FARMINGTON VALLEY ORTHOPEDIC ASSOCIATES, P.C.

Patient Name_____ Home Phone (___)_____

Address _____ Cell Phone (____) _____

Town _____ State ____ Zip _____ Age _____ Date of Birth_____

Sex (M) (F) Marital Status (S) (M) (W) (D) Social Security Number _____

Parent's Name (if minor) _____ Parent's SSN (if minor)_____

Place of Employment _____ Occupation _____

Address _____ Spouse's Name _____

Town _____ State ____ Zip _____ Spouse's Employer _____

Work Phone _____ Spouse's Work Phone _____

Reason for Visit _____ Primary Physician _____

Date of Injury _____ PCP's Address _____

Referred by _____ PCP's Phone _____

Is this injury related to: Workers Comp _____ Car Accident _____ Liability ____ Other _____

Carrier Name _____ State where injury occurred _____

Address _____ Claim/Policy # _____

Town _____ State ____ Zip _____ Adjuster _____

Employer Contact _____ Phone _____

PRIMARY INSURANCE _____ Group # _____

Policy Number _____ Employer _____

Subscriber Name _____ Relationship to Patient _____

Subscriber Address if Different than Patient's _____

Subscriber DOB _____ SSN of Subscriber _____

SECONDARY INSURANCE _____ Group # _____

Policy Number _____ Employer _____

Subscriber Name _____ Work Address _____

Subscriber Address _____ Relationship to Patient _____

Subscriber DOB _____ SSN of Subscriber _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other insurance company benefits be made to either me or on my behalf to Farmington Valley Orthopedic Associates, P.C. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying in my treatment. (Section 1128b of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information)

Signature: _____ Date: _____

(please complete 2nd page)

Patients Name:		Birth Date: / /	Age:
Primary Care Physician:	Height:	Weight:	Pregnant? ☐ Yes ☐ No
Referred By:	Smoker: ☐ Yes ☐ No	Number of Packs/Day:	
	Alcohol: ☐ Yes ☐ No	How much?	
	Drug Use: ☐ Yes ☐ No	Explain:	
Reason for Visit:		Right Left	
Date of Onset/Injury:	Job Related?	Auto Accident?	
Was there an injury: ☐ Yes ☐ No	Explain:		
What Makes the Pain/Problem Better/Worse?			
Have you had any X-Rays, MRI or CT Scans related to this injury? ☐ Yes ☐ No			
If yes, when and where?			
On a scale of 0-10 (10 is the worst), how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10			
What is the **quality** of the pain? ☐ Sharp ☐ Dull Stabbing ☐ Throbbing ☐ Aching ☐ Burning			
Prior Treatment: (Surgery, Braces, Physical Therapy, Injections, Medications)			

Medical History (Check all that apply - provide explanation in space provided below)

☐ Diabetes	☐ High Blood Pressure	☐ Heart Problems	☐ Bleeding Problems	☐ Cancer	☐ Ulcers
List **ALL** Current Medical Conditions:					
Family History: Have any direct relatives had any of the following ☐ Diabetes ☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ None					
Review of Systems / Problems (Check all that apply - provide explanation in space provided below)					
☐ Hepatitis / HIV ☐ Steroids Use? ☐ Headaches / Dizziness ☐ Fever / Chills	☐ Shortness of Breath ☐ Chest Pain ☐ Wheezing / Coughing ☐ Ears / Nose / Throat	☐ Eye / Vision ☐ Stomach / Intestine ☐ Swollen Glands ☐ Urinary Problems	☐ Skin / Rash ☐ Varicose Veins ☐ Weight Loss / Gain ☐ Psychiatric		
Explain Conditions / Symptoms from above					
List **ALL** Prior Surgeries/Hospitalizations:					
List **ALL** Current Medications – include dietary Supplements, vitamins and / or diet pills					
Do you have allergies to medication? ☐ Yes ☐ No If Yes please explain.					
Do you have a Latex Sensitivity? ☐ Yes ☐ No					

Reviewed By:_____ M.D. Date: _____ / _____ / _____

Summary Of Notice Of Privacy Practices
As Required By Federal Law

Farmington Valley Orthopedic Associates, P.C.
Susan Baldwin, Practice Administrator
(860) 677-0079

The following is a brief summary of your rights and our responsibilities as detailed in the Notice of Privacy Practices posted in our waiting room. This summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the notice.

1. **Information we may collect.**
   Identification and insurance information
   Medical information and reports from other healthcare providers
2. **How we use your information.**
   Your information is used for treatment, payment and healthcare operations within our practice
   To refer you to other healthcare providers for additional treatment
3. **Disclosures of Your Health Information.** We may disclose your information to our business associates such as, medical transcriptionists, collection agencies and others who assist in the operations of our practice. We may call you regarding appointments, insurance information and test results and may also leave a message on your answering machine if applicable. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.
4. **Other Uses and Disclosures.** Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization. (refusal to release information to your insurance company for payment will result in your personal and immediate responsibility for your bill.)
5. **Your Health Information Rights.** You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
   - **a.** You may request restrictions on certain uses and disclosures of your information
   - **b.** You may request that your receive your information from us in a certain way
   - **c.** You may inspect and copy your medical records with reasonable advance notice
   - **d.** You may request an amendment to any record you believe is inaccurate
   - **e.** You may request an accounting of disclosures made of your records
   - **f.** You have the right to receive a copy of the Notice of Privacy Practices
   - **g.** You have the right to be notified of a Breach of PHI
6. **Changes to the Notice.** We reserve the right to change the Notice. If we do so, we will post it in our office, and provide a copy upon request.
7. **Complaints.** You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing a complaint.

Farmington Valley Orthopedic Associates, P.C.

Susan Baldwin, Practice Administrator
(860) 677-0079

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient:_____Date:_____

I hereby acknowledge that I received a copy of Farmington Valley Orthopedic Assoc., P.C.'s Notice of Privacy Practices.

Signed:_____

If not signed by the patient, please indicate your relationship to the patient_____

Print your Name_____

Permission to Disclose Information

□ I give my permission for Farmington Valley Orthopedic Assoc., P.C. to disclose/discuss my health information with the following:

_____

_____

_____

Patient's Signature:_____Date:_____

For Office Use Only:

□ Signed form received by:_____

□ Acknowledgement refused:

Efforts to obtain:_____

Reason for refusal:_____