New York Hand Surgery
Hand • Wrist • Elbow • Microsurgery

Date : _____
Patient Name: _____ **DOB: _____** **Age: ___** **Sex:** M / F
Dominant hand: **Side of injury:**
Are you taking any medication? ○ Yes ○ No If yes, please List: _____
_____
List allergies to medication: _____
Reason for visit today _____
Have you been treated by another physician for this problem? Yes No
If yes, by whom? _____

PAST MEDICAL HISTORY: Do you now have or have you ever had any of the following:

1. Diabetes	○ Yes	○ No	7. Pneumonia	○ Yes	○ No
2. Heart Attack	○ Yes	○ No	8. Cancer	○ Yes	○ No
3. High Blood Pressure	○ Yes	○ No	9. Hepatitis	○ Yes	○ No
4. Tuberculosis	○ Yes	○ No	10. Ulcers	○ Yes	○ No
5. Asthma/Emphysema	○ Yes	○ No	11. Thyroid Disease	○ Yes	○ No
6. Lyme Disease	○ Yes	○ No	12. Stroke	○ Yes	○ No
			13. Blood Clots	○ Yes	○ No

PAST SURGERIES:
1. Type_____Year_____Hospital_____
2. Type_____Year_____Hospital_____
3. Type_____Year_____Hospital_____
4. Type_____Year_____Hospital_____
5. Type_____Year_____Hospital_____

SOCIAL HSTORY
Do you drink alcohol? ○ Yes ○ No If yes, how much? _____
Do you smoke now: ○ Yes ○ No If yes, how many packs per day? _____
Have you ever been a drug user? ○ Yes ○ No
Do you drink coffee? ○ Yes ○ No if yes, how much cups per day? _____

FAMILY HISTORY:	Alive/Dead	cause of Death	age
Father:	_____	_____	_____
Mother:	_____	_____	_____

1. Heart Disease	○ Yes ○ No	5: Thyroid disease	○ Yes ○ No
2. High Blood Pressure	○ Yes ○ No	6: Cancer	○ Yes ○ No
3. Diabetes	○ Yes ○ No	Location: _____	
4. Strokes	○ Yes ○ No	7: Other Disease_____	

REVIEW OF BODY SYSTEMS: Do you now have or have you ever had any of the following?

1. Notable weight change	○ Yes ○ No	10. Gallbladder Disease	○ Yes ○ No
2. Frequent Headaches	○ Yes ○ No	11. Bladder Infections	○ Yes ○ No
3. Excessive Thirst	○ Yes ○ No	12. Blood in Urine	○ Yes ○ No
4. Chest Pain	○ Yes ○ No	13. Kidney Stones	○ Yes ○ No
5. Palpations	○ Yes ○ No	14. Swollen or Painful Joints	○ Yes ○ No
6. Shortness of Breath	○ Yes ○ No	15. Ankle Swelling	○ Yes ○ No
7. Chronic Cough	○ Yes ○ No	16. Venereal Disease	○ Yes ○ No
8. Rectal Bleeding	○ Yes ○ No	17. Epilepsy	○ Yes ○ No

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www.handsurgeon.com
Ph. 718-369-4263 Fax. 718-369-4265 Text. 917-473-9890
Brooklyn Office : 330 9th street Brooklyn, NY 11215
Queens Office : 54-07 Roosevelt Avenue Woodside, NY 11377

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.:	Previous Name (If applicable)
Mailing Address: Apartment:		City/State/Zip:	
Home Phone:	Cell Phone:		Work Phone w/ext:
Family Physician:	Date of Birth:		Sex: □ Male □ Female
Marital Status:	Social Security #:		
Employer Name:		Employer Address:	
Emergency Contact:	Phone:	Relationship to Patient:	

Insurance & Paymern Information

Person responsible for the bill (**ONLY IF DIFFERENT THAN THE INSURED**): Name:		
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		City/State/Zip:
Employer of Person Responsible:		Relationship to Patient:
Primary Medical Insurance		Secondary Medical Insurance
Ins. Co. Name		Ins. Co. Name
Policy Holder Name:		Policy Holder Name:
Insurance ID #:		Insurance ID #:
Employer Name:		Employer Name:

