

## **Ranawat Orthopaedics HSS**

- Chitranjan S. Ranawat, M.D.**
- Amar S. Ranawat, M.D.**
- Anil S. Ranawat, M.D.**

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

As your treating physician(s) and as a member of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopaedics HSS:

#### **Dr. Amar Ranawat:**

Dr. Amar Ranawat holds stock options and receives royalties from ConforMis, Inc. Dr. Ranawat is also a consultant and a member of the Hip Advisory Board of MAKO Surgical Inc. for which he receives royalties for software development. In addition, he is also a consultant for Convatec, DePuy, Medtronic, Nova Surgical, Pacira and Pipeline Orthopedics for product development. Dr. Ranawat also receives research support from Stryker and Ceramtec. He is a member of the editorial board of CORR, JOA, COP, BJJ, and the HSS journal. He is on the AAOS Adult Hip Committee, Co-Director of the AAOS Adult Knee Webinar: Management of Complication in TKR, and the Program Chairman for the Eastern Orthopaedic Association.

#### **Dr. Anil Ranawat:**

Dr. Anil Ranawat holds stock options and receives royalties from ConforMis, Inc. He is also a consultant and member of the Hip Advisory Board of MAKO Surgical Inc. Dr. Ranawat is also a consultant for Mitek, Pipeline Orthopedics, Conmed Linvatec and Nova Surgical. In addition, he is Editor-in-Chief of “Current Trends in Musculoskeletal Medicine” where he receives salary support from Springer-Verlag and royalties from Elsevier. He is on the Sports Committee of AAOS and Chairman Member of Eastern Orthopaedic Association.

#### **Dr. Chitranjan Ranawat:**

Dr. Chitranjan Ranawat is a product designer for DePuy on the Sigma® total knee prosthesis for which he receives royalty payments. In addition, he is a product designer on the Accolade® hip system for Stryker and receives royalty payments. Dr. Ranawat receives education support for the Ranawat Orthopaedic Research Foundation from Depuy.

Please be aware that under no circumstances do we receive 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 us, you may either contact the Chief of Service, (212-606-1852), 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 financial interest or relationship disclosed to you, you choose to refuse a particular treatment, 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 you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

**Signature**

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

**Print Name** \_\_\_\_\_  
**Patient/Parent/Guardian/Health Care Agent**

\_\_\_\_\_  
**Relationship to Patient**

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

**PATIENT REGISTRATION**

**Chitranjan Ranawat**

**Amar Ranawat**

**Anil Ranawat**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex M F Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Occupation \_\_\_\_\_ presently working \_\_\_\_\_ Yes \_\_\_\_\_ No

May we contact you via email regarding:

Your Appointment, Billing, Research Y \_\_\_\_\_ N \_\_\_\_\_ Email: \_\_\_\_\_

Is your current problem related to a claim for worker's compensation or a current or potential lawsuit? Y \_\_\_\_\_ N \_\_\_\_\_

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**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

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**Primary Care Physician**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Referring Physician**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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**Primary Insurance Information**

*(Please present your insurance card to the front desk staff)*

Primary Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of insured \_\_\_\_\_

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**Secondary Insurance (Circle one)**

Medicare, Private Insurance, Workmen's Compensation, NO-Fault

Insurance Carrier \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

WCB# (worker's comp) \_\_\_\_\_ Date of Accident \_\_\_\_\_

**PATIENT REGISTRATION**

Chitranjan Ranawat

Amar Ranawat

Anil Ranawat

Assignment and Release

I, the undersigned, have insurance coverage with \_\_\_\_\_ and assign all medical benefits to: Ranawat Orthopaedics or Anil Ranawat. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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Referral

I realize that my particular insurance plan might require a referral for me to be seen by any of the physicians employed by Ranawat Orthopaedics or Anil Ranawat. If at any time I fail to obtain a referral for a particular visit, I will be responsible for obtaining a valid referral from my primary care physician (PCP). If a valid referral is not possible, I will be solely responsible for all charges.

Signature of Insured/ Guardian \_\_\_\_\_ Date \_\_\_\_\_

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HIPPA Privacy Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that Ranawat Orthopaedics, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Insured/Guardian \_\_\_\_\_ Date \_\_\_\_\_

CONFIDENTIAL MEDICAL HISTORY

Chitranjan Ranawat

Amar Ranawat

Anil Ranawat

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Age \_\_\_\_\_

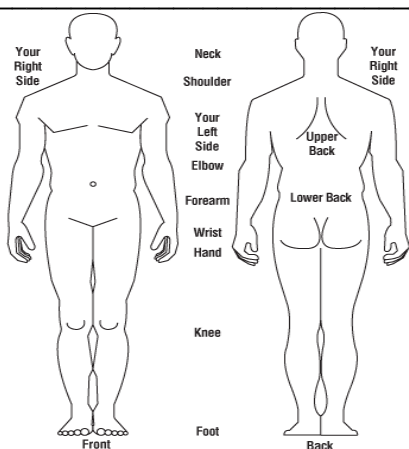
Occupation \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Date of injury or onset of symptoms: \_\_\_\_\_

Describe the injury or problem: \_\_\_\_\_



Where is your pain? Please Mark the Drawing  
Rate your pain:

0= No Pain                      10= Extreme pain  
Right now:    0 1 2 3 4 5 6 7 8 9 10

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_  
\_\_\_\_\_

**YOUR MEDICAL HISTORY**

Have you ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, why?) \_\_\_\_\_

Have you ever had surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, when?) \_\_\_\_\_

Do you think you might be pregnant at this time? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you ever had a blood clot? Yes \_\_\_\_\_ No \_\_\_\_\_

Does anyone in your family have any of the following problems? Please Circle

- Heart Disease
- Cancer
- Stroke

- High Blood Pressure
- Nerve problems
- Diabetes

- Anesthesia complications
- Blood problems (anemia, abnormal bleeding)
- Other: \_\_\_\_\_

# Medical Profile

Name: \_\_\_\_\_

**Current Medications:**

Medications	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

**Medical History:** Please **circle** appropriate response(s) and **write in answer where appropriate**

**General Health:**    Excellent                  Good                  Fair                  Poor

**Head:**                  Headaches                  History of Injury                  Other (Please Describe): \_\_\_\_\_

**Neck:**                  Any Issues (Please Describe): \_\_\_\_\_

**Skin:**                  Any Issues (Please Describe): \_\_\_\_\_

**Eyes:**                  Loss of Vision                  Glasses                  Cataract                  Other (Please Describe): \_\_\_\_\_

**Ears:**                  Hearing Loss                  Other (Please Describe): \_\_\_\_\_

**Nose/Throat:**                  Bleeding                  Sinus Trouble                  Other (Please Describe): \_\_\_\_\_

**Respiratory:**                  Asthma                  Other (Please Describe): \_\_\_\_\_

**Heart:**                  Chest Pain                  Heart Disease                  Irregular Heartbeat                  High Blood Pressure                  Other \_\_\_\_\_

**Bleeding:**                  Any Issues (Please Describe): \_\_\_\_\_

**Metabolic:**                  Diabetes                  Hypothyroid                  Other (Please Describe): \_\_\_\_\_

**Stomach/Bowel:**                  Constipation                  Nausea/Vomiting                  Bleeding                  Other (Please Describe): \_\_\_\_\_

**Urinary:**                  Leakage                  Discharge/Drainage                  Other (Please Describe): \_\_\_\_\_

**Neurological:**                  Headaches                  Seizures(epilepsy)                  Stroke                  Numbness                  Other: \_\_\_\_\_

**Prior Diseases:**                  Hepatitis                  AIDS                  Herpes                  Infection Involving Joint                  Other: \_\_\_\_\_

**Prior Surgeries:**                  Thyroid Surgery                  Heart Bypass                  Appendectomy                  Back Surgery                  Arthroscopy                  Other \_\_\_\_\_

**Allergies:**                  Penicillin                  Food (list): \_\_\_\_\_                  Other: \_\_\_\_\_

**Do you Smoke?**                  Yes                  No                  If yes, number of packs per day? \_\_\_\_\_                  Number of years? \_\_\_\_\_

**Do you Drink?**                  Yes                  No                  If yes, number of drinks per week? \_\_\_\_\_                  Number of years? \_\_\_\_\_

**Current Height:** \_\_\_\_\_

**Current Weight:** \_\_\_\_\_