HSS

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:_____

New Patient Questionnaire

Orthopedic Sports Medicine and Shoulder

Name:	DOB:	Date:
Height:	Weight:	Age:

What is your dominant hand? ○ Right ○ Left ○ Ambidextrous

Chief Complaint

What is the reason for your visit? _____

_____

_____

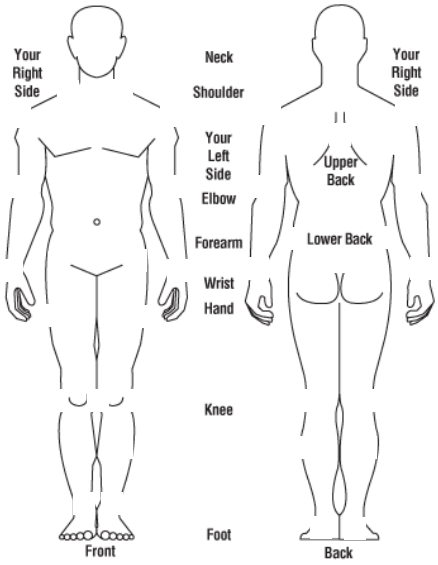
Please describe your symptoms:

☐ Swelling	☐ Stiffness	☐ Locking	☐ Instability
☐ Giving Away	☐ Numbness	☐ Weakness	☐ Tingling
☐ Catching	☐ Clicking	☐ Other:	

Current Pain Level (no pain 0 – 10 highest):

○ **0**	○ **1**	○ **2**	○ **3**	○ **4**	○ **5**	○ **6**	○ **7**	○ **8**	○ **9**	○ **10**

Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Onset:		○ Gradual	○ Sudden
Pain Frequency:	○ Constant	○ Intermittent	○ Rarely
Quality:	Sharp	Dull	Burning
	Tingling	Throbbing	Other
Night Pain:		○ Yes	○ No
Swelling:		○ Yes	○ No
Feels unstable/gives way:		○ Yes	○ No
Range of Motion:		○ Normal	○ Decreased

Everyday Activities:	○ No Restrictions	○ Limited	○ Unable
Recreational Activities:	○ No Restrictions	○ Limited	○ Unable

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play:	○ Professional	○ College	○ High School	○ Recreational

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?
☐ Acupuncture Treatment			○ Yes ○ No
☐ Anti-Inflammatory Medications			○ Yes ○ No
☐ Chiropractic Treatment			○ Yes ○ No
☐ Injections			○ Yes ○ No
☐ Physical Therapy			○ Yes ○ No
☐ Massage Therapy/Deep Tissue			○ Yes ○ No
☐ MRI			
☐ CT			
☐ X-Ray			

Referring Physician: _____ Phone Number: _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? ○ Yes ○ No

Have you ever had a MRSA Infection? ○ Yes ○ No

Have you had Deep Vein Thrombosis (DVT)? ○ Yes ○ No

Have you had a Pulmonary Embolism (PE)? ○ Yes ○ No

Have you ever had any problems with anesthesia? ○ Yes ○ No Problem: _____

Have you ever had complications from prior surgery? ○ Yes ○ No Problem: _____

Have you had surgery for this same condition before? ○ Yes ○ No

Do you have any of the following medical devices? (Mark all that apply)

☐ Pain Pump	☐ Neurostimulator	☐ Pacemaker and/or Defibrillator	☐ Shunt for hydrocephalus

Do you have diabetes? ○ Yes ○ No

If yes, do you have an insulin pump? ○ Yes ○ No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? ○ Yes ○ No

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	○ Yes ○ No	Date:
Do you use birth control?	○ Yes ○ No	Type:
Have you experienced menopause?	○ Yes ○ No	When:
Have you had a hysterectomy?	○ Yes ○ No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	
Age you began your first period:		
When was your most recent menstrual period?	Date:	
How many periods have you had during the last 12 months?		
Number of pregnancies:		

Please list any allergies below (including medications, foods, and environment):

