MANHATTAN ORTHOPEDIC & SPORTS MEDICINE GROUP, P.C.

EDMOND CLEEMAN , M.D.
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MARVIN S. GILBERT, M.D.

RICHARD S. GILBERT, M.D.
MARK J. KLION, M.D.
VIKAS VARMA, M.D.

Today's Date: _____

Name: _____ E-Mail: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell#: _____

Date of Birth: _____ Age: _____ S.S.#: _____

Sex: MALE FEMALE Marital Status: SINGLE MARRIED DIVORCED WIDOWED

Preferred method of communication with office (Please circle all that apply): Phone: **Work Cell Home E-Mail**

Who may we thank for your referral to our office? _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Pharmacy Name: _____ Pharmacy Phone # _____ Fax# _____

Is your visit here due to an auto accident or worker's compensation case? YES NO If yes, date of accident: _____

Referring Physician: _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Primary Care Physician: _____ Phone: _____
(If different from referring M.D.)

Address: _____ City/State: _____ Zip: _____

Health Insurance Carrier: _____ **(Receptionist will copy your card)**
Insured's Information if not the same as the patient:

Name: _____ **D.O.B:** _____ **SS#:** _____

Secondary Insurance Carrier: _____ **(Receptionist will copy your card)**
Insured's Information if not the same as the patient:

Name: _____ **D.O.B:** _____ **SS#:** _____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Manhattan Orthopedics & Sports Medicine, P.C. for services described. I accept full responsibility for total amount of bill. I understand that if anything above is untrue, I am responsible for the full bill. If payment is not made on time I am responsible for a finance charge.

Signed: _____ Date: _____

MEDICARE INFORMATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administration or their intermediaries or carriers, or to the billing agent of this practice, any information needed for this or a related Medicare 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. In addition, I authorize release of my medical information as necessary to other health care providers, including physicians, pharmacies and physical/occupational therapists.

Signed: _____ Date: _____

NAME: _____

Date of Visit: _____

What is your injury or complaint? _____

Are you right or left handed? **RIGHT** **LEFT**

Pt. Height: _____ **Pt. Weight:** _____**Lbs.**

Please circle all that apply:	**Circle**	**If Yes Date**	**Please circle all that apply:**	**Circle**	**If Yes Date**
Constitutional e.g. Fever, weight loss, malaise	YES NO		**Musculoskeletal** e.g. fracture, sprains, stiffness	YES NO	
Eyes e.g. Blurring, double vision, glasses	YES NO		**Skin/Breast** e.g. Rashes, lesions, scars, masses	YES NO	
Ear, Nose, Throat e.g. Deafness, sinusitis, vertigo	YES NO		**Neurological** e.g. Seizures, balance, memory, stroke	YES NO	
Cardiovascular e.g. chest pain, palpitations, high blood pressure	YES NO		**Psychiatric** e.g. Depression, sleep disturbance, hallucination	YES NO	
Respiratory e.g. Shortness of breath, cough, asthma	YES NO		**Endocrine** e.g. increased urination, obesity, growth or hair changes	YES NO	
Gastrointestinal e.g. appetite, abdominal pain, constipation, weight change	YES NO		**Hematologic/Lymphatic** e.g. Bleeding tendency, anemia, lymph node pain or enlargement	YES NO	
Genitourinary e.g. Hesitancy, incontinence, pregnancies, menstrual problems	YES NO		**Allergic/Immunologic** e.g. Allergies, dermatitis, eczema	YES NO	

Please list current or past medical history/problems: _____

_____

Please list all previous surgeries: _____

_____

Please list all medications you are taking: _____

_____

Are you allergic to any medications? **YES** **NO** **If YES, please list:** _____

_____

Family History of medical problems: _____

_____

What is your profession? _____

I certify that the information I have provided is correct:

_____

Patient Signature

_____

Today's Date: _____

If you would please take a moment to answer the following questions that we are now required by law to retrieve from you:

Please circle your answers:

Language: English
Other: _____

Ethnicity: Hispanic or Latino
Not Hispanic
Unknown

Race: American Indian
Asian
African American
White
Pacific Islander
Other: _____

Smoker: Current Every Day
Current Some Day
Current Status Unknown
Former Smoker
Never Smoker
Unknown if ever smoked

Alcohol: Non-Drinker
Social Drinker
Alcoholic
Recovering Alcoholic

HIPAA PRIVACY NOTICE

HIPPA PRIVACY LAWS EXPLAINS HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY LOCATED IN THE GLASS CABINET.

ACKNOWLEDGEMENT

I, _____, on _____
Name of Patient **Date**

Acknowledge that I have been provided with a copy of Manhattan Orthopedic & Sports Medicine Group, PC's Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Protecting Patients From Identity Theft

We recognize that identity theft is a crisis in our country, exposing victims to financial loss, credit destruction, business disruption, and confusion of personal information. Medical identity theft, in particular, also may lead to false patient information that could jeopardize the delivery of safe, quality health care.

We will comply with all federal and state laws pertaining to identity theft or "Red Flag Rules" such as those pursuant to the Fair and Accurate Credit Transactions Act of 2003.

In order to do so, it is **REQUIRED** to scan a copy of your photo license or State issued photo ID.

Thank you for your understanding