



**410 Lakeville Road Suite 303 New Hyde Park, NY 11042**  
**Tel: (516) 775-7898 www.ortho-md.com Fax: (516) 775-4796**

**Philip D'Ambrosio, M.D. F.A.C.S.**

**Ronald Light, M.D. F.A.C.S.**

**Neil Watnik, M.D. F.A.C.S.**

**PATIENT NAME:** \_\_\_\_\_ **SEX:** M F

FIRST NAME MIDDLE INITIAL LAST NAME

**STREET ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**EMERG NAME & PHONE:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**PHARMACY NAME:** \_\_\_\_\_

**PHARMACY CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**REFERRING PHYSICIAN/PHONE NUMBER:** \_\_\_\_\_

**IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING:** \_\_\_\_\_

**PRIMARY INSURANCE:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**RELATIONSHIP TO INSURED:** \_\_\_\_\_

**POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):** \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):** \_\_\_\_\_

**TERTIARY INSURANCE:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE #:** \_\_\_\_\_

**POLICY HOLDER NAME & DATE OF BIRTH (IF DIFF. FROM PATIENT):** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES FOR SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES INCLUDING REASONABLE ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT.**

**I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.**

**I AUTHORIZE THE PHYSICIANS AND ALLIED STAFF OF ORTHOPAEDIC SURGEONS OF LONG ISLAND, ASSOC. TO ADMINISTER AND TREAT ALL ORTHOPAEDIC CONDITIONS AS DEEMED NECESSARY FOR MYSELF, MY FAMILY AND/OR MY DESIGNATED HEALTHCARE PROXY.**

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**PLEASE ADVISE THE FRONT DESK STAFF IF YOU WERE INJURED IN A CAR ACCIDENT OR ON THE JOB**

Yes  No **Patient Initials:** \_\_\_\_\_

## Your Insurance Company

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know, or keep up with, each program's provisions.

- Some programs require that a specific facility be used for your x-rays, ultrasounds, or blood tests.
- Some programs require pre-authorization, while others do not.
- Some companies require **patients** to notify them of hospital admissions or emergency room visits.
- Some programs require specific information regarding hospitalizations.

It is **your responsibility** (to know):

- To advise this office of your program's requirements in advance, each time we provide a service.
- Out of Network: will require any deductible or co-insurance payment
- Whether this office is participating with your particular plan and program
- We will do our very best to comply with any reasonable requirements that your program may have.

Please understand this if we have not been advised in advance of your programs requirements or conditions, and we provide a service or use a laboratory that is outside of the program, you will be responsible for the appropriate fees. In addition, there are times that we may not be able to obtain a consultant or laboratory that is participating with your program. It will be up to **you** to work this out with your insurance company.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may deny all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use if you have any questions about your coverage.

•**Assignment of benefits:** I authorize payment of medical benefits directly to Orthopaedic Surgeons of L.I. for services described. I understand that I am responsible to pay for services, including insurance co-payments as well as reasonable attorney fees and costs of collection in the event of default.

•I have been provided with a copy of the Orthopaedic Surgeons of L.I.'s **HIPPA Privacy Notice** and have been given an opportunity to read and ask questions about the notice.

•**Lastly, I authorize the following individual(s):** \_\_\_\_\_

**to receive any medical information on my behalf.** \_\_\_\_\_

*Patient Signature*

•**For patients insured by Medicare:** I authorize any holder of medical or any other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician, any information used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Date*

## PATIENT RESPONSIBILITY

**Having the correct insurance information at all times is very important to us.**

Most insurance companies have a timely filing period of 60 days. If we are given inaccurate information and bill the wrong insurance, it could affect the filing time limit with the correct carrier. **So please, anytime you have new information, let us know immediately.**

*I am aware that all insurance information I have provided Orthopaedic Surgeons of LI is to be accurate and up to date. I am also aware that I am responsible to follow all the rules and regulations that are implemented by my insurance carrier. This includes obtaining a proper referral form/authorization for my visits / MRI / X-Ray / PT / (if applicable), bring the referral form and/or referral number/authorization number with me to my appointments and any other rules I must follow with my insurance carrier. If my insurance does not cover my visits / MRI /X-Ray /PT / for any reason, I am responsible for the payment within 30 days of the denial.*

*I understand that there will be a billing service charge of \$10 for each statement mailed to me. I also understand that if I do not pay the balance in full within 60 days of the date of the statement, Orthopaedic Surgeons of LI may enter this balance on credit reporting registries, which will likely affect my overall credit rating.*

**PHYSICAL THERAPY: Appointment Cancellation /No Show Policy - If you cancel an appointment for physical therapy less than 24 hours in advance, or fail to show up for an appointment, you will be charged \$25.00 for the allotted time.**

### **DOES YOUR INSURANCE REQUIRE A REFERRAL?**

Please Initial: YES \_\_\_\_\_ NO \_\_\_\_\_

Print Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_



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## Email Consent Form

OSLI would like to correspond with you via email communication. As a provider of care, we would like to be as efficient as possible and we believe this method of communication will allow us to do so.

