

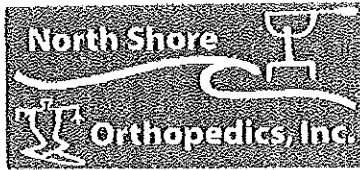
LAST NAME:	FIRST NAME/MIDDLE INITIAL:	DATE OF BIRTH:
SOCIAL SECURITY NUMBER:	GENDER: (PLS CIRCLE ONE) <b>M F</b>	PERSONAL STATUS: (PLS CIRCLE ONE) <b>MARRIED SINGLE OTHER</b>

MAILING ADDRESS: **PLS INCLUDE CITY, STATE, & ZIP CODE**		
PHYSICAL ADDRESS (IF DIFFERENT FROM ABOVE): **PLS INCLUDE CITY, STATE, & ZIP CODE**		
EMAIL ADDRESS:		
PRIMARY TELEPHONE NUMBER:	ALTERNATE TELEPHONE NUMBER:	
IN CASE OF EMERGENCY, CONTACT:	RELATIONSHIP TO PATIENT:	EMERGENCY CONTACT'S TELEPHONE NUMBER:

EMPLOYER:	
EMPLOYER'S ADDRESS:	EMPLOYER'S TELEPHONE NUMBER:
JOB/OCCUPATION:	
PHYSICAL REQUIRMENTS OF YOUR JOB: (BRIEFLY DESCRIBE THE PHYSICAL REQUIRMENTS OF YOUR JOB – EXAMPLES: DESK WORK, STANDING, STOOPING, BENDING, CLIMBING, REACHING, ETC...)	

INSURANCE:	
SUBSCRIBER'S NAME (IF DIFFERENT FROM "SELF"):	SUBSCRIBER'S DATE OF BIRTH:
NAME OF YOUR PRIMARY CARE PHYSICIAN:	NAME OF YOUR DENTIST:

SECONDARY INSURANCE (IF APPLICABLE):	
SUBSCRIBER'S NAME (IF DIFFERENT FROM "SELF"):	SUBSCRIBER'S DATE OF BIRTH:



<b>PATIENT NAME:</b>	<b>DATE OF BIRTH:</b>
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**HIPAA NOTICE OF PRIVACY PRACTICES**

NORTH SHORE ORTHOPEDICS, INC. is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to protect the privacy of healthcare information obtained when treating you (known as protected health information or PHI) and to provide you with a notice of privacy practices concerning the use of such information shortly following the time of service. This notice describes how and when our office can use and disclose your PHI along with describing your legal rights pertaining to the use and disclosure of such information. This notice also provides contact information for questions and for obtaining further assistance if you need more help. Our office is required to abide by the terms of this notice as long as it is in effect. We reserve the right to change the terms of this notice and apply such changes to all protected health information that we maintain. A copy of our current (or revised) privacy policy is always available at our business office or on our website.

By signing this form I, or the person signing for me, acknowledge receiving a "Notice of Privacy Practices" from NORTH SHORE ORTHOPEDICS, INC. I understand that the Notice I received explains my rights and contains information to assist me if I should have questions or a complaint.

**Permission to Use Healthcare Information for Billing Purposes and Financial Responsibility Statement**

By signing this form, I authorize NORTH SHORE ORTHOPEDICS, INC. to release any information, including protected health information or PHI, to any insurance company, insurance company representative or other authorized third party for the purpose of paying my MEDICAL SERVICE(S) fees and charges. I authorize any holder of healthcare information or documentation, including PHI, needed to determine benefits or benefits payable for related services or any service rendered to me now or in the future to be released to NORTH SHORE ORTHOPEDICS, INC. if requested. I authorize that direct payment be made by any insurance company or other third party for any medical service fees and charges that are reimbursable and owed by me to NORTH SHORE ORTHOPEDICS, INC.

