NEW MILFORD ORTHOPEDICS
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Authorization to Use SRS Communicator and Access Limited Medical Records Electronically at New Milford Orthopedic Associates, P.C.

I, _____, elect to enroll in the SRS Communicator at New Milford Orthopedics and authorize its staff to communicate with me electronically via the patient portal.

Please use the following **email address:** _____

☐ **Decline patient portal**

_____ _____

Patient Signature **Date**

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Meaningful Use Patient Questionnaire:

Ortho Connecticut needs to ask you additional questions in order to comply with new Federal regulations, but these questions are asked to help enhance the quality, coordination and safety of your care among all your medical providers, now and in the future. We are enhancing our electronic health record (EHR) system in order to achieve these worthy goals and to provide you, your referring physician, and your medical providers (when requested) with your records in a secure and confidential fashion. The Federal government will only receive summary reports of all patient totals, not your specific answers which remain private.

Name: _____ **DOB:** _____

Marital Status: ☐Married ☐Single ☐Divorced ☐ Widowed ☐Refuse to answer

Ethnic Group: ☐Hispanic/Latino ☐Not Hispanic or Latino ☐Refuse to answer

Race: ☐ Asian ☐Black or African American ☐American Indian/Alaska Native ☐White ☐Hawaiian or Pacific Islander ☐Other ☐Refuse to answer

Primary Language: ☐English ☐Spanish ☐Portuguese ☐Cantonese ☐Mandarin ☐Japanese ☐ Korean ☐Russian ☐Hebrew ☐Italian ☐Other

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ASSIGMENT OF BENEFITS, RELEASE OF INFORMATION & PATIENT FINANCIAL RESPONSIBILITY:

I authorize New Milford Orthopedic Associates, PC to submit my medical claims to the insurer benefit plan administrator or third-party payor and allow the claim to be paid to New Milford Orthopedics Associates. I understand that all information requested by the Insurer, benefit plan administrator, or third-party payor to process the claim will be released.

New Milford Orthopedic Associates, PC will submit the claim to the insurer, benefit plan administrator or third-party payor I provided. Co-pays, deductibles, and other charges considered the responsibility of the patient will be collected at the time of service.

I understand my insurer or benefit plan administrator, may not cover the medical services rendered by New Milford Orthopedic Associates, PC or third-party payor, and I am financially responsible for any unpaid claims.

I understand that if I have identified the incorrect insurer, benefit plan administrator, or third-party payor which delays the claims submission to the correct payor, I will be financially responsible for the payment of the medical services denied due to untimely filing of the claim.

I understand that New Milford Orthopedic Associates, PC may refer the unpaid balance on my account to a collection agency, and I will be responsible for all reasonable attorney's fees, court costs, collection agency costs and other charges incurred to collect the unpaid balance.

Signature of Patient/Parent/Guardian ______________________ Date ______________________

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

ePrescription Consent Form

I agree that New Milford Orthopedic Associates, PC may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Patient Signature (or Legal Representative) ______________________ Date ______________________

☐ Patient refused to sign

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

New Milford Orthopedic Associates Privacy Notice for New Milford Orthopedics

I, ______________________ acknowledge and agree that I have received a copy of the Privacy Practice Notice for New Milford Orthopedic Associates, PC.

Patient Signature (or Legal Representative) ______________________ Date ______________________

☐ Patient refused to sign ☐ Patient was unable to sign because: ______________________

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

If there is a family member or friend with whom we may discuss or to whom we may release information and/or prescriptions on your behalf, please list them here:

Name: ______________________ Relationship: ______________________

Name:
Chart:
Age:
Date:

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PATIENT INFORMATION FORM

DATE: _____

Patient's Name (First, Middle, Last)	Date of Birth	Social Security No,
Patient's Address	Apt. No,	
City	State	Zip
Home Phone with Area Code	Cell Phone No.	Sex: ☐ M ☐ F
Primary Care Physician's Name	Phone with Area Code	
Referring Doctor	Address	City, State, Zip

FILL IN IF PATIENT IS A MINOR

Parent's Name (First, Middle, Last)	Date of Birth	Social Security No.

ACCIDENT INFORMATION ☐ Work Injury ☐ Automobile Injury ☐ School/Sports Related ☐ Liability ☐ Other

Date of Accident and Description		
Employer at Time of Accident	Employer's Address	Phone with Area Code

INSURANCE - PRIMARY

Policy Holder's Name (if other than Patient)	Date of Birth	Social Security No,
Policy #	Group#	Phone with Area Code
Employer Name	Address	Phone with Area Code

INSURANCE - SECONDARY

Policy Holder's Name (if other than Patient)	Date of Birth	Social Security No,
Policy #	Group#	Phone with Area Code
Employer Name	Address	Phone with Area Code

ASSIGNMENT OF MEDICAL BENEFITS/GUARANTEE OF FINANCIAL RESPONSIBILITY

I request that payment of authorized medical benefits be made directly to New Milford Orthopedics, PC This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event that I fail to pay charges due and New Milford Orthopedics, PC refers my account to collection, I agree to pay cost of collections, including a reasonable attorneys' fee. For Medicare patients, this applies to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries or carriers.

Patient or Legal Guardian Signature _____ Date _____

Name:
Chart:
Age:
Date:

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MEDICAL HISTORY FORM

Name: _____ Date: _____

Height: _____" Weight: _____ lbs. Heart Rate: _____ DOB: _____
(Physician Use Only)

Orthopedic History: _____

Reason for Visit: _____

Is this problem a result of: ☐ MVA ☐ Liability ☐ Work Related ☐ Trauma

Date of Injury: _____ Description of Injury: _____

Side: ☐ Right ☐ Left Dominant: ☐ Right-Handed ☐ Left-Handed

History of Present Injury or Complaint: _____

PERSONAL HISTORY:
Cigarettes ☐ Yes ☐ No Amount: _____ ☐ Former Smoker Start Date: _____ Quit Date: _____
Alcohol ☐ Yes ☐ No Amount: _____
Race: _____ ☐ Declined Ethnicity: ☐ Hispanic Origin ☐ Non Hispanic Origin ☐ Declinec
Preferred Language: _____ ☐ Declined

OCCUPATION: _____

DO YOU HAVE ALLERGIES, SENSITIVITIES OR HAVE YOU AN ADVERSE REACTION TO MEDICATIONS OR LATEX? ☐ Yes ☐ No
Please List: _____

CURRENT MEDICATIONS: _____

When did you last use aspirin in any form? _____

Name:
Chart:
Age:
Date:

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MEDICAL HISTORY FORM

Do you now have or have you ever had:

CONSTITUTIONAL:

Recent weight changes	❑ Yes	❑ No				
Recent fever, weakness or fatigue	❑ Yes	❑ No				

EYES:

Wear glasses or contact lenses	❑ Yes	❑ No				
Glaucoma	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Cataracts	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____

EARS, NOSE, THROAT:

Hearing problems	❑ Yes	❑ No				
Dizziness	❑ Yes	❑ No				
Recent cold or sinus pain	❑ Yes	❑ No				
Recent sore throat	❑ Yes	❑ No				
Hoarseness or difficulty swallowing	❑ Yes	❑ No				

CARDIOVASCULAR:

Chest pain	❑ Yes	❑ No				
Heart attack	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Stroke	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Heart failure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
High bood pressure	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Irregular heartbeat	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Swelling of hands or feet	❑ Yes	❑ No				
Blood clots	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
High cholesterol	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____

RESPIRATORY:

Asthma	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Emphysema	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Bronchitis	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Pneumonia	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____
Tuberculosis	❑ Yes	❑ No	Family History	❑ Yes	❑ No	Member:_____

Name:
Chart:
Age:
Date:

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MEDICAL HISTORY FORM

GASTROINTESTINAL:
Recent changes in bowel habits ☐ Yes ☐ No
Rectal bleeding ☐ Yes ☐ No
Liver disease ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____

URINARY:
Problems with urination ☐ Yes ☐ No
Urinary tract infections ☐ Yes ☐ No
Kidney disease ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____

SKIN:
Recent or current rashes or eruptions ☐ Yes ☐ No Where: _____

NEUROLOGICAL:
Seizures ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____
Paralysis ☐ Yes ☐ No Where: _____
Numbness or tingling ☐ Yes ☐ No Where: _____
Depression / mental illness ☐ Yes ☐ No When: _____
Anxiety disorders ☐ Yes ☐ No When: _____

ENDOCRINE:
Thyroid ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____
Diabetes ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____

Treatment: ☐ Diet ☐ Oral Meds ☐ Insulin
Medical Complications: ☐ Vascular ☐ Renal ☐ Neuropathy ☐ Other:_____

HEMATOLOGIC/LYMPHATIC:
Anemia ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____
Transfusions ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____

CANCER/TUMOR: ☐ Yes ☐ No Family History ☐ Yes ☐ No Member:_____
Type:_____ Location:_____ Treatment: _____

OTHER MEDICAL PROBLEMS: _____

HISTORY OF OPERATIONS: ☐ Yes ☐ No
Type:_____

Name:
Chart:
Age:
Date:

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MEDICAL HISTORY FORM

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ Bone Scan ☐ Bone Density ☐ Bloodwork

Tests performed at: _____

PRIOR TREATMENT (Best recollection - Check and explain):

☐ Anti-inflammatories:
☐ Injections (dates & number):
☐ Chiropractic:
☐ Surgery:

Physical Therapy:
☐ Ultrasound ☐ Massage ☐ Strengthening ☐ ROM Stretching
☐ Cybex Machines ☐ Cryotherapy ☐ Cortisone Cream ☐ Manipulation
☐ Electrical Stimulation

YOUR MEDICAL DOCTOR:
Name: _____
Address: _____
Phone: _____

YOUR REFERRING DOCTOR:
Name: _____
Address: _____
Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____