HSS HOSPITAL FOR SPECIAL SURGERY

NewYork-Presbyterian

Gregory S. DiFelice, MD

MRN#_____

PATIENT REGISTRATION FORM

LAST NAME:	**FIRST NAME:**	**MI:**
DATE OF BIRTH:	**SOCIAL SECURITY #:**	**SEX:**
ADDRESS:	**CITY/STATE:**	**ZIP CODE:**
HOME TELEPHONE:	**WORK TELEPHONE:**	**CELL PHONE:**
EMAIL ADDRESS:		
EMPLOYER:	**EMPLOYER ADDRESS:**	
SPOUSE'S NAME:		
REFERRAL SOURCE:		
PRIMARY CARE PHYSICIAN:	**ADDRESS:**	**TELEPHONE:**
EMERGENCY CONTACT:	**PHONE NUMBER:**	

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:		
POLICY HOLDER'S NAME:	**RELATIONSHIP:**	**DATE OF BIRTH:**
ID NUMBER:	**GROUP NUMBER:**	
SECONDARY INSURANCE NAME:		
POLICY HOLDER'S NAME:	**RELATIONSHIP:**	**DATE OF BIRTH:**
ID NUMBER:	**GROUP NUMBER:**	

ASSIGNMENT AND RELEASE OF BENEFITS

I certify that the information given by me is correct. I understand that this information is entered into a database, and I authorize the sharing of such information with affiliated physicians who are responsible for my care. I hereby also authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I hereby assign my insurance benefits to the Physician and understand that, in the absence of accepted insurance coverage, my legal guardian or I am responsible for full payment of services rendered.

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services, and 20% coinsurance on ancillary services. When Medicare is deemed as the secondary insurance, I will follow payment terms specified by the individual Physician's policies.

EFFECTIVE DATE: These statements shall be effective from the date of the signature below until my insurance changes, at which time I understand that I am obligated to notify the Physician.

Signature of Patient/Guardian:_____ Date:_____

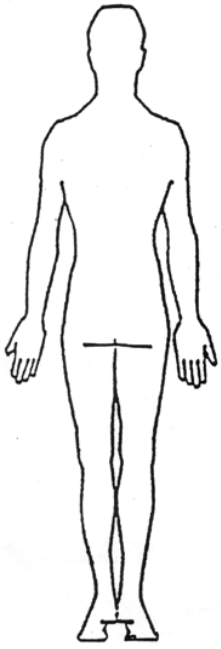
Relationship to Patient:_____

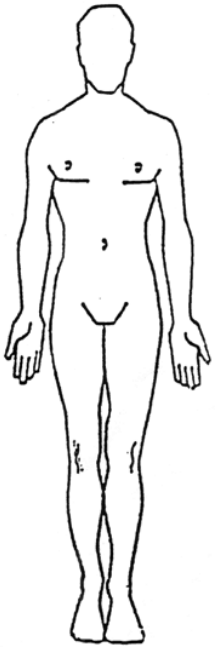
Gregory S. DiFelice, MD

New Patient Questionnaire

Name:_____ Age:_____ Date of Birth:_____
Referred by (First and Last Name): _____

Chief Complaint:_____
Date of injury or symptom onset:_____
Please describe the injury or problem:_____
_____





Where is your pain? Please mark the drawing.

Rate your pain: 0=No pain 10=Extreme Pain

Please indicate your pain level:

1. Right now: 0 1 2 3 4 5 6 7 8 9 10
2. At best: 0 1 2 3 4 5 6 7 8 9 10
3. At worst: 0 1 2 3 4 5 6 7 8 9 10

1. What makes it better?

_____
_____

2. What makes it worse?

_____
_____

Current Height:_____ Current Weight:_____

Which words best describe your symptoms? (Please check all that apply)

☐ Dull/Ache	☐ Gnawing	☐ Heaviness
☐ Shooting	☐ Burning	☐ Weakness
☐ Awareness	☐ Numbness	☐ Tightening
☐ Sharp/Stabbing	☐ Throbbing	☐ Constricting

Please list any studies you have had in the past (MRI, CAT Scans, X-Ray, etc.)

_____ Date _____

_____ Date _____

_____ Date _____

Gregory S. DiFelice, MD

Please describe your past treatments (Including and/other than Orthopedic):

Surgery:

Type _____ Date _____

Surgeon_____

Type _____ Date _____

Surgeon_____

Physical Therapy:
Therapist _____ Date _____

Injections:
Type_____ Date _____

Please check off any ongoing medical problems/symptoms:

- ☐ Arthritis/Rheumatoid Arthritis
- ☐ Asthma
- ☐ Bleeding disorder (DVT, P.E.)
- ☐ Cancer_____
- ☐ Change in urinary habits
- ☐ Chest pain
- ☐ Constipation
- ☐ Despressed mood
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Fever/chills
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Headaches
- ☐ Heart disorder
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infectious Diseases
- ☐ Joint stiffness, pain or swelling
- ☐ Loss of bowel control
- ☐ Memory loss
- ☐ Nausea/vomiting
- ☐ Night pain
- ☐ Numbness
- ☐ Recent weight change
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin rash/disease
- ☐ Sleep Apnea
- ☐ Strokes
- ☐ STD's
- ☐ Thyroid Disorder
- ☐ Visual changes
- ☐ None
- ☐ Other:_____
  _____
  _____

- ☐ **I have reviewed all symptoms and affirm that none are noted at this time**.

Are you allergic to any medication? Yes No If yes, please list_____

Please list medications (including vitamins, herbal/nutritional supplements) you are currently taking:

Name of Medication	Dosage

Preferred Pharmacy

Name:_____ Tel:_____

Address: _____

Gregory S. DiFelice, MD

Gynecological History (**For Women, if applicable**)

Date of last menstrual period:_____ Age you began menstruating:_____
Have you experienced menopause? Hysterectomy? Yes No If yes, when_____
How many periods have you had in the last 12 months?_____
Are you currently on birth control? Yes No If yes, what type_____

Family History

Does anyone in your family have any of the following conditions? (Please check all that apply)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Cancer_____
- ☐ Bleeding disorder
- ☐ Heart disorder
- ☐ Asthma
- ☐ Arthritis
- ☐ Headaches
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Epilepsy
- ☐ Fibromyalgia

Are you under any emotional stress or suffer from anxiety or depression? If yes, are you undergoing any treatment?_____

What is your occupation or former occupation? Are you retired or disabled?_____
_____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow/Widower

Who lives in your household?_____
What type of physical activity do you do and for how many hours per week?_____
_____

Do you:

- ☐ Smoke? How many?_____ ☐ Daily ☐ Weekly
- ☐ Drink Alcohol? How much?_____ ☐ Daily ☐ Weekly
- ☐ Use Illegal substances? How often?_____ ☐ Daily ☐ Weekly
- ☐ **Never Drink**
- ☐ **Never Smoke**

Do you consider your current weight ideal? Yes No If not, what is your ideal weight?_____
Do you have any questions about healthy ways to control your weight?_____
_____

What are your goals or expectations from our treatment?_____
_____
What specific issues would you like to address today?_____

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents, and Fellows

As your treating physician and as a member of the Medical Staff of the Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with the following orthopedics device and other related companies whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with Arthrex, Inc.:

> I am a Speakers Bureau participant for Arthrex, Inc., a company that develops orthopedic products and provides educational services to orthopedic surgeons. I am compensated for my time and effort as a lab instructor and lecturer.

I DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact David L. Helfet, MD, Chief of Service, (212-606-1888), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature_____
Patient/Parent/Guardian/Health Care Agent Date

Print Name_____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD