CONFIDENTIAL PATIENT QUESTIONAIRE

REFERRED BY:_____ **ACCT.#**_____

LAST NAME_____ FIRST NAME _____ MI_____

ADDRESS _____ CITY _____ .STATE_____ ZIP_____

HOME(_____)_____ WORK(_____)_____ CELL (_____)_____

AGE_____ DATE OF BIRTH_____/_____/_____ SEX ☐ M ☐ F SOC .SEC.# _____–_____–_____

MARITAL STATUS ☐ S ☐ M ☐ D ☐ W SPOUSE'S NAME_____

PRIMARY CARE PHYSICIAN: _____ TEL. (_____) _____

ADDRESS: _____

EMPLOYER INFORMATION

EMPLOYER NAME:_____ OCCUPATION_____

ADDRESS: _____ TEL.(_____) _____- _____

_____ FAX.(_____) _____ - _____

INSURANCE INFORMATION

INSURANCE NAME:_____ TEL. (_____) _____-_____

ADDRESS: _____ POLICY#_____

_____ WCB#G-_____ CLAIM#_____

AUTO INJURY/WORK INJURY/PERSONAL INFORMATION

CASE TYPE: ☐AUTO ☐WORK ☐LIEN/SLIP & FALL ☐ PRIVATE INSURANCE

DATE OF INJURY _____

DESCRIBE HOW INJURY OCCURRED?_____

WHICH BODY PART/S WERE INJURED?_____

DID YOU REPORT THE INJURY ☐ NO ☐YES, TO WHOM _____

DID YOU GO TO THE HOSPITAL? ☐NO ☐YES NAME OF HOSPITAL_____

IF YES, WERE YOU TAKEN BY AMBULANCE? ☐NO ☐YES

WAS MEDICATION PRESCRIBED? ☐NO ☐YES

X-RAYS TAKEN? ☐NO ☐YES

WERE YOU WORKING AT THE TIME OF THE ACCIDENT? ☐NO ☐ YES

ARE YOU PRESENTLY WORKING? ☐NO ☐ YES, IF NO DATES LOST FROM WORK _____

IF AUTO INJURY, WERE YOU? ☐DRIVER ☐PASSENGER ☐PEDESTRIAN

#OF PEOPLE IN YOUR VEHICLE? _____ WORE SEAT BELT? ☐NO ☐YES, DID AIRBAG INFLATE ☐NO ☐ YES

ATTORNEY INFORMATION

NAME: _____ TEL. (_____) _____-_____

ADDRESS: _____ Fax. (_____) _____ -_____

PATIENT HISTORY OF PRESENT ILLNESS

Chief complaints/Injured sites:_____

Where is the pain/problem? Does it travel to other areas? _____

What caused the pain? Was there a specific injury? _____

Describe the pain (Dull, throbbing, sharp?)_____ How severe is the pain (scale 1-10)_____
(with 10 most severe)

How long have you had this pain/problem? When did it start? _____

When does the pain/problem occurs (after exercise, at night etc),_____

Is the pain constant or intermittent? _____ How frequent is the pain/problem?_____

What other associated problems are you having _____
(Numbness, swelling, cracking, popping, grinding, locking, etc)

What makes the problem better? _____ What makes the problem worse?_____
(Rest, ice, medications) (work, athletics, specific activity)

Have you seen any other physicians for this problem prior to coming to our office? ☐Yes ☐No

If yes, please list 1._____ when? _____

2._____ when? _____

Were x-rays, MRI, CT scan, or EMG tests performed?_____ when? _____

What treatment, if any, have you received for this condition? (please check all that apply)

☐Physical therapy ☐Chiropractic ☐Acupuncture ☐Surgery ☐Injections ☐Medication

Did the treatment help?_____ For how long?_____ Other _____

PAST HISTORY OF PRESENT ILLNESS

Have you previously experienced same or similar symptoms ? ☐Yes ☐No

What type of treatment/s did you received? _____

Did the treatment resolved your symptoms? _____

PATIENT'S PAST MEDICAL HISTORY

Patient Name _____ Height: _____'_____ Weight: _____lbs

Chief complaints:_____

Have you had any of the following? Please check all that apply.

☐Aids or HIV+	☐Diabetes	☐Low blood pressure	☐Smallpox
☐Anemia	☐Diphtheria	☐Measles	☐Stroke
☐Arthritis	☐Epilepsy/Seizures	☐Migraine Headaches	☐Thyroid Disease
☐Asthma	☐Glaucoma	☐Mitral Valve prolapse	☐Ulcer
☐Back trouble	☐Heart Disease	☐Mumps	☐Venereal Disease
☐Bladder infections	☐Hemorrhoids	☐Pneumonia	☐Whooping cough
☐Blood transfusions	☐Hight blood pressure	☐Polio	☐Other _____

MEDICATIONS (please include non-prescriptions and Herbal Supplements)

