Lilia Gorodinsky, D.O.

NYC Osteopathic,PLLC

Welcome!

NEW PATIENT REGISTRATION FORM: **PLEASE PRINT or TYPE**

Fax completed form: **917-423-0452** or bring it with you to your appointment.

PERSONAL INFORMATION

Today's date _____

Name_____Birth Date_____Sex_____

Address_____

Email_____ Referred by_____

Phone(home)_____(work)_____(cell)_____

Closest relative (include address)_____

_____

Relative phone_____ Spouse/significant other_____

Who lives at home?_____

Employer_____ Occupation_____

Medications/supplements/herbs/home remedie: _____

_____

Allergies(including medications)_____

Diet (please describe)

Breakfast_____

Lunch_____

Dinner_____

Exercise (please describe)_____

_____

Education_____

INSURANCE INFORMATION:

Please fill out the following information for the holder of the insurance policy or legal guardian.

Insurance Co_____Group #_____Policy #_____

Insured name_____ Birth Date_____ Sex _____

Please list Surgeries, Serious Injuries, Fractures or illnesses, or hospitalizations:

Event Date Outcome

_____

_____

_____

_____

_____

_____

_____

_____

REASON FOR VISIT:

_____

Was there an initiating event? _____

What was different within 6 months before the onset of the problem? _____

_____

_____

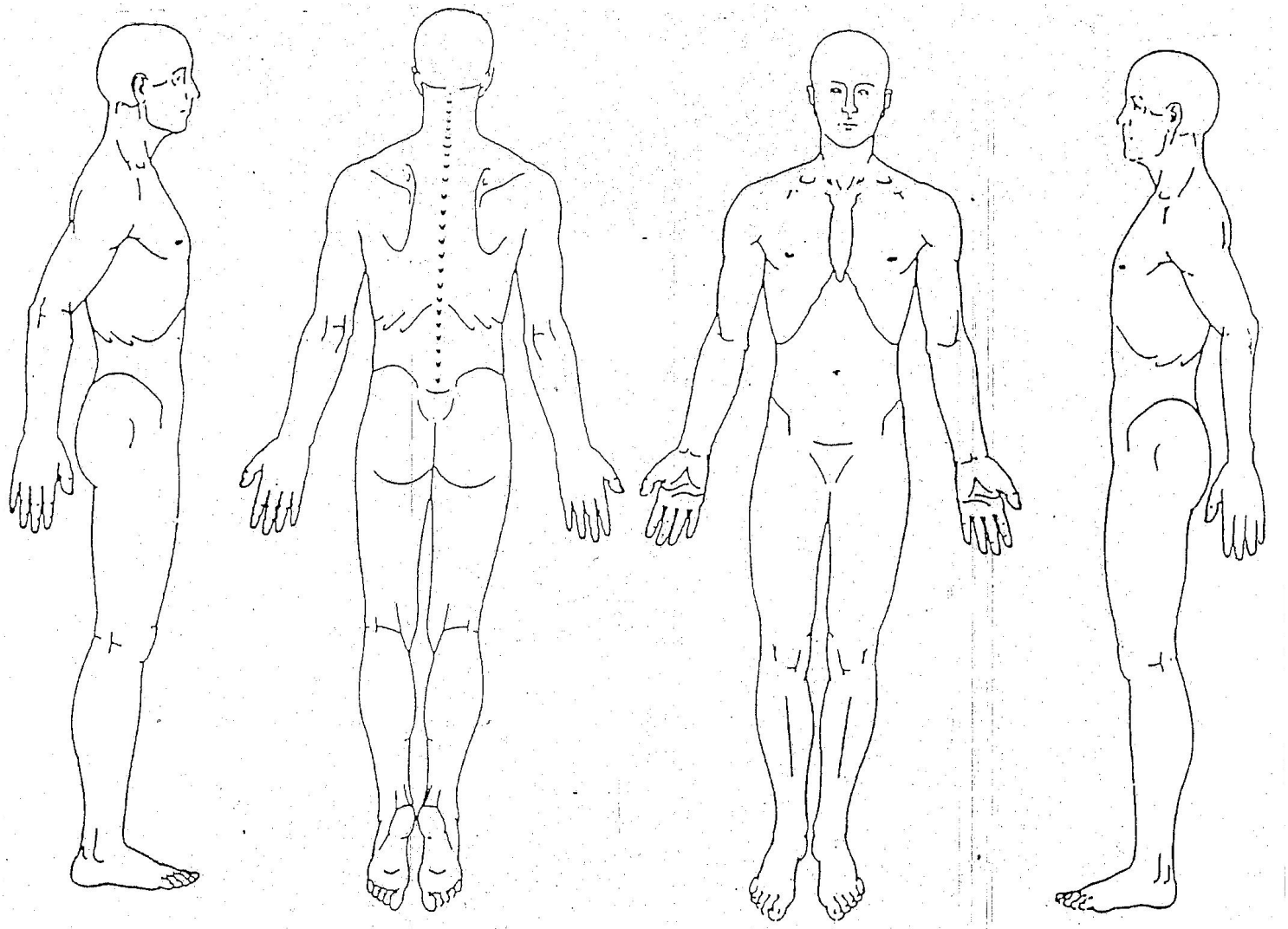
LOCATION: Where does it hurt?_____

(Using the symbols below, mark the areas of your body where you feel the described sensation. Include all affected areas.)

WORSE PAIN= WWW ACHING= AAA SHOOTING= SSS PAIN=PPP

NUMBNESS= NNN BURNING= BBB TINGLING= TTT STABBING= ZZZ

Right Left Right Right Left Left



INTENSITY: How bad is the pain? (Circle the number 0=no pain, 10 = worst pain possible)

NOW: 1 2 3 4 5 6 7 8 9 10

At ITS WORST: 1 2 3 4 5 6 7 8 9 10

AT ITS BEST: 1 2 3 4 5 6 7 8 9 10

ONSET: When did it start? (Most recent episode)_____

DURATION: (since initial event)_____

QUALITY: (circle all that apply)

1. Sharp dull burning deep ache pressure pins and needles other_____

TIMING: constant?___ or intermittent?___

Worse: morning?___ afternoon? __evening? ___ night awakening?___ Same all day?____

WHAT MAKES IT WORSE? (circle all that apply)

Sitting Standing Walking Lying down Sustaining one position

Changing position (e.g. sit to stand, turn over in bed) other_____

WHAT MAKES IT BETTER? (circle all that apply)

Sitting Standing Walking Lying down Rest Stretching Exercise Heat Ice other_____

Have you had any of the following tests *for this or a similar* problem? Fill in dates.
(approx):X-Ray?_____ MRI?_____CT scan?_____ Bone Scan?_____Myelogram?_____ Other? _____

Treatments for *this* problem?
Manipulation (osteopathic/chiropractic): When? _____ Result ? _____
Medications: (types) _____ Result? _____
Injections: (types) _____When? ____ Result?_____
Physical Therapy:? ____ When?_____ For how long?_____ Result?_____
Surgery? (types) _____ When? _____ Result?_____

DOES PAIN AFFECT YOUR (check all that apply) :

Daily routine?_____HOW?_____
Mood?_____HOW?_____
Recreation?_____HOW?_____
Work?_____HOW?_____
Sleep?_____HOW?_____
Sex life?_____HOW?_____

MEDICAL HISTORY

aCheck every condition you have had *ever* had. **Circle conditions currently present.** Write age of onset.

EYES
c Failing vision
c Double or blurred vision
c Squinting/"crossed" eyes
c Asymmetric gaze
c Eye pain
c Eye infections
c Lose placement reading
c Poor reading comprehension
c Eyestrain or fatigue from reading
c Headache from reading
c Glasses or contacts
c Monovision/progressive lens

ENT
c Decreased hearing
c Loud voice
c Snoring/mouth breathing
c Ringing/buzzing in the ears
c Ear infections
c Allergies/hay fever/runny nose
c Sinus problems,
c Nosebleeds
c Frequent sore throats
c Prolonged hoarseness
c Speech problems

CARDIOPULMONARY
c Asthma
c Emphysema
c Chronic cough
c Bronchitis
c Pneumonia
c Tuberculosis
c Shortness of breath on exertion
c Shortness of breath on lying flat
c Chest pains
c Heart murmurs
c Palpitations
c Swollen ankles
c Fainting spells
c Weight leg pain when walking
c Varicose veins/phlebitis

GI
c Eating disorder
c Recent loss of appetite
c Difficulty swallowing
c Heartburn
c Persistent nausea/vomiting
c Ulcers

c Chronic abdominal pain
c Recent change in bowel habits
c Diarrhea
c Constipation
c Black or tarry stools
c Red blood in stools
c Hemorrhoids
c Diverticulosis
c Gallbladder trouble
c Jaundice/hepatitis
c Hernia

ENDO
c Chronic fatigue
c Recent weight loss
c Excessive weight gain
c Thyroid disease
c Cancer
c Diabetes

NEURO
c Convulsions/seizures
c Stroke
c Tremors
c Muscle weakness
c Numbness/tingling sensation
c Frequent headaches
c Clumsiness

MS
c Joint pain
c Scoliosis/kyphosis
c Arthritis
c Gout
c Cold or numb feet
c Involved in contact sports

DERM
c Rashes
c Psoriasis
c Eczema
c Hives
c Unusual moles

PSYCH/EMOTIONAL
c Difficulty sleeping
c Nightmares
c Nervousness/anxiety
c Stress
c Depression
c Memory loss
c Moodiness
c Phobias
c Nail biting/thumb sucking
c Bad temper/breath-holding
c Jealously

ILLNESSES
c Mumps
c Measles
c German measles
c Chicken pox
c Polio
c Scarlet fever
c Rheumatic fever
c TB
c Meningitis

HABITS
c Alcoholism
c Alcohol _____
c Cigarettes_____/day
c Coffee/tea_____ cups/day
c Chocolate
c Sugar
c Other

HEME
c Anemia
c Malaria
c Bruise easily/bleeding
c Mononucleosis
c Unexplained lumps
c Fever/chills/excessive sweating

GU
c Bedwetting
c Bladder infections
c Kidney infection
c Pain on urination
c Poor control of urination
c Decreased force of urination
c Blood in urine
c Kidney stones
c Discharge from penis or vagina
c Sexually transmitted disease

FEMALE ONLY:
Number of pregnancies_____
Number of live births_____
Number of miscarriages_____
Method of birth control_____
Age of onset of menses _____
Flow: c Light c Moderate c Heavy
Length of flow_____
Length of cycle _____
c Period not regular
c Pain/bleeding with intercourse
c PMS (medium to severe)

STRESS
Check any of the following that occurred in your family the past year:
c Married c Births c Serious illness
c Divorcedc Deaths c Separation
c Job loss c Move c Other_____

DENTAL
c Orthodontic treatment: age_____
c Dental extractions
c Crowns
c Root canal work
c Fillings
c Bridgework
c Retainer/nightguard
c Gum problems
c TMJ

OTHER MEDICAL Conditions not listed above:

_____

_____

_____

Major life trauma and or stressor (physical or emotional):

_____

_____

_____

_____

_____

_____

OTHER MEDICAL TREATMENT: List all physicians from whom you are currently receiving treatment along with the condition(s).

Physician Name Illness(es) Treatment program

_____

_____

_____

_____

_____

_____

Current Medications and Supplements:

_____

_____

_____

_____

_____

Family History:

Mother_____

Father_____

Maternal Grandmother_____

Maternal Grandfather_____

Paternal Grandmother_____

Paternal Grandfather_____

NYC Osteopathic, PLLC **Effective: April 1, 2003**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At NYC Osteopathic, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This notice is effective November 1, 2010, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit NYC Osteopathic, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,

- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of NYC Osteopathic, the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
NYC Osteopathic is required to:
1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

NYC Osteopathic reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How NYC Osteopathic May Use or Disclose Your Health Information

For treatment, payment, health care operations, appointments, to appropriate business associates, notification, or communication with family members, research, funeral director, organ procurement organizations, marketing, Food and Drug Administration (FDA), Workers Compensation, Public Health Department, in cases as required by law, public health and safety, and for certain government functions.

For More Information or to Report a Problem, or If you have questions and would like additional information, you may contact our practice.
NYC Osteopathic,PLLC
405 lexington 26th floor, suite 2634
New York NY 10174
Phone: (212) 537-0614
Fax: (917) 423-0452

If you believe your privacy rights have been violated, you can file a complaint with the practice, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Effective Date: April 1, 2003

Acknowledgment of Receipt of this Notice

Note this is to document that I have received a copy of the notice of crepitus he practices for NYC Osteopathic, PLLC. I have read this copy and agree to the terms

Name of Patient (PRINT)_____

_____ _____
Signature of Patient or Authorized Representative Date