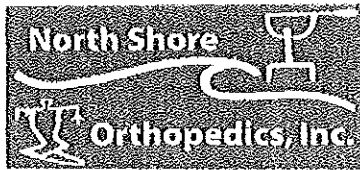
If I am insured by a federal health insurance plan, such as Medicare or other forms of federal health insurance, by signing this form I authorize NORTH SHORE ORTHOPEDICS, INC. to release any information, including PHI, to the Department of Health and Human Services, the Center for Medicare and Medicaid Services or their contracted agents, for the purpose of paying my fees and charges. I understand that such insurance plans require a co-payment or even a deductible that I or my supplemental insurance may be responsible for paying.

If I am an active duty member of the United States Military, I authorize NORTH SHORE ORTHOPEDICS, INC. to release any information, including PHI, to the Department of Defense or my command upon written request by appropriate authority.

Finally, by signing this form I understand that if I am insured, I am responsible for providing my insurance information to NORTH SHORE ORTHOPEDICS, INC. for the purpose of paying all fees and charges. I also understand that in the event I am uncooperative or refuse to provide my insurance information and/or subsequent information to support the filing of an insurance claim on my behalf, NORTH SHORE ORTHOPEDICS, INC. may determine that I alone must pay all fees and charges directly and that I will be responsible for paying these fees and charges within thirty (30) days of such a determination.

**All patients please read this statement and sign:** By signing this statement I acknowledge that I have read, understand and agree to the terms and conditions explained above.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(ADULT'S SIGNATURE FOR MINORS PLEASE)



OUR GOAL IS TO PROVIDE QUALITY MEDICAL CARE IN A TIMELY MANNER. IN ORDER TO DO SO, WE HAVE HAD TO IMPLEMENT AN APPOINTMENT CANCELLATION/NO-SHOW POLICY. THE POLICY ENABLES US TO BETTER USE AVAILABLE APPOINTMENTS FOR PATIENTS IN NEED OF MEDICAL CARE.

WE KINDLY REQUEST THAT YOU READ AND INITIAL THE FOLLOWING POLICIES.

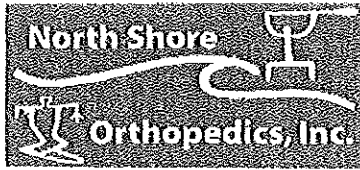
1. \_\_\_\_\_ CANCELLATION POLICY

A 24-HOUR ADVANCED NOTICE IS REQUIRED IF YOU ARE UNABLE TO KEEP AN APPOINTMENT. SAME DAY CANCELLATIONS WILL RESULT IN A \$50.00 CHARGE TO YOUR ACCOUNT. YOU WILL BE RESPONSIBLE FOR THIS CHARGE, NOT THE INSURANCE COMPANY. EXCEPTIONS TO THIS POLICY ARE DETERMINED ON AN INDIVIDUAL BASIS ACCORDING TO CIRCUMSTANCES IF REQUESTED.

2. \_\_\_\_\_ NO-SHOW POLICY

A NO-SHOW IS SOMEONE WHO MISSES AN APPOINTMENT WITHOUT ANY NOTIFICATION. FAILURE TO BE PRESENT AT THE TIME OF A SCHEDULED APPOINTMENT WILL RESULT IN A \$50.00 CHARGE TO YOUR ACCOUNT. YOU WILL BE RESPONSIBLE FOR THIS CHARGE, NOT THE INSURANCE COMPANY. EXCEPTIONS TO THIS POLICY ARE DETERMINED ON AN INDIVIDUAL BASIS ACCORDING TO CIRCUMSTANCES IF REQUESTED.

\*WE TRY TO REMIND PATIENTS OF THEIR APPOINTMENTS BY TELEPHONE A DAY BEFORE YOUR APPOINTMENT IS SCHEDULED BUT PLEASE DO NOT DEPEND ON THIS COURTESY. IN THE EVENT WE DO NOT CONTACT YOU, YOUR APPOINTMENT CARD SERVES AS CONFIRMATION OF YOUR APPOINTMENT AND IMPLIES YOUR OBLIGATION TO BE PRESENT.