Drug name	Dosage	Frequency	Drug name	Dosage	Frequency

ALLERGIES

Medication	Reaction	Medication	Reaction

Tape Allergy ☐Yes ☐No Latex Allergy ☐Yes ☐No

PAST SURGICAL HISTORY

Please list previous hospitalizations/surgeries/serious illnesses	When?	Hospital, City, State

DO YOU HAVE ANY METAL IN YOUR BODY ☐Yes ☐No

What kind of metal/screws?_____

WORK HISTORY

Current occupation _____ Employer _____ Length of employment _____

Work status ☐Full Duty ☐Light Duty ☐Not working/list reason_____

Physical work duties (please check all that apply)

☐Lift ☐Walk ☐Stand ☐Carry ☐Kneel ☐Climb ☐Type ☐Write ☐Site ☐computer use

Other work duties not listed above _____

HOBBIES/SPORTS What type of hobbies/sports do you play? (please check all that apply)

☐Running ☐Weightlifting ☐Tennis ☐Bicycling ☐Aerobics ☐Swimming, ☐Skiing

☐Softball ☐Racquetball ☐Other _____

REVIEW OF SYMPTOMS **Have you experienced any of the following signs or symptoms listed below**

Musculoskeletal

Joint pain	___Yes	___No
joint stiffness or swelling	___Yes	___No
Weakness of muscles or joint	___Yes	___No
Muscle pain or cramps	___Yes	___No
Back pain	___Yes	___No
Cold extremities	___Yes	___No
Difficulty Walking	___Yes	___No

Constitutional Symptoms

Bad general health lately	___Yes	___No
Recent weight change	___Yes	___No
Fever	___Yes	___No
Fatigue	___Yes	___No
Headaches	___Yes	___No

Ear / Nose /Mouth /Throat

Hearing loss or ringing	___Yes	___No
Earaches or drainage	___Yes	___No
Chronic sinus problem	___Yes	___No
Nose bleeds	___Yes	___No
Bleeding gums	___Yes	___No
Sore throat /voice change	___Yes	___No
Swollen glands in neck	___Yes	___No

Cardi

Cardiovascular		
Heart trouble	___Yes	___No
Chest pain angina pectoris	___Yes	___No
Palpitation	___Yes	___No
Shortness of breath	___Yes	___No
While walking	___Yes	___No
Swelling of feet / ankles/hands	___Yes	___No

Genitourinary

Frequent urination	___Yes	__No
Burning or painful urine	___Yes	__No
Blood in urine	___Yes	__No
Incontinence or drilling	___Yes	__No
Female-number of pregnancies	_____	
Female-number of deliveries	_____	

Integumentary (Skin, breast)

Rash or itching	___Yes	__No
Changes in skin color	___Yes	__No
Varicose veins	___Yes	__No
Breast pain	___Yes	__No
Breast lump	___Yes	__No

Neurological

Light headed or dizzy	___Yes	__No
Numbness or tingling	___Yes	__No
Tremors	___Yes	__No
Paralysis	___Yes	__No

Endocrine

Excessive thirst or urination	___Yes	__No
Heat or cold intolerance	___Yes	__No
Skin becoming dryer	___Yes	__No
Hematologic/Lymphatic	___Yes	__No
Slow to heal after cuts	___Yes	__No
Bleeding or bruising tendency	___Yes	__No
Anemia	___Yes	__No
Enlarged glands	___Yes	__No

Psychiatric

Memory loss or confusion	___Yes	___No
Nervousness	___Yes	___No
Depression	___Yes	___No
Insomnia	___Yes	___No

Gastrointestinal

Los of appetite	___Yes	___No
Nausea or vomiting	___Yes	___No
Frequent Diarrhea	___Yes	___ No
Constipation	___Yes	___No
Rectal bleeding/blood	___Yes	___No
Abdominal pain	___Yes	___No

Respiratory

Chronic or frequent coughs	___Yes	___No
Spitting up blood	___Yes	___No
Shortness of breath	___Yes	___No
Wheezing	___Yes	___No

Eyes

Eyes disease or injury	___Yes	___No
Wear glasses/contact lenses	___Yes	___No
Blurred double vision	___Yes	___No

Allergies/immunologic

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorized the health care provider staff to perfume the necessary services I may need.

Patient's signature or parent of minor X_____ Date_____

PATIENT SOCIAL HISTORY

Marital status	Use of alcohol	Use of Tobacco	Living situation	Dominant hand
☐Single	☐Never	☐Never	☐With Family	☐Right
☐Married	☐Rarely	☐Previously, but quit	☐With Friends	☐Left
☐Divorced	☐Moderate	☐Currently	☐Alone	
☐Widowed	☐Daily	☐_____Packs per day	☐Other_____	

PATIENT FAMILY HISTORY

	Age	Condition or Diseases	If Diseased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status. I also authorized the health care provider staff to perfume the necessary services I may need.

Patient's signature or parent of minor X_____ Date_____

INFORMED CONSENT

I have received information about my condition and proposed Chiropractic Rehab as well as alternative courses of treatment along with associated risks, benefits and side effects of the treatment and consequences of not having the proposed treatment.

