New York Hand Surgery
Hand • Wrist • Elbow • Microsurgery

Vipul Patel, MD *Phay Huynh, PA-C*
Andrew Yang, MD *Timothy Godfrey, PC-A*

New York Hand Surgery
New York Hand Surgery of Queens
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

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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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, 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: Workers Compensation Patients

AGREEMENT TO PAY MEDICAL COST IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

WCB CASE NO.	CARRIER CASE NO.	DATE OF INJURY	DESCRIPTION OF INJURY	CLAIMANT'S SOCIAL SECURITY NO.

	NAME:	ADDRESS:
CLAIMANT		
EMPLOYER		
INSURANCE CARRIER		

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR THE WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE.

I, _____ hereby agree to pay New York Hand Surgery Queens, PC, 54-07 Roosevelt Avenue Woodside, NY 11377 their usual and customary fees for the services rendered to the above name's claimant in the above identified case.

Signature : _____ Date: _____

If signed by other than claimant, print below: Name, Address and Relationship of signer

Name & Address : _____ Date: _____