Frank R. DiMaio, M.D.
Orthopaedic Surgery

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

PATIENT INFORMATION

Patient Name:		**Date:**
DOB:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? _____

II. Which side is affected? O Right O Left O Bilateral

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV: Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other: _____

Have you had physical therapy? O Yes O No

Are you taking any pain medications?

Anti-inflammatory agent O Yes O No Drug Name: _____

Pain Medication O Yes O No Drug Name: _____

Tylenol O Yes O No

Have you been putting ice on the area? O Yes O No

Have you had any testing? O Yes O No

Which tests? O X-Ray O MRI O EMG/NCS O Bone Scan O CT Scan

Medical History

Osteoporosis	O	Yes	O	No	Cancer	O	Yes	O	No
Hypertension	O	Yes	O	No	Prolonged Steroid Treatment	O	Yes	O	No
Diabetes	O	Yes	O	No	Degenerative Joint Disease	O	Yes	O	No
Arthritis	O	Yes	O	No	Degenerative Disk Disease	O	Yes	O	No

Social History

Do you smoke cigarettes? O Yes O No

How long have you smoked? O >1 year O 1-10 years O 10+ years

How many packs per day? O >1 pack O 1-2 packs O 3+ packs

Have you ever smoked cigarettes in the past? O Yes O No

Do you drink alcohol regularly? O Yes O No

How many drinks per day? O 1 drink O 2-3 drinks O 4+ drinks

Do you have a history of substance abuse? O Yes O No

Have you ever had a blood transfusion? O Yes O No

Do you participate in sports/recreational activities? O Yes O No

If yes, please list _____

Family History

Mother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Paternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandmother	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis
Maternal Grandfather	O	Cancer	O	Osteoporosis	O	DJD	O	Arthritis

Review of Systems: *Are you experiencing any of these issues now?*

Constitutional

Fatigue	O	Yes	O	No
Weight change	O	Yes	O	No
Fever	O	Yes	O	No

Neurological

Migraine Headaches	O	Yes	O	No
Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No
Dizziness	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No
Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No
Chronic Coughing	O	Yes	O	No

Cardiovascular

Chest Pain	O	Yes	O	No
Irregular Heartbeat	O	Yes	O	No
High Blood Pressure	O	Yes	O	No
Leg/Ankle swelling	O	Yes	O	No

Musculoskeletal

Joint pain	O	Yes	O	No
Joint stiffness	O	Yes	O	No
Joint swelling	O	Yes	O	No
Back Pain	O	Yes	O	No

Gastrointestinal

Nausea/ Vomiting	O	Yes	O	No
Stomach Ulcer	O	Yes	O	No
Diarrhea	O	Yes	O	No
Blood in stool	O	Yes	O	No

Skin

Rashes/sores	O	Yes	O	No
Skin Cancer	O	Yes	O	No
Itching/ Burning	O	Yes	O	No

Hematologic

Anemia	O	Yes	O	No
Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No

Other

Sexually Transmitted Diseases	O	Yes	O	N

Allergies

Are you allergic to any medications?	O	Yes	O	No	If yes, please list:_____
Are you allergic to food or environmental substances?	O	Yes	O	No	If yes, please list:_____
Do you have any known Metal allergies?	O	Yes	O	No	

Medications (Please list name of medication and dosage) a copied updated list is acceptable for this section	

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

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Orthopaedic Surgery

Last Name: _____First Name: _____MI: _____

Sex: _____DOB: _____SSN: _____ Marital Status: M S W D

Home Address: _____

City/State/Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email: _____ Pharmacy: _____ #: _____

Emergency Contact Name_____Telephone#_____Relation_____

Who referred you to the doctor? _____

Primary Care Physician: _____

PCP Phone, Address: _____

Are you currently working? _____ Retired? _____ Last date worked? _____

Employer: _____Employer Address: _____

Telephone: _____Occupation: _____

The following information is now required by Medicare:

Ethnicity: (check one) ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: (check one) ☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Other Race: _____

Primary Language: (check one) ☐ English ☐ Spanish ☐ French ☐ Italian ☐ Polish ☐ Greek ☐ Portuguese

