

FARMINGTON VALLEY ORTHOPEDIC ASSOCIATES, P.C.

Patient Name _____
Address _____ Apt# _____ Contact Number (c) (h) (w) _____
Town _____ State _____ Zip _____ Secondary (c) (h) (w) _____
Sex (M) (F) Age _____ Date of Birth _____
Parent's Name (if minor) _____ Social Security Number _____
Employer _____ Parent's SSN (if minor) _____
Emergency Contact:
Name: _____ Relationship _____
Contact Number (c) (h) (w) _____

Primary Physician _____
Address _____ Phone _____

Is this injury related to: Workers comp _____ Car Accident _____ Liability _____ Other _____
Carrier Name _____ State where injury occurred _____
Address _____ Claim/Policy # _____
Town _____ State _____ Zip _____ Employer Contact _____
Adjuster _____ Phone _____
Attorney Name _____ Phone _____

PRIMARY INSURANCE _____
Membership ID # _____ **Group Number** _____
Subscriber Name _____ Relationship to Patient _____
Subscriber DOB _____
SECONDARY INSURANCE _____
Membership ID # _____ **Policy Number** _____
Subscriber Name _____ Relationship to Patient _____
Subscriber DOB _____
GUARANTOR INFORMATION (Financial Responsibility)
Name _____ Date of Birth _____ SSN _____
Contact Number (c) (h) (w) _____ Secondary (c) (h) (w) _____
Address _____ Apt # _____
City _____ State _____ Zip _____

INSURANCE AUTHORIZATION AND ASSIGNMENT
I request that payment of authorized Medicare/Other insurance company benefits be made on my or my dependents behalf to Farmington Valley Orthopedic Associates, P.C. for services rendered to me by a FVOA provider. I authorize any holder of medical information about me or my dependents to release to CMS or my insurance company any information needed to determine the benefits payable for services provided. I understand I am financially responsible for any services/charges not provided by my health plan.

Patient Signature: _____ **Date:** _____
(Please complete 2nd page)

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

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

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

Reviewed By M.D: _____ 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 you 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 have been offered or 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 _____

**With whom do you allow us to share your personal medical
information?**

Name	Relationship	Phone Number

**Patient's
Signature:** _____ **Date:** _____

For Office Use Only:

Signed form received by: _____

Acknowledgement refused:

Efforts to obtain: _____

Reason for refusal: _____