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	Yourself?	Family Member?	Condition	Yourself?	Family Member?
☐ Anxiety	☐ Yes	☐ Yes	☐ Open Wounds/Ulcers	☐ Yes	☐ Yes
☐ Arrhythmia (Irregular heartbeat)	☐ Yes	☐ Yes	☐ Osteoarthritis	☐ Yes	☐ Yes
☐ Asthma	☐ Yes	☐ Yes	☐ Osteoporosis	☐ Yes	☐ Yes
☐ Bleeding Problems	☐ Yes	☐ Yes	☐ Peripheral Vascular Disease	☐ Yes	☐ Yes
☐ Blood Clots (DVT)	☐ Yes	☐ Yes	☐ Pneumonia	☐ Yes	☐ Yes
☐ Cancer	☐ Yes	☐ Yes	☐ Psychiatric Illness (Depression)	☐ Yes	☐ Yes
☐ Diabetes	☐ Yes	☐ Yes	☐ Pulmonary Embolus	☐ Yes	☐ Yes
☐ Heart Attack	☐ Yes	☐ Yes	☐ Reflex Sympathetic Dystrophy	☐ Yes	☐ Yes
☐ Heart Disease	☐ Yes	☐ Yes	☐ Reflux	☐ Yes	☐ Yes
☐ High Blood Pressure	☐ Yes	☐ Yes	☐ Rheumatoid Arthritis	☐ Yes	☐ Yes
☐ High Cholesterol	☐ Yes	☐ Yes	☐ Seizures	☐ Yes	☐ Yes
☐ Infection	☐ Yes	☐ Yes	☐ Stroke	☐ Yes	☐ Yes
☐ Kidney Disorders	☐ Yes	☐ Yes	☐ Ulcers	☐ Yes	☐ Yes
☐ Lung Disease	☐ Yes	☐ Yes	☐ Other:	☐ Yes	☐ Yes

Please list the family member (father, mother, etc.) to any of the positive responses you listed above:

_____

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? ○ Yes ○ No

Do you consume alcohol? ○ Yes ○ No

If yes, how many drinks per week? _____

Occupation: _____ Employer: _____

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? ○ Yes ○ No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? ○ Yes ○ No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? ○ Yes ○ No

If yes, do you have vision problems that may have contributed to your fall? ○ Yes ○ No

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
☐ Activity Change	☐ Congestion	☐ Dryness	☐ Chest tightness
☐ Appetite Change	☐ Ear pain	☐ Discharge	☐ Choking
☐ Chills	☐ Nosebleeds	☐ Itching	☐ Cough
☐ Fatigue	☐ Sinus pressure	☐ Pain	☐ Shortness of breath
☐ Fever	☐ Sore throat	☐ Redness	☐ Wheezing
☐ Weight Change			
☐ None	☐ None	☐ None	☐ None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
☐ Chest pain	☐ Abdominal pain	☐ Cold intolerance	☐ Difficult urination
☐ Leg swelling	☐ Blood in stool	☐ Heat intolerance	☐ Flank pain
☐ Palpitations	☐ Constipation	☐ Excessive thirst	☐ Frequent urination
☐ Poor circulation	☐ Heartburn	☐ Excessive hunger	☐ Painful urination
	☐ Nausea		
☐ None	☐ None	☐ None	☐ None

Musculoskeletal	Skin	Environmental Allergies	Neurological
☐ Joint pain	☐ Color change	☐ Pollen	☐ Dizziness
☐ Joint stiffness	☐ Hair loss	☐ Dust Mites	☐ Headaches
☐ Joint swelling	☐ Rash	☐ Pets/Animals	☐ Light-headedness
☐ Joint warmth/heat	☐ Skin tightening	☐ Mold/Mildew	☐ Memory loss
☐ Muscle pain	☐ Wound	☐	☐ Numbness
☐	☐	☐	☐ Weakness
☐ None	☐ None	☐ None	☐ None

Hematologic	Psychiatric	Other
☐ Enlarged lymph nodes	☐ Agitation	
☐ Bruises	☐ Hyperactive	
☐ Clotting problem	☐ Nervous/anxious	
☐ Excessive bleeding	☐ Depression	
☐ None	☐ None	

GENERAL CONSENT/PERMISSION FOR TREATMENT

I authorize and consent to performance upon _____
(**Insert "me" or Name of Patient**)

By Dr. Gregory S. DiFelice and Hospital for Special Surgery (HSS) and its staff of such physical examinations, diagnostic imaging procedures (such as x-rays, ultrasounds), laboratory tests, and other non-invasive diagnostic and therapeutic procedures and /or treatments, as my/the patient's physician or others on Dr. Gregory S. DiFelice or HSS's medical staff consider to be necessary or appropriate for the purpose of diagnostic and/or treatment of my/the patient's condition.