☐ Russian ☐ Chinese ☐ Japanese ☐ German ☐ Other _____

INSURANCE INFORMATION

Primary Insurance: _____Phone #: _____

Primary Insurance Address: _____

Policy #: _____Group #: _____Group Name: _____

Name of Insured: _____

Insured Address (if different from patient): _____

Insured's DOB: _____Insured's SSN: _____Relation to Patient: _____

Insured's Employer: _____

Secondary Insurance: _____Phone #: _____

Secondary Insurance Address: _____

Policy #: _____Group #: _____Group Name: _____

Name of Insured: _____

Insured Address (if different from patient): _____

Insured's DOB: _____Insured's SSN: _____Relation to Patient: _____

I hereby give my permission to Dr. Frank R. DiMaio to release medical information to insurance companies. I understand that charges incurred by me that are rendered by Dr. DiMaio that not covered by medical insurance are my responsibility.

Signature: _____ Date: _____

Long Island Orthopaedics & Joint Replacement Services

Long Island Orthopaedics and Joint Replacement Services

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the facility and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, sexually transmitted diseases, alcohol and substance abuse treatment information, mental health information, and genetic information.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient or Personal Representative

_____ _____

Description of Personal Reprentative's Authority Date

_____ _____

Signature of Facility Representative Date

EXPRESS AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been advised of my rights to obtain access to and control my Protected Health Information. I also understand that in providing treatment, submitting billing and conducting healthcare operations. Long Island Orthopaedic & Joint Replacement Services may need to disclose my protected health information to members of my family or certain close personal friends. By providing the requested information below, I further authorize the disclosure of my protected health information as follows:

If I am unavailable, I expressly permit long Island Orthopaedic & Joint Replacement Services to disclose my protected health information for the purposes of appointment/test/procedure reminders and follow-up to the following individuals:

_____ _____

(Relationship to me)

_____ _____

(Relationship to me)

I expressly permit Long Island Orthopaedic & Joint Replacement Services to disclose my protected health information for the purposes of appointment/test/ procedure reminder and follow-up by leaving such information in the form of a message on the following recorded media:

Home answering machine: Tel. # _____

Office voicemail: Tel. # _____

Other (specify):_____ Tel. # _____

_____ _____

Signature of Patient Date

Understanding and Acknowledgment of Office Policies and Procedures

Referrals

If your insurance plan requires a referral, it is your responsibility to visit or call your primary care physician prior to your appointment to ensure that you have a referral on file with us (either paper or electronic). Please be advised that some insurance companies may take up to 48 hours to provide a referral. Failure to produce your referral at the time of your visit may result in the cancellation of your appointment.

Disability Paperwork, Injection & MRI Authorization

Disability paperwork and injection authorizations require one week for processing and you may be charged a fee for completion of disability forms. If you have not had an office visit within the past 30 days, you may need to make an appointment to review the status of your disability. You will be contacted if an appointment is necessary.

Medical Records

If you need to obtain copies of your medical records, a signed release is necessary. If you need to obtain copies of medical records for someone other than yourself, a signed release from the patient or his/her guardian is necessary. The medical records department requires at least five business days to process requests and there is a fee associated with copying records and films.

Prescription Refills

If you require a refill on your prescription you can call our office during business hours on weekdays at least one- to three days before you'll need your medication. Pain medications will not be prescribed unless you have been seen by Dr. DiMaio within the past 60 days.

By signing this you are acknowledging that you read and understand the policies and procedures of this office. A copy will be given to you and one will be kept in our files as well.

_____ _____

Print Name Date

_____

Signature

Workers' Compensation Insurance Information

Insurance Carrier: _____Phone:_____

Address: _____

Claim #:_____WCB#:_____

Policy Holder: _____Date of Accident: _____

Attorney Name: _____Phone:_____

Address: _____

Were you referred here for a consultation by another Physician, Physical Therapist or Lawyer? ☐ Y ☐ N
If yes, who is requesting this? _____
Name Phone Fax
Chief complaint: What is the reason for this visit_____

Did you bring films/disc? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

What is the location of your injury? **Check all that apply**

☐ Spine/Back ☐ Neck ☐ R Shoulder ☐ L Shoulder ☐ R Arm ☐ L Arm ☐ R Elbow ☐ L Elbow ☐ R Wrist ☐ L Wrist
☐ R Hand ☐ L Hand ☐ R Hip ☐ L Hip ☐ R Knee ☐ L Knee ☐ R Ankle ☐ L Ankle ☐ Pelvis ☐ Ribs ☐ Clavicle
☐ R Leg ☐ L Leg ☐ R Foot ☐ L Foot ☐ Other: _____

State of NY – Workers Compensation: If this injury was WORK RELATED, Please answer all of the questions below.
Check the ONE box which best describes <u>how your problem started</u>.
☐ **NO INJURY** or onset was: ☐ Gradual ☐ Sudden
☐ **INJURY AT WORK** From a: ☐ lift ☐ twist ☐ fall ☐ bend ☐ pull ☐ reach Date: _____ Time: _____ Where _____
☐ **Work Related (BUT NO INJURY)** Date: _____ How did your job cause the problem_____
Have you missed time from work? ☐ Y ☐ N If yes, how much? _____
days/weeks/months/years
When is the last date you worked at your regular job? Date: _____
If you are **NOT** currently working, is your goal to return to work? ☐ Y ☐ N
Current Work Status? ☐ Regular ☐ Light Duty ☐ Not working due to this injury ☐ Disabled ☐ Retired ☐ Student
Are you currently receiving or plan to apply for: Disability ☐ Y ☐ N Worker's Comp: ☐ Y ☐ N Unemployment:☐ Y ☐N

Was your injury reported to your employer? ☐ Y ☐ N
If so who did you report it to? _____

Were you hospitalized for this injury? ☐ Y ☐ N On date of injury what was your job title/description? _____
Have you attended PT for your WC injury? ☐ Y ☐ N If so, when was your first visit? _____ last visit_____don't know_____
If you are attending PT, where are you going? _____
Please write specific details of your problem (if accident/injury, list details): _____
_____
_____

Are you being treated by another physician for this condition/injury? ☐ Y ☐ N If yes: Dr. _____
Dominant Hand ☐ R ☐ L ☐ Ambidextrous (both)

Signature: _____ Date: _____

AUTO INSURANCE INFORMATION

Insurance Company: _____ Phone: _____
Address: _____
Policy#: _____ Claim#:_____
PolicyHolder: _____ Phone: _____
Name of Examiner: _____ Phone: _____

Attorney Name: _____ Phone: _____

Address: _____

Were you wearing a seat belt at the time of the accident? ☐ Y ☐ N Did your airbag deploy? ☐ Y ☐ N

Your Car: ☐ Hit another car was hit in the: ☐ Right ☐ Left ☐ Rear ☐ Front

Type of Accident: ☐ Head on collision ☐ Broad side collision ☐ Rear end collision ☐ Front impact ☐ T collision

☐ You were a Pedestrian Date of Accident: _____

Did you go to the hospital for this problem? ☐ Y ☐ N If yes, which hospital? _____

Chief complaint: What is the reason for this visit? _____

Did you bring films/disc? ☐ X-Ray ☐ MRI ☐ CT scan ☐ Bone scan ☐ Nerve Test (EMG/NCV)

What is the location of your injury? **Check all that apply**

☐ Spine/Back ☐ Neck ☐ R Shoulder ☐ L Shoulder ☐ R Arm ☐ L Arm ☐ R Elbow ☐ L Elbow ☐ R Wrist ☐ L Wrist ☐ R Hand ☐ L Hand ☐ R Hip ☐ L Hip ☐ R Knee ☐ L Knee ☐ R Ankle ☐ L Ankle ☐ Pelvis ☐ Ribs ☐ Clavicle ☐ R Leg ☐ L Leg ☐ R Foot ☐ L Foot ☐ Other: _____

Were you hospitalized for this injury? ☐ Y ☐ N On date of injury what was your job title/description? _____
Have you attended PT for your MV injury? ☐ Y ☐ N If so, when was your first visit? _____
Last visit: _____ don't know: _____

If you are attending PT, where are you going? _____

Please write specific details of your problem (of accident/injury, list details): _____
_____
_____

Are you being treated by another physician for this condition/injury? ☐ Y ☐ N
If yes: Dr. _____

Dominant Hand ☐ R ☐ L ☐ Ambidextrous (both)

Signature: _____ Date: _____