YEVGENIY A. KORSHUNOV, M.D.

NEW PATIENT/UPDATE INTAKE FORMS

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Last Name: ____________________________ First Name: ________________________ DOB: ____/____/_____

Social Sec #: _______-______-___________ Sex: ________ Marital Status: ___S ___M ___D ___Sep

Address: ____ APT#: ______ City/State/Zip: _______________

Home Phone (_____) ______-______ Cell Phone (_____) ______-______ Work Phone (____) _____-______

Email Address: ____

Race: ________________ Ethnicity: _________________ Preferred Language: __________________ ☐ Decline to Answer

EMPLOYER INFORMATION

Employer: ____________________________ Job Title: ______________________ Phone: (____) ______-______

Address: ____

EMERGENCY CONTACT

Last Name: ____________________________ First Name: ________________________ DOB: ____/____/_____

Relationship: ______________ Address: ____

Home Phone (____) ______-______ Cell Phone (____) ______-______ Work Phone (____) _____-________

Is the injury work related, a car accident, or as a result of playing a sport at school? __Yes __No

If yes, please circle one of the following: ___Work Related ___Car Accident ___Sports Injury

INSURANCE INFORMATION

Primary Insurance: Plan/Company: ____________________________ Policy #:____________________________

Group #: _________________________ ❑Self ❑Spouse ❑Dependent ❑Other

Policy Holder: Last Name: ____________________ First Name: ___________________ DOB: ____/____/_____

Address: ____

Secondary Insurance: Plan/Company: ____________________________ Policy #:__________________________

Group #: _______________________ ❑Self ❑Spouse ❑Dependent ❑Other

Policy Holder: Last Name: ____________________ First Name: ___________________ DOB: ____/____/_____

Address: ____

YEVGENIY A. KORSHUNOV, M.D.

Prior Medical History/ Other Information

Pharmacy Name: ____ Phone: (____) _____-________
Pharmacy Address: ____
Primary Care Physician: ____________________ Phone: (____) _____-______ Fax: (____) ______-_______

Smoking status ❑ Smoker ❑ Non-smoker ❑ Trying to quit

Affected Side
❑ Right ❑ Left ❑ Bilateral

INSTRUCTIONS: Answer every question by filling in the appropriate box. If you are unsure about how to answer a question, please give the best answer you can. If "Other" is marked, please describe it in the space provided or, if necessary, on the back of this form; for example, "Prior Surgeries- Tonsillectomy".

MEDICAL HISTORY

General Health
❑ Excellent
❑ Good
❑ Fair
❑ Poor

Head
❑ Headaches
❑ History of injury
❑ Other

Neck
❑ Stillness
❑ Pain
❑ Arthritis
❑ Thyroid trouble
❑ Other

Skin
❑ Infections
❑ Boils
❑ Psoriasis
❑ Other

Eyes
L R Loss of vision
❑ Glasses
L R Cataract
L R Cataract surgery
L R Pain
❑ Other

Ears
L R Hearing loss
L R Hearing aid
L R Ringing/buzzing
L R Infection
❑ Other

Nose/ Throat
❑ Bleeding
❑ Hoarseness
❑ Polyps
❑ Sinus trouble
❑ Trouble swallowing
❑ Other

Respiratory
❑ Asthma
❑ Wheezing
❑ Chronic cough
❑ Shortness of breath
❑ Coughing up blood
❑ Pain on breathing
❑ Other

Heart
❑ Chest pain
❑ Heart disease
❑ Leg cramps at night
❑ Leg cramps when walking
❑ Leg/ ankle swelling
❑ Irregular heartbeat
❑ Fast heartbeat
❑ High blood pressure
❑ Low blood pressure
❑ Cold fingers & toes
❑ Sweating fingers& toes
❑ Other

Bleeding
❑ Anemia
❑ Bleeding
❑ Other

Metabolic
❑ Diabetes
❑ Hypoglycemia
(*low blood sugar*)
❑ Other

Stomach/ Bowel
❑ Ulcer
❑ Loss of appetite
❑ Swelling ❑ Colitis
❑ Constipation ❑Pancreatitis
❑ Hemorrhoids
❑ Change in bowel habits
❑ Nausea/ vomiting
❑ Pain
❑ Gall bladder problems
❑ Other

Urinary
❑ Leakage
❑ Strong urine
❑ Pain on urination
❑ Back pain
❑ Sores on genitalia
❑ Discharge/ drainage
❑ Bloody urine
❑ Frequent urination
❑ Night time urination
❑ Trouble starting
❑ Trouble stopping
❑ Infections
❑ Herpes
❑ Other

Neurological
❑ Headaches
❑Seizures
(*epilepsy*)
❑ Paralysis
❑ Fainting
❑ Stroke (Right)
❑ Stroke (Left)
❑ Numbness
❑ Other

Prior diseases/Infections
❑ Hepatitis ❑ Herpes
❑ Syphilis ❑ AIDS
❑ AIDS related complex
❑ Cancer (localized to one area)
❑ Cancer (metastatic-spread)
❑ Systemic infection
❑ Local infection
❑ Infection involving joint
❑ Other

Prior Surgeries
❑ Neck fusion
❑ Back fusion
❑ Brain surgery
❑ Thyroid surgery
❑ Heart bypass
❑ Bowel removal
❑ Kidney removal
❑ Hysterectomy
❑ Kidney stones
❑ Lumbar disc removal
❑ Cataract removal
❑ Chest surgery
❑ Stomach removal
❑ Colostomy
❑ Gall bladder removal
❑ Caesarian Section
❑ Appendectomy
❑ Prostate removal
❑ Balloon angioplasty
❑ Bladder repair
❑ Hemorrhoidectomy
❑ Tubal ligation
❑ Vascular surgery
❑ Vein ligation/ stripping
❑ Hernia repair
❑ Hernia repair
❑ Other

Allergies
❑ Pollen
❑ Penicillin
❑ Other Medicine
____
❑ Food
____
❑ Other
____

Habits		Never	Occasionally	Moderate	Heavy
Caffeine beverages	❑ Now	❑	❑	❑	❑
	❑ Past	❑	❑	❑	❑
Alcoholic beverages	❑ Now	❑	❑	❑	❑
	❑ Past	❑	❑	❑	❑
Tobacco	❑ Now	❑	❑	❑	❑
	❑ Past	❑	❑	❑	❑

MEDICATIONS: ❑ Yes ❑ No

____
____
____
____
____
____
____

Prior Medical History/ Other Information

Current problem with:

Left Hip	Right Hip	Left Knee	Right Knee
❑	❑	❑	❑

Other (please specify):

Work status:

❑ Full time
❑ Part time
❑ Retired
❑ Fully disabled
❑ Partially disabled
❑ Unemployed

Work capacity for the Past three months:

❑ 0%
❑ 25%
❑ 50%
❑ 75%
❑ 100%

Level of physical activity

❑ Bedridden of confined to wheelchair
❑ Sedentary- minimum capacity for walking or other activity
❑ Semi-sedentary- white collar job, bench work, light housekeeping
❑ Moderate manual labor
❑ Heavy manual labor

Is the current problem related to a claim for worker's compensation?
❑ Yes ❑ No

❑ Is the current problem related to any current lawsuit or is there a possibility of a claim against another party for legal liability?
❑ Yes ❑ No ❑ Unsure

Height: _______
Weight: _______

ADDITIONAL NOTES:

HIP ONLY

Pre-Op Physician Evaluation

Reason for visit: ____ **Smoking status** ❑ Smoker ❑ Non-smoker ❑ Trying to quit

DURATION OF SYMPTOMS: ______________________________________ Side of Symptom: ❑ Right ❑ Left ❑ Bilateral

Age: __________ Height: ___________ Weight: _____________

Current Symptoms

Side		Side
L ❑	**Pain**	❑ R
L ❑	**Weakness**	❑ R
L ❑	**Aching**	❑ R
L ❑	**Swelling**	❑ R
L ❑	**Loss of Motion**	❑ R
L ❑	**Radiating pain**	❑ R
L ❑	**Other**	❑ R

____

Cause of Symptoms

Side		Side
L ❑	**Unknown**	❑ R
L ❑	**Injury**	❑ R
L ❑	**Fracture**	❑ R
L ❑	**Sprain**	❑ R
L ❑	**Work related**	❑ R
L ❑	**Auto accident**	❑ R
L ❑	**Other**	❑ R

____

Location of Symptoms

Side		Side
L ❑	**Groin**	❑ R
L ❑	**Side of Hip**	❑ R
L ❑	**Buttock**	❑ R
L ❑	**Front of thigh**	❑ R
L ❑	**Back of thigh**	❑ R
L ❑	**Down leg**	❑ R
L ❑	**Lower back**	❑ R
L ❑	**Other**	❑ R

____

Symptoms worse with

Side		Side
L ❑	**Sitting**	❑ R
L ❑	**Standing**	❑ R
L ❑	**Walking**	❑ R
L ❑	**Stairs**	❑ R
L ❑	**Exercise**	❑ R
L ❑	**Carrying**	❑ R
L ❑	**Sexual activity**	❑ R
L ❑	**Other**	❑ R

____

Symptoms better with

L ❑	**Medication**	❑ R
L ❑	**Exercise**	❑ R
L ❑	**Heat**	❑ R
L ❑	**Ice**	❑ R
L ❑	**Rest**	❑ R
L ❑	**Extending leg**	❑ R
L ❑	**Nothing**	❑ R
L ❑	**Other**	❑ R

____

Pain level at Rest

L ❑	**None**	❑ R
L ❑	**Slight**	❑ R
L ❑	**Mild**	❑ R
L ❑	**Moderate**	❑ R
L ❑	**Moderate/ sever**	❑ R
L ❑	**Severe**	❑ R
L ❑	**Disabling**	❑ R
L ❑	**Other**	❑ R

____

Pain Level W/ Walking

L ❑	**None**	❑ R
L ❑	**Slight**	❑ R
L ❑	**Mild**	❑ R
L ❑	**Moderate**	❑ R
L ❑	**Moderate/ sever**	❑ R
L ❑	**Severe**	❑ R
L ❑	**Disabling**	❑ R
L ❑	**Other**	❑ R

____

Pain Level at Night

L ❑	**None**	❑ R
L ❑	**Mild**	❑ R
L ❑	**Moderate**	❑ R
L ❑	**Severe**	❑ R
L ❑	**Other**	❑ R

____

Hip Function with Stairs

L ❑	**Normally w/ no railing**	❑ R
L ❑	**Normally with railing**	❑ R
L ❑	**Pain going down stairs**	❑ R
L ❑	**Pain going up stairs**	❑ R
L ❑	**Severe difficulty**	❑ R
L ❑	**Unable to do stairs**	❑ R

____

Distance able to walk

L ❑	**Unlimited**	❑ R
L ❑	**6-10 blocks**	❑ R
L ❑	**1 to 3 blocks**	❑ R
L ❑	**Indoors only**	❑ R
L ❑	**Unable to walk**	❑ R

____

Assistance Needed to Walk

L ❑	**None**	❑ R
L ❑	**One cane: part time**	❑ R
L ❑	**One cane: full time**	❑ R
L ❑	**Two canes**	❑ R
L ❑	**One crutch**	❑ R
L ❑	**Two crutches**	❑ R
L ❑	**Walker**	❑ R
L ❑	**Wheelchair only**	❑ R

____

Previous studies of Hip

L ❑	**X-rays**	❑ R
L ❑	**CT/ CAT scan**	❑ R
L ❑	**MRI**	❑ R
L ❑	**Nerve Conduction**	❑ R
L ❑	**Bone scan**	❑ R
L ❑	**Aspiration**	❑ R
L ❑	**Other**	❑ R

____

Presence of a Limp

L ❑	**None**	❑ R
L ❑	**Slight**	❑ R
L ❑	**Moderate**	❑ R
L ❑	**Severe**	❑ R
L ❑	**Can't walk**	❑ R

____

Pain with Sitting

L ❑	**None**	❑ R
L ❑	**in 1 to 2 hours**	❑ R
L ❑	**in 30 minutes**	❑ R
L ❑	**Immediately**	❑ R

____

Ability to use public transport

L ❑	**Yes, no difficulty**	❑ R
L ❑	**Yes, with difficulty**	❑ R
L ❑	**No**	❑ R

____

Ability to put on sock/shoes

L ❑	**Yes, with ease**	❑ R
L ❑	**Yes, w/ difficulty**	❑ R
L ❑	**Unable**	❑ R

____

Current level of activity

L ❑	**Wholly inactive**	❑ R
L ❑	**Mostly inactive**	❑ R
L ❑	**Occasionally in mild events** (Walking, limited housework & shopping)	❑ R
L ❑	**Regularly in mild events**	❑ R
L ❑	**Occasionally in moderate events** (Swimming, unlimited housework& shopping)	❑ R
L ❑	**Regularly in moderate events**	❑ R
L ❑	**Regularly in active events** (Bicycling)	❑ R
L ❑	**Regularly in very active events** (Bowling, golf)	❑ R
L ❑	**Occasionally in impact sports** (Jogging, tennis, skiing, acrobatics, heavy labor)	❑ R
L ❑	**Regularly impact sports**	❑ R

Previous Treatment of the Hips

L ❑ **None** ❑ R

L ❑ **Physical therapy** ❑ R

Date: _________ Duration: _________

Improvement? ❑ Yes ❑ No

L ❑ **Injections** ❑ R

L-type? ________ R-type? __________

L-date: _____________ R-date: ______________

Improvement? ❑ Yes ❑ No

L ❑ **Arthroscopy/ Scope** ❑ R

L-date: _____________ R-date: ______________

Improvement? ❑ Yes ❑ No

L ❑ **Hip Replacement** ❑ R

L-date: _____________ R-date: ______________

L ❑ Other: ________________________________ ❑ R

L-date: _____________ R-date: ______________

other joint problem

❑ **Knee:** __________________

Procedure: __________________

❑ **Ankles**: __________________

Procedure: __________________

❑ **Feet:** __________________

Procedure: __________________

❑**Back:** __________________

Procedure: __________________

❑ **Shoulder:** __________________

Procedure: __________________

❑ **Other** __________________

____

HIP Continue

Other surgeries: ____

____

Medications: ____

____

Medical problems: ❑ High blood pressure ❑ Diabetes ❑ Cholesterol ❑ Stroke ❑ Heart disease ❑ Cancer
❑ Other: ____

Please elaborate: ____

Allergies to any metal? ❑ Yes ❑ No ❑ Unsure
If yes, please elaborate: ____
Allergies to medications & occurred
That occurred: ____

____

Profession: ____
Activities: ____

PHYSICAL EXAM: HIP—Physician use only

Side of patient SX: ❑ Right ❑ Left ❑ Bilateral **Limp:** ❑ Yes ❑ No **Timed up and go test:** _________sec
Led length discrepancy: ____ cm R/L, shorter/ longer **Lumbar motion:** ❑ Normal ❑ Impaired ❑ Painful

RIGHT- RANGE OF MOTION

Extension ❑ flexion contracture **Flexion**

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
-10	0	10	20	30	40	50	60	70	80	90	100	110	120	130	>130

Abduction ❑ Fixed **Adduction**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
>60	60	50	40	30	20	10	0	10	20	30	40	>40

External Rotation ❑ Fixed **Internal Rotation**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
>50	50	40	30	20	10	0	10	20	30	40	50	>50

Apprehension: ❑ Yes ❑ No
Impingement: ❑ Yes ❑ No
Resistance: ❑ Yes ❑ No
Tenderness: ❑ medial ❑ retropatellar ❑ lateral
❑ Other: ___________________________
Swelling: ❑ Yes ❑ No ____________________
Atrophy: ❑ Yes ❑ No ____________________
Muscle tightness: ❑ Yes ❑ No: ______________
❑ Hamstring: ___________❑Quadriceps: __________
❑ ITB: _____________ ❑ Other: ________________
Scars: ❑ Yes ❑ No
Skin Appearance: ____________________________

LEFT- RANGE OF MOTION

Extensions ❑ flexion contracture **Flexion**

❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
-10	0	10	20	30	40	50	60	70	80	90	100	110	120	130	>130

Abduction ❑ Fixed **Adduction**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
>60	60	50	40	30	20	10	0	10	20	30	40	>40

External Rotation ❑ Fixed **Internal Rotation**

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
>50	50	40	30	20	10	0	10	20	30	40	50	>50

Apprehension: ❑ Yes ❑ No
Impingement: ❑ Yes ❑ No
Resistance: ❑ Yes ❑ No
Tenderness: ❑ Trochanter ❑ Thigh ❑ Glutes ❑ Groin
❑ Other: ___________________________
Swelling: ❑ Yes ❑ No ____________________
Atrophy: ❑ Yes ❑ No ____________________
Muscle tightness: ❑ Yes ❑ No: ______________
❑ Hamstring: ___________❑Quadriceps: __________
❑ ITB: _____________ ❑ Other: ________________
Scars: ❑ Yes ❑ No
Skin Appearance: ____________________________

Diagnosis: ❑ DJD knee ❑ Torn Meniscus ❑ Chondromalacia ❑ ______________________________
Recommendation: ❑ PT ❑ TKR ❑ Cortisone injection ❑ Synvisc ❑ MRI ❑ ___________________

Financial Policy

Thank you for choosing ________________________ as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient case.

Insurance

We must emphasize that as medical care providers; our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date the service is rendered are your responsibility. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract.

If the physician participates with your managed care medical insurance, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment. If your insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we will bill surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account.

Canceled Appointments

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged $50.00.

Dependent Children

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of the practice.

Workers Compensation/ No Fault

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (212)737-3301.

Payment

I hereby authorize and instruct the insurance company(s) noted to pay authorized benefits on my behalf to **NY Orthopedics**. This payment will not exceed my current indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. I also authorize the release of any medical information required to process payment claims.

I have read and understand the above financial policy:

Patient Name (Print): ____________________________ Parent/Guardian Name (Print):____________________

Signature: _____________________________________ Date: ____

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **NY Orthopedics** or disclosed to others for the purposes pf treatment, obtaining payment, or supporting the day to day health care operations of the practice.

Fundraising: Unless you request us not to, we may use your name and address to support Lenox Hill Hospital and NISMAT fundraising efforts. If you do not want to participate in fundraising efforts, please check off the following box.

❑ I do not wish to participate in fundraising efforts

Notice of Privacy Practices

You should review the Notice of Privacy Practices for more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. NY Orthopedics may or may not agree to restrict the use or disclosure of your protected health information. If NY Orthopedics agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal policy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing, any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Rights to Change Privacy Practices

NY Orthopedics reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and received a copy of Notice of Privacy Practices. I give my permission to NY Orthopedics to use and disclose my health information in accordance with it. Additionally, I agree that NY Orthopedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Patient's Name (Print): ____________________________________ Signature: ________________________

Signature of patient representative: ___________________________ Relationship: ______________________

Date: ________________________________

Patient Request for Confidential Communication

Patient Name: ____ DOB: ___/___/_____

Patient Address: ____

Phone (_____) ______-___________ Social Sec #: ______-______-_________

NY Orthopedics may contact you by telephone at your home, work or cell unless you instruct us otherwise.

Under HIPAA, you have the right to request that communications with you be confidential and by means of your selection. We will approve your request if in our opinion it is reasonable. Once we agree to your request, we are obliged to honor it, except if any emergency arises.

I wish to be contacted as follows (check all that apply)

- ❑ At my home telephone number (_____) _____-_______
- ❑ Leave me a message with a call back number only

- ❑ At my work telephone number (_____) _____-_______
- ❑ Leave me a message with a call back number only

- ❑ On my cell telephone number (_____) _____-_______
- ❑ Leave me a message with a call back number only
- ❑ Send a message reminder via text message

- ❑ Send a message reminder via email
  Email: ____

- ❑ Other: Please specify any other person(s) allowed to contact our office on your behalf:

____

____

____

Print Name: ______________________________________ Date: ___________________

Signature: _______________________________________ Date: ___________________

Financial Disclosure Form

Out of Network, Lack of Referral, Non Participating Provider

I, (print name) ______________________, hereby attest that I fully understand my financial responsibility for the charges resulting from my decision to do the following:

- ❑ I choose to use a specialist (name of doctor) ______________________, who **does not** participate in (name of insurance carrier) _______________________________.

- ❑ I choose to see an **in network** specialist (check one) ❑with ❑without an authorized referral from my Primary Care Physician. The specialist I will see is __________________________.

I understand that my financial liability will be determined by the provisions of my coverage plan.

Date of Service: ____________________________

Member name: ____________________________

Member ID #: _____________________________

Member/ Guardian Signature ____________________________________ Date: _________________