New Patient Form

STONY BROOK
ORTHOPAEDIC
ASSOCIATES
JOINT REPLACEMENT
CENTER

Name:_____

Today's Date:_____

Phone Number:_____

Main problem(s) you would like to talk about today (tell me how/ when it started):

What is the degree of pain you usually have (please circle a number 0-10);

No Pain [0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10] Worst Pain

Tell me about the location of the pain origin:

Tell me where the pain radiates to (does it travel anywhere):

What is the character of the pain: ☐ Sharp ☐ Aching ☐ Burning ☐ Tight ☐ Stiff

What have you found make your pain less severe?

What makes you experience more pain?

Do you experience any catching, locking, or giving way of the joint (include falls), if so please explain:

Tell me what activities of your daily living are limited due to your pain:

Tell me if you have or are seeking any of the following due to this pain (mark all that apply):

☐ litigation ☐ workers compensation claim ☐ full disability

Tell me what treatments you have already tired

Weight loss attempts (what is your current weight_____ and height_____)

Physical therapy (if so tell me when)

Arthritis medication or supplements (please list)

Narcotics used to control pain (list names dose, number per day)

Injections (if so, was it a steroid/cortisone or was it a gel/hyaluronic acid)

Braces, orthotics, or assistive devices (canes/walkers)

Previous surgeries on this painful joint

Please tell me about your social history (check or write):

Personal relationship: ☐ Married ☐ Divorced ☐ Widow ☐ Domestic partner

Home Environment: ☐ Live alone ☐ Live with family/friend ☐ Live in assistive living ☐ Other

Are you currently Working: ☐ Yes ☐ No ☐ Retired

What is your occupation? _____

Tobacco use? _____

How often do you consume alcohol (more than two drinks)?_____

Family history of parents and/or siblings (please detail any family history of heart disease, diabetes, cancer, blood clots or bleeding issue):

Review of systems-check any problems area from your medical history:

_Caner	_Recent weight loss/gain	_Neurologic
_Pulmonary	_Cardiac/MI	_Diabetes/thyroid
_Bowel/bladder	_Gout/RA	_Bleeding/blood clots
_Psoriasis/ rashes	_Psychiatric	_Auto-immune disease

_____(doc sig): I have personally reviewed this intake form and ACSL on date of service

Stony Brook Medicine

Department of Radiology

Hospital Radiology Services

Dear Patient,

Thank you for choosing Stony Brook Medicine for your care and treatment. Please be advised that the Radiological Services provided here during this office visit are a Stony Brook University Hospital Service.

If you are having x-rays taken as part of today's visit, your insurance carrier will be billed separately for the professional and technical portions of the x-ray as a Hospital Service. The technical portion of the bill covers the costs of equipment, supplies, the radiology technician and other hospital personnel. The professional portion covers the personal professional services of the radiologist (physician) who will interpret the radiological test.

In addition to your usual co-payment for your doctor office visit, you may incur another co-payment for the hospital based x-ray services or based on your insurance carrier, the fees could be applied towards your Hospital Deductible.

Please call your insurance carrier to determine your benefits related to outpatient hospital diagnostic services.

Please acknowledge that you have read the above statement by signing below:

_____ _____

SIGNATURE NAME OF PATIENT

_____

PRINT NAME

_____

DATE OF SERVICE

HSC-L4-092, STONY BROOK, NEW YORK 11794-8420 TEL: 631-444-2420 FAX: 631-444-3443

Stony Brook Medicine

NARCOTIC MEDICATION POLICY

Please note that Stony Brook Orthopedics is a consultation and treatment center. We are here to diagnose and treat orthopedic conditions. We are not a Pain Management Center. Our physicians will only dispense narcotic medication to post-operative patients, or patients with acute conditions such as fractures. These patients will then be weaned off of narcotic medications over a period of weeks. If you require narcotic medications on a regular basis, we suggest you seek the services of a pain management service or obtain them from your Primary Care Physician.

Please acknowledge that you have read the above statement by signing below.

MR#: _____ Date: _____

Print Name: _____

Signature: _____

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