Realizing that email communication is not completely secure, we would like to obtain your consent below giving us permission to contact you in this fashion. If you agree to have certain office correspondence, which may include requests for payment, scheduling updates, general office information, etc, please sign below and enter your primary email address.

Please Print:

\_\_\_\_\_

*Full Name*

\_\_\_\_\_

*Primary Email Address*

\_\_\_\_\_

*Signature*

\_\_\_\_\_

*Date*



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## Musculoskeletal Orthopaedic Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Today's date \_\_\_\_\_ Your Date of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_

Name of your referring physician \_\_\_\_\_

Name of your primary care physician \_\_\_\_\_

What brings you here?

**CHIEF COMPLAINT:** \_\_\_\_\_

**HISTORY:**

Date symptoms started/accident occurred: \_\_\_\_\_ Problem: Body part(s) \_\_\_\_\_

Describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any treatments or tests you have had for this problem:

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY: (check if applies and explain)**

Heart Disease \_\_\_\_\_  Diabetes \_\_\_\_\_

High Blood Pressure \_\_\_\_\_  Circulation Problems \_\_\_\_\_

Arthritis (type?) \_\_\_\_\_  Stomach/intestine problems \_\_\_\_\_

Neurological \_\_\_\_\_  Cancer(type?) \_\_\_\_\_

Bleeding/Clotting problems \_\_\_\_\_  Hepatitis \_\_\_\_\_

Breathing/Lung problems \_\_\_\_\_  Broken bones \_\_\_\_\_

Other Problems \_\_\_\_\_

List all past **SURGERIES** and dates:

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS:** (list all)

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES:** (meds, environmental)

\_\_\_\_\_

Have you ever had a Bone Densitometry test?  Yes, when: \_\_\_\_\_  No



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**SOCIAL HISTORY:**

**Living situation: (check if applies)**

- Single  Married  Widowed  Separated  Divorced

**PERSONAL HISTORY:**

- Drink Alcohol \_\_\_\_\_ (amt/day)  Smoke: \_\_\_\_\_ (amt/day)  
Your height: \_\_\_\_\_ (Feet) \_\_\_\_\_ (Inches) Your weight \_\_\_\_\_ (lbs)  
I am:  Right hand dominant  Left hand dominant  Ambidextrous

**DISABILITY:**

Are you disabled?  Yes  No If yes, date last worked: \_\_\_\_\_

**For Workman's Compensation / No-Fault Cases:**

Date of injury \_\_\_\_\_ First date of disability \_\_\_\_\_ Are you out of work?  Yes  No

**FAMILY HISTORY: Please list any illness in family members living or deceased**

**Mother:**  Alive  Deceased **Father:**  Alive  Deceased #Siblings: \_\_\_\_\_ #Children: \_\_\_\_\_

**REVIEW OF SYSTEMS (Circle words that apply to you)**

**Gastrointestinal** ----- bleeding ulcers, hiatal hernia, frequent indigestion, colitis

**Genitourinary**-----urination is: frequent, burning, painful, has blood

**Neurologic** ----- paralysis, weakness, numbness, tingling in arms or legs, seizures

**Skin**----- rashes, frequent itching, sores that don't heal, infections or boils

**Vascular & Hematologic & Lymphatic**-----vein problems, phlebitis, clots, anemia  
bleeding problems, calf pain on exertion, bruise easily, swollen nodes

**Cardiac & pulmonary**----chest pain, shortness of breath, cough, enlarged heart,  
irregular heart beat, heart murmur, wheezing

**Endocrine**--thyroid problems, weight loss, weight gain, excessive sweating, tremor

**Please give any other insights, information or concerns that you feel might be helpful in your care:** \_\_\_\_\_

**If this is a work-related injury or motor vehicle accident, please inform staff**

**This is a confidential record of your medical history and will be kept in your chart.  
Information contained here will not be released except when you have authorized us to do so.**