I understand that for each procedure/treatment the following will be explained to and discussed with me/the patient: the nature, intended purpose, anticipated benefits, material risks, and possible complications of such procedure/treatment; the alternative procedures/treatments if such procedure/treatment is not performed; and the probable consequences if such procedure/treatment or alternative procedures/treatments are not performed.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure/treatment may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures and treatments that can cause adverse consequences not ordinarily anticipated in advance.

I consent to the diagnostic study by Dr. Gregory S. DiFelice or HSS of any blood, urine or other bodily fluids, stool specimens, or tissues that are obtained in the performance of such procedures/treatments, and to the disposal of such fluids/specimens/tissues by New York Presbyterian or HSS in accordance with its customary practice. I further grant permission for HSS to use such fluids/specimens/tissues for medical, scientific and/or educational purposes.

I consent to the photographing, videotaping, televising, or other observation of the procedures/treatments as Dr. Gregory S. DiFelice or HSS or it's surgeon (s)/physician(s) may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedures/treatments of a visitor or visitors, which may include any visiting physician(s) and/or vendor representative(s) whose presence has been requested by the above named surgeon(s)/physician(s). I understand that the visitor(s) will at all times be under the supervision and direction of the above named surgeon(s)/physician(s) and other HSS personnel, and subject to all relevant HSS policies and procedures.

I understand that information about me/the patient will be disclosed as required by applicable law, including reporting mandated by the federal, state and local governments to oversight agencies such as Centers for Disease Control and Prevention, the New York State Department of Health, and the New York City Department of Health and Mental Hygiene. Examples of such mandated reporting include reporting of suspected or confirmed communicable diseases, child abuse, firearm wounds, and certain knife wounds and burns.

I understand that HSS or Dr. Gregory S. DiFelice does not provide all of the medical services that I/the patient could ever possibly require, and that in the event I/the patient need treatment not provided by HSS during my/the patient's hospitalization at HSS, it may become necessary to transfer me/the patient to another hospital that provides the medical services required by me/the patient (including, for the patients at HSS's main campus). I hereby consent to the transfer to such other hospital of me/the patient for such treatment when HSS determines that transfer is medically necessary or advisable.

I understand that Dr. Gregory S. DiFelice or HSS will electronically transmit prescriptions to my pharmacy (ePrescribing) as required by New York Law. I also understand that in connection with ePrescribing, HSS and members of its Medical Staff will obtain medication history (information about the medications I/the patient are currently taking or have taken within the past year) for purposes of coordinating my/the patient's treatment. I hereby consent to ePrescribing by HSS and members of its Medical Staff, including obtaining my medication history and making it part of the HSS medical record.

FINANCIAL AGREEMENT

Assignment of Benefits

I assign, transfer and set over to HSS and members of its Medical Staff sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient by HSS and its Medical Staff.

If I am entitled to Medicare benefits, 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; 20% co-insurance on all ancillary services. I also understand that when Medicare is deemed that the secondary insurance responsible for payment of my medical care, I will be financially classified under HSS's and Dr. Gregory S. DiFelice policies and will follow payment terms under said policies.

Authorization for Release of Information

I authorize and direct HSS and those members of its Medical Staff who have treated me/the above-named patient to release to government agencies, insurance carriers, and others who are financially liable for hospitalization and medical care of me/the above-named patient, all information needed to substantiate and obtain payment for such hospitalization and medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Guarantee of Hospital Charges

I agree to be responsible for payment in full of the charges for all hospital services and other medical care rendered to me/the above-named patient for this period of care. I understand that even if I have/the patient has domestic or international health insurance coverage accepted by HSS or Dr. Gregory S. DiFelice, I will be responsible for payment in full of unpaid balances after insurance company payment to HSS or Dr. Gregory S. DiFelice , to the full extent permitted under federal, state and local laws. I understand that my responsibility also includes payment for charges not ordinarily covered by health insurance, such as private room charges.

I confirm that I have read and fully understand this General Consent/Permission for Treatment & Financial Agreement, that I have been given the opportunity to ask questions and have had my questions answered satisfactorily, and that I am eligible to give this consent and agreement. I further confirm that I understand that I have the right to revoke this consent, or any part of it, at any time during my/the patient's treatment by HSS or Dr. Gregory S. DiFelice.

Signature of Patient/Parent/Guardian/Healthcare Agent/Other Surrogate:

_____

Relationship to Patient:_____

Date: _____ Time: _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this General Consent/Permission for Treatment & Financial Agreement.

Signature of Witness:_____

Date: _____ Time: _____

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