**SYMPTOM REPORT**

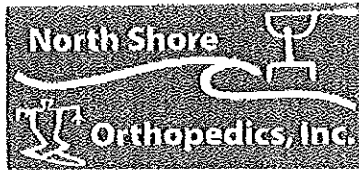
PATIENT NAME:	DATE OF BIRTH:
DATE OF INJURY/ONSET OF SYMPTOMS: (PLEASE ESTIMATE IF UNSURE)	
WHERE DID THIS HAPPEN? (PLEASE CIRCLE ONE) <div style="text-align: center;">HOME    WORK    SPORT    OTHER</div>	
DESCRIBE OCCURANCE: (I.E. WHILE PLAYING SOCCER...)	
WHICH AREA OF THE BODY IS AFFECTED? (I.E. KNEE, SHOULDER, WRIST...PLEASE INDICATE LEFT OR RIGHT)	

DESCRIBE YOUR PAIN (PLEASE CIRCLE ONE) <div style="text-align: center;">SHARP    DULL ACHE    BURNING    THROBBING    TINGLING    NUMB</div>
DO YOU FEEL YOUR PAIN (PLEASE CIRCLE ONE) <div style="text-align: center;">CONSTANTLY    INTERMITTENTLY    RARELY</div>
WHAT POSITION MAKES THE PAIN INCREASE?
WHAT POSITION MAKES THE PAIN DECREASE?
DO YOU FEEL ANY (PLEASE CIRCLE ONE) <div style="text-align: center;">CLICKING    POPPING    INSTABILITY</div>
PLEASE LIST THE KINDS OF TREATMENTS YOU HAVE SOUGHT & TRIED: (I.E. MASSAGE, PHYSICAL THERAPY, ELEVATION, ICE/HEAT...)
DO YOUR SYMPTOMS INTERFERE WITH (PLEASE CIRCLE ONE) <div style="text-align: center;">WORK    SPORTS    SLEEP    OTHER _____</div>
PAIN LEVEL (LOW) 1   2   3   4   5   6   7   8   9   10 (HIGH)

HAVE YOU SEEN ANOTHER PHYSICIAN/THERAPIST FOR THESE SYMPTOMS?    YES    NO

IF YES, PLEASE GIVE THE NAME OF THAT PERSON: \_\_\_\_\_

PROVIDE THE DATE(S) OF TREATMENT BY THAT PERSON: \_\_\_\_\_



PATIENT NAME:	DATE OF BIRTH:
HEIGHT:	WEIGHT:
MEDICAL HISTORY: (LIST ALL YOUR MEDICAL PROBLEMS)	
SURGICAL HISTORY: (LIST ALL SURGICAL PROCEDURES)	
CURRENT MEDICATIONS AND HERBAL OR NUTRITIONAL SUPPLEMENTS:	
ALLERGIES OR ADVERSE DRUG REACTIONS: (PLEASE GIVE NAME OF DRUG OR SUBSTANCE AND TYPE OF REACTION)	

**FAMILY MEDICAL HISTORY:** (PLEASE CHECK ALL THAT APPLY)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> BLEEDING DISORDER  | <input type="checkbox"/> DVT/BLOOD CLOT DISORDER |
| <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> STROKE             | <input type="checkbox"/> STOMACH ULCERS          |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> ARTHRITIS          | <input type="checkbox"/> HEARTBURN               |
| <input type="checkbox"/> CANCER ( _____ )    | <input type="checkbox"/> DEPRESSION/ANXIETY | <input type="checkbox"/> OTHER: _____            |

**SOCIAL HISTORY**

HAVE YOU EVER SMOKED?      YES      NO

IF YES, WHAT DID/DO YOU SMOKE? \_\_\_\_\_

DO YOU DRINK ALCOHOL?      YES      NO

IF YES, WHAT DO YOU DRINK? \_\_\_\_\_

HOW MANY DRINKS DO YOU HAVE PER WEEK? \_\_\_\_\_