Additional Information

Email Address:	Can we leave a message regarding your medical care & test results? □ Yes □ No			
Race (please select one):	□ American Indian or Alaska Native	□ Aslan	□ Black or African American	
□ Hispanic	□ Native Hawalian or Pacific Islander	□ White	□ Other	□ Decline
Ethnicity (please select one):	□ Not Hispanic or Latino	□ Hispanic or Latino	□ Decline	□ Other
Language	□ English	□ Spanish	□ Decline	□Other:_____
Preferred Pharmacy Name & Location:				

I have read and agree to the New York Hand Surgery payment policy. I understand that payment is my responsibility regardless of Insurance coverage. I hereby authorize NYHS to furnish insured's Insurance company all information (Including HIV, sexually transmitted diseases, drug/alcohal abuse, mental illness, or psychiatric treatment) which may be requested concering my illness or Injury. I also authorize the release of information regarding work related injuries to my employer. I hereby assign to NYHS all money to which I am entitled for medical expenses related to the services performed from time to time by NYHS, but not to exceed my Indebtedness to NYHS. Any money received from such Insurance company over and above such Indebtedness wll be refunded to me when my bill is paid in full. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside billing service. If my account is sent to an outside billing service there will be a setup fee up to $20.00 and finance charge(s) (1% per month/APR 12%). Note: Medicare patients will not be charged the setup fee or finance charge(s).

MEDICARE BENEFICIARIES: As a Medicare patient, I understand that interest will not be Imposed on any outstanding balance. I request that payment of authorized Medicare benefits be made to NYHS. I authorize any holder of medical information about me to release to NYHS and its agents any information needed to determine these benefits payable for related services.

Signature of Responsible Party: X_____Date:_____

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RECEIPT OF HIPAA PRIVACY NOTICE

Date: _____

I, _____ hereby authorize New York Hand Surgery Queens, PC to discuss my Medical Information with the following Individuals:

NAME	RELATIONSHIP

ACKNOWLEDGEMNT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received copy of New York Hand Surgery Queens, PC's Notice of Privacy Practices.

_____ _____

Signature Date

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ATTENTION: No Fault Patients

- Patients are responsible for their NO FAULT applications.
  Your Insurance company will deny payment if the application is not received in time.
  Patient will be responsible if payment is denied

- Patients are responsible for the NO FAULT deductible in full.

- Patients are responsible for any denials or correspondence from their insurance company.

- All visits after the date of No-Fault denial will be the patient's responsibility in full.
  This balance due is between Dr._____ and patient, nit the attorney. This is NOT for the office of Dr._____ to work out with the attorney

Authorized By: _____ _____

Patient's Signature ***Date***

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NO FAULT INFORMATION

DATE: _____/_____/_____

PATIENT NAME: _____DOB : _____ SSN: _____

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

DATE OF ACCIDENT: _____/ _____/ _____

NO FAULT INSURANCE NAME: _____

ADDRESS: _____

PHONE: (_____) _____ - _____

ADJUSTER NAME: _____

POLICY# _____

CLAIM# _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE NY HAND SURGERY QUEENS, PC TO FURNISH INFORMATION TO THE GOVERNMENTAL AGENCIES, INSURANCE CARRIERS OR OTHERS CONCERNING MY ILLNESS AND TREATMENTS, AND PERMIT REPRESENTATIVES TO EXAMINE AND RETAIN COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NO COVERED BY MY INSURANCE.

_____ _____

Patient's Signature **Date**

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NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM
(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
(Print name of Patient) **(Signature of Patient)**

_____ _____
(Date of signature)

_____
(Address of Patient)

_____ _____
(Print name of Provider) **(Signature of Provider)**

_____ _____
(Date of signature)

_____
(Address of Provider)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ **, ("Assignor") hereby assign to** _____ **, ("Assignee")**
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ **, not withstanding any other agreement**
(Print accident date)
to the contrary.

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(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)