Rochester
NY 14609-1746

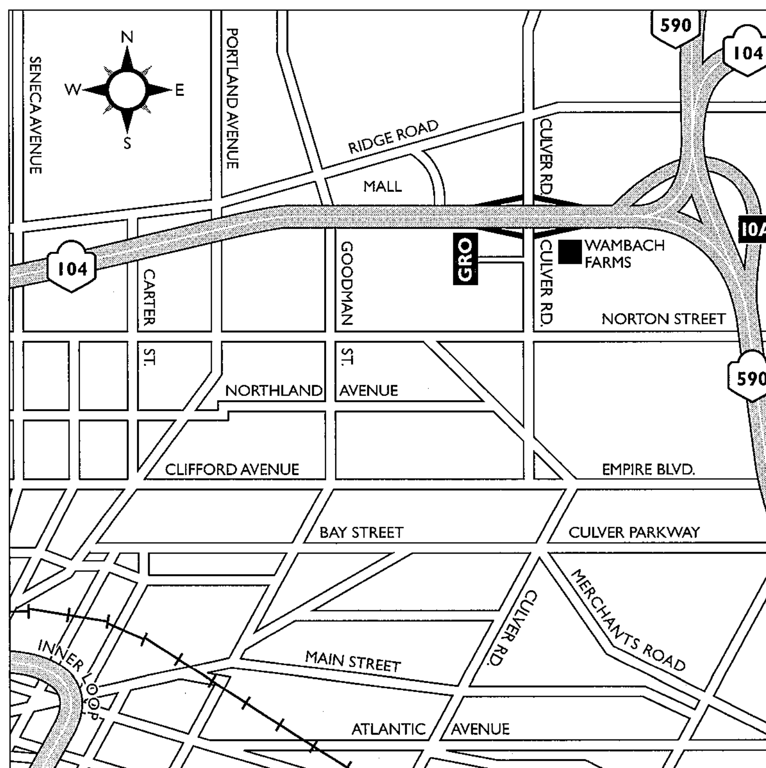
Directions (585) 295-5352

Appointment Details

Date:__________________

Time:__________________

Provider:________________



Greater Rochester Orthopaedics, PC

General and Specialty Orthopaedic Surgery

Linden Oaks Medical Campus
30 Hagen Drive, Suite 220
Rochester, NY 14625-2658

2621 Culver Road @Culver Pk.
Rochester, NY 14609-1746

Orthopaedic Surgeons

Peter N. Capicotto, MD
Spine Surgery

Gregory S. Finkbeiner, MD
Joint Replacement Surgery / Foot & Ankle

Paul K. Peartree, MD
Sports Injury / Arthroscopy / General

Frank Pupparo, MD
Joint Replacement Surgery

Todd Stein, MD
Hand & Upper Extremity

Everett S. Weiss, MD
Joint Replacement Surgery

Physician Assistants

Aaron Bishop, RPA-C

Margaret M. Casper, RPA-C

Thomas A. Frosini, RPA-C

Raymond C. Montanaro, RPA-C

Leslie R. Sonders, RPA-C

Main number (585) 295-5476
Appointments (585) 295-5350
Billing (585) 295-5351
Directions (585) 295-5352
Medical records (585) 295-5354
Nurse (585) 295-5355
Toll-free 1(800) 724-7712

24 hr medication renewals (585) 295-5353
Information required:

- Patient's name (spell last name)
- Patient's date of birth
- Daytime phone number
- Patient's orthopaedic provider
- Medication needed
- Dosage
- Pharmacy name and number

<table>
<tr><td rowspan="4">

HIPAA Form

PRIVACY RULES

FAMILY/FRIEND DESIGNATION AND RELEASE FORM

</td><td>PRACTICE:
Greater Rochester Orthopaedics, P.C.</td></tr>
<tr><td>LEGAL REFERENCE:
Privacy Rules---—45 CFR 164.510 (b)</td></tr>
<tr><td>INITIAL EFFECTIVE DATE OF FORM:
April 14, 2013</td></tr>
<tr><td>REVISION DATE(S):
September 23, 2013;
February 1, 2015</td></tr>
</table>

Name: ______________________________________ Date of Birth: _____/_____/_____

Greater Rochester Orthopaedics, P.C. (the "Practice") may disclose to a family member, other relative, a close personal friend, or any other person identified by you your protected health information relevant to that individual's involvement with your care or the payment for your care. However, this can only occur if you agree to a disclosure to such individual.

If you wish to name individuals to whom the Practice may make such disclosures, please complete the following Release of Information:

[ ] I authorize the release of information including, but not limited to, information related to my examination, diagnosis, records, and claims information. This information may be released to the individual(s) named below:

[ ] Spouse ______________________________________

[ ] Child(ren) ____________________________________

[ ] Parents______________________________________

[ ] Other ______________________________________

This **Release of Information** will remain in effect until terminated by me in writing.

[ ] Information is <u>not</u> to be released to anyone, except as otherwise authorized by law.

<u>Messages</u>

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message just asking me to return your call

Signed: ______________________________________ Date:_____/_____/_____

ROCHESTER **RHIO**

Regional Health Information Organization

RHIO CONSENT FORM

PROVIDER: GREATER ROCHESTER ORTHOPAEDICS PC

Using this Consent Form, you can choose whether to allow the above-named provider to obtain access to your medical records through a computer network operated by the Rochester RHIO, which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care and make them available electronically to our office.

You may decide whether or not to allow the Provider named above to see and obtain access to your electronic health records by using this form. You can give consent or deny consent. This form may be filled out now or at a later date. **Your decisions will not affect your ability to get medical care or health insurance coverage. In addition, your choice to give or deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, the above named Provider's staff involved in my care may see and get access to all of my medical records through the Rochester RHIO."

If you check the **"I DENY CONSENT"** box below, you are saying "No, the Provider named above may NOT have access to my medical records through the Rochester RHIO for any purpose."

The Rochester RHIO is a not-for-profit organization. It shares information about peoples' health electronically and securely to improve the quality of health care services. This kind of sharing is called e-health or health information technology (HIT). To learn more about e-health in New York State, read the brochure, "Better Information Means Better Care." You can ask this provider for it, or go to the website www.ehealth4ny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices:

☐ **I GIVE CONSENT for the Provider named above to access ALL** of my electronic health information through the Rochester RHIO in connection with providing me any health care services, including emergency care.

☐ **I DENY CONSENT for the Provider named above to access** my electronic health information through the Rochester RHIO for any purpose, *even in a medical emergency.*

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the Rochester RHIO.

____________________________ ________________________

Print Name of Patient | Patient's Date of Birth

____________________________ ________________________

Signature of Patient | Date

____________________________ ________________________

Print Name of Legal Representative | Relationship of Legal Representative to Patient (if applicable)

____

Signature of Legal Representative

The following disclosures are required by the NYS Surprise Bill:

You are required to understand what your health care plan covers if you obtain services from an out-of-network provider. Your plan may not cover out-of-network services at all, leaving you to pay the full cost. If your plan covers out-of-network services your plan may require higher co-pays, deductibles and co-insurance for out-of-network care. You will have to pay these higher amounts plus any difference between your plan's allowed amount and what the out-of-network provider charges for the services. In the event our health care providers do not participate with your health plan network, upon request we will disclose in writing the amount or estimated amount that we will bill the patient or prospective patient for health care services provided or anticipated to be provided for non-emergency services. If at the time services are provided, unforeseen medical circumstances arise, the amount to be billed for services may be adjusted and may be higher.

The health care providers of GRO participate with the following health care plans:

Aetna – Blue Choice Option – Excellus BCBS of Rochester – Child Health Plus

Cigna – Excellus Blue Choice – Family Health Plus – Medicare – MVP – MVP Gold

Sidney Hillman – United Health Care – Workers Compensation – Motor Vehicle Ins.

Fidelis Care of New York – Empire Plan

The health care providers of GRO may attend and have affiliations with the following Hospitals/Facilities:

Rochester General Hospital 1425 Portland Ave., 14621, 585-922-4000

Rochester Ambulatory Surgical Center 360 Linden Ave., 14625, 585-922-6200

Unity Hospital, 1555 Long Pond Rd., 14626, 585-723-7000

Unity Linden Oaks Surgery Center, 10 Hagen Dr., 14625, 585-267-8200

Acknowledgment of Receipt:

Signature:________________________ Date: ____________

If Legal Representative, indicate relationship to patient: __________________

Print Name of Patient:______________________________

Print Name of Legal Representative:________________________

GRO

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ORTHOPAEDICS

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