I understand that I am informed that, as in all Health Care, in the practice of spinal manipulation there are some risks to treatments, including but not limited to muscle strains, fractures, dislocation, disc injuries, and vascular accidents.

My doctor has responded to all my requests for information about the proposed treatment. I have read or have read to me, the above consent. I have also had the opportunity to ask questions about this consent. By signing below, I consent to Chiropractic Rebah.

Name _____ Signature X_____

Witness by _____ Date _____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
MAXIMUM ORTHOPEDICS-369 E. 149TH STREET-9TH FLOOR, BRONX, NEW YORK 10455

9(a). Specific information to be released:

☑ Medical Record from (insert date) _____ to (insert date) **PRESENT**

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☑ Other: **Please include all triage records**

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**ONE YEAR**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

✓ _____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

DOCTOR'S LIENS

TO: Attorney/Insurance Carrier

_____

_____

_____

Doctor/s

_____

_____

_____

_____

Re: _____

I do hereby authorized the above doctor to furnish you, my attorney/insurance carrier, with a full report of his/her case history, examination, diagnosis, treatment, and prognosis of myself regarding my accident/illness which occurred/began on _____.

I do hereby give a lien to said doctor on any settlement, claim judgement, or verdict as a result of said accident/illness, and authorize and direct you, my attorney/insurance carrier, to pay directly to said doctor such sums as may be due and owing him/her for service rendered me, and to withhold such sums from such settlement, claim, judgement, or verdict as may be necessary to protect said doctor adequately.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered to me, and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, claim judgement, or verdict by which I may eventually recover said fee.

Dated: _____ Patient's Signature: _____

Patient's Name: _____

The undersigned, being attorney or record or authorized representative of insurance carrier for the above patient does hereby acknowledge receipt of the above lien, and does agree to honor the same to protect adequately said above named doctor.

Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign, and return one copy to the doctor's office at once.
Keep one copy for your records.

DOCTOR'S LIENS

TO: Attorney/Insurance Carrier

_____

_____

_____

Doctor/s

Danny Fuzaylov, RPA-C
369 E. 149th Street-9th Floor
Bronx, New York 10455

Re: _____

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Dated: _____ Patient's Signature: _____

Patient's Name: _____

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Dated: _____ Authorized Signature: _____

NOTICE: Please date, sign, and return one copy to the doctor's office at once.
Keep one copy for your records.

MAXIM TYORKIN, M.D.

521 PARK AVENUE • NEW YORK, NEW YORK 10021 • TEL: 212-731-2002

ASSIGNMENT & LIEN

RE: AMOUNT: $

DATE OF INJURY:

KNOWN ALL MEN BY THESE PRESENTS THAT I,_____, IN CONSIDERATION OF MEDICAL CARE SERVICES RENDERED AND TO BE RENDERED TO ME BY MAXIM TYORKIN, MD FOR THE CARE AND TREATMENT OF PERSONAL INJURIES SUSTAINED BY ME, ARISING OUT OF AN ACCIDENT THAT OCCURRED ON THE_____DAY OF_____ I HEREBY ASSIGN AND TRANSFER TO MAXIM TYORKIN, M.D. SUCH PART OF ANY AMOUNT THAT MAY HEREAFTER BE PAYABLE TO ME AS THE RESULT OF ANY JUDGEMENT, OR SETTLEMENT OF CLAIM. NO ASSIGNMENT IS INTENDED OF MY CLAIM OR CAUSE OF ACTION, BUT A PORTION OF THE PROCEEDS THEREOF, AS IF SAID PROCEEDS WERE PRESENTLY A LIQUIDATED AMOUNT. THIS ASSIGNMENT IS MADE VOLUNTARILY BY ME, BECAUSE OF MY PRESENT INABILITY TO PAY THE AFOREMENTIONED MEDICAL SERVICE CHARGES.

I HEREBY AUTHORIZE AND DIRECT SUCH PERSONS, PARTIES, FIRMS OR CORPORATIONS WHO WILL OR MAY BECOME INDEBTED TO ME BY REASON OF THE AFORESAID INJURY TO PAY MAXIM TYORKIN, M..D. AS SUCH ASSIGNEE, OUT OF THE AMOUNT DUE OR WHICH MAY BECOME DUE TO ME, FOR MEDICAL SERVICES AS HAS BEEN RECEIVED OR WILL BE RECEIVED BY ME WITHOUT FURTHER NOTICE TO SUCH PARTIES FROM ME. I HEREBY AGREE TO HOLD SUCH PARTIES HARMLESS ON ACCOUNT OF ANY SUCH PAYMENTS.

I FURTHER STIPULATE AND CONSENT THAT THE CHARGES OF MAXIM TYORKIN, M.D. SHALL BE LIEN WHICH MAY BE PLACED OR CHARGED AGAINST SUCH CLAIM AND/OR FUNDS SECURED AS A RESULT OF