Winthrop Orthopaedic Associates, PC

Main Office: 1300 Franklin Avenue, Garden City NY 11530 ● Tel: (516) 747-8900 ● Fax: (516) 663-3015
Satellite Office: 2339 Hempstead Turnpike, East Meadow, N.Y. 11554 ● Tel: (516) 520-3164 ● Fax: (516) 520-5713
www.winthroporthopaedics.com

Pediatric Demographic and Insurance Information Form

PATIENT INFORMATION:			
Child's Name:	**Date of Birth:**	**Age:**	**Sex:**
Social Security #:	**Phone Number:**		
Address:			
Reason for office visit:			
Referred by:			
Child's pediatrician:	**Pediatrician's phone #:**		
Pediatrician's address:			
Ethnicity:** ***(Please circle) **Hispanic / Non-Hispanic**	***Preferred Language:**		
Race:** ***(Please circle) **American Indian/Alaska Native** **Asian** **Black/African American** **Hispanic/Latino** **Native Hawaiian/Other Pacific Islander** **White**			

Meaningful use requirement

PARENT INFORMATION:	
Father's Name:	**Mother's Name:**
Address:	**Address:**
Telephone #:	**Telephone #:**
Employer:	**Employer:**
Employer address:	**Employer address:**
Employer phone #:	**Employer phone #:**

INSURANCE INFORMATION:			
Primary:		**Secondary:**	
Insured's Name:		**Insured's Name:**	
Relationship:		**Relationship:**	
Social Security #:		**Social Security #:**	
Insured's DOB:	**Sex:**	**Insured's DOB:**	**Sex:**
Member ID #:		**Member ID #:**	
Group #:	**Plan#:**	**Group #:**	**Plan#:**
Effective date:		**Effective date:**	

I authorize the release of any medical information necessary to process claims. I also authorize payment of medical benefits directly to the provider. I understand that I am financially responsible for all non-covered services, deductibles, co-insurance and co-payments.

Signature: _____ Date of visit: _____

WINTHROP ORTHOPAEDIC ASSOCIATES, PC

PEDIATRIC Medical History Information Form (rev 8/17/2011)

Name:	Date of Birth:

Have you seen one of our Orthopaedic doctors over the past 3 years? *(please circle)* YES NO

For this problem or for another problem? Please explain:

Does your primary care physician know about the child's problem for today's visit? YES NO

What is the problem?	When did it start?

Has anyone else in the family had the same problem? YES NO

How did the injury happen?

Location of problem:	Type of pain: Sharp Dull Throbbing Occasional
Severity: Mild 1 2 3 4 5 6 7 8 9 10 Most Severe.	Duration (how long pain lasts):
When is it painful?	Context: Getting better Getting worse recurrent

Associated Signs and Symptoms: *(please circle)* Bruising Swelling Numbness Tingling/burning

Does pain wake patient at night? YES NO If yes, does it require medicine to get back to sleep? YES NO

Have you treated this problem? YES NO Ice Elevation Brace Physical Therapy Other

What diagnosis were you given?

List diagnostic tests or treatment: ***(Please bring all reports & CDs of any testing to your appointment)***

Test Type	Where	When
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgeries/Hospitalizations:

Year:_____ Illness:_____ Year:_____ Illness: _____

Year:_____ Illness:_____ Year:_____ Illness: _____

Year:_____ Illness:_____ Year:_____ Illness: _____

Have you ever had **GENERAL ANESTHESIA**? YES NO

Did you have any problems with anesthesia? YES NO

If yes, describe _____

How long have you had this problem? _____

Medications ***(Please list any and all medications that you are currently taking)***

Medication Name:	Dose:	Reason for medication:	Any side effects:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies : ☐ **No** ☐ **Yes** (if yes, please list names and type of reaction)

Name:_____ Name:_____

Name:_____ Name:_____

Name:_____ Name:_____

Family History: Please provide the following information:

Member	Alive	Deceased	Age	Health status or cause of death
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Please circle all that apply:

Arthritis Hip dysplasia Clubfoot Cancer Diabetes
Heart Disease Hypertension Muscular/Bone Disease Strokes Rheumatoid Arthritis
Scoliosis

Birth History:

Birth Weight:	Natural Delivery C-Section Full term Premature wks gestation
Time in hospital after birth:	Time in NICU
Birth Complications: Head first Breech Other	Age first walked:

Social History (circle all that apply):

Tobacco: unknown if ever smoked never smoker former smoker current some day smoker current every day smoker
smoker, current status unknown PPD: <1 1 2 3 >3 Years smoking: Quit when:

Alcohol: Yes No **Recreational Drugs:** Yes No Type:

Patient employment:	**Sports Participation:**
Exercise: If yes, please specify type	**Recreational:**

Review of Systems: Does the patient have a history of:

Cardiac (Heart Problems):	**YES**	**NO**	
Lung or Breathing problems:	**YES**	**NO**	
Eye problems:	**YES**	**NO**	
ENT/ Mouth problems:	**YES**	**NO**	
Gastrointestinal problems:	**YES**	**NO**	
Musculoskeletal/Arthritis:	**YES**	**NO**	
Skin problems:	**YES**	**NO**	
Neurological problems:	**YES**	**NO**	
Psychiatric/Depression:	**YES**	**NO**	
Seizures:	**YES**	**NO**	
Endocrine problems:	**YES**	**NO**	
Hematologic/Lymphatic:	**YES**	**NO**	
Allergic/Immunologic:	**YES**	**NO**	
Other:			

Female patients: Onset of menstrual period: Regular Irregular

Signature of Patient/Guardian: _____ Date: _____

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PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I have been provided with a copy of Winthrop Orthopaedic Associates, PC Practice's Privacy Notice.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Relationship to Patient

Winthrop Orthopaedic Associates, PC

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INSURANCE WAIVER

I. Individual's Responsibility for Non-Covered Services:

In consideration of services rendered to Winthrop Orthopaedic Associates, PC to the undersigned patient, the undersigned promise(s) to pay Winthrop Orthopaedic Associates, PC any co-payment, co-insurance or other charges required be paid by health insurance coverage.

II. Assignment of Benefit Proceeds:

I request that payment of authorized HMO/Third-Party Payor/Government Agencies (Medicare and Medicaid) benefits be made either to me or on my behalf of Winthrop Orthopaedic Associates, PC for services furnished to me by the provider.

III. Authorization to Release Records:

I hereby authorize Winthrop Orthopaedic Associates, PC to release to my insurer/HMO/Third-Party Payor, governmental agencies, or to whomever is financially responsible for my medical care, all information, needed to substantiate payment for such medical care and, if required, for precertification/prior approval purposes.

IV. Medicare Patients:

Upon receipt of the Medicare Explanation of Benefits, we will bill you for the difference between what Medicare has paid us and the amount Medicare legally allows us to charge you, we will bill your secondary insurance if you have one. ACCEPTED ASSIGNMENT DOES NOT EXEMPT YOU FROM PAYMENT OF BALANCE DUE.

V. HMO Plans (VYTRA, OXFORD, AETNA, etc.):
For plans requiring referrals from the primary care physicians, AUTHORIZATION MUST BE OBTAINED PRIOR TO THE TIME OF VISIT. Unauthorized visits will be billed to you according to the regular fee schedule. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. If benefits are denied due to lapsed coverage, you will be billed according to the regular fee schedule.

VI. Private Insurance:

PAYMENT IS EXPECTED AT THE TIME OF THE VISIT.

_____ _____

Signature of Patient or Authorized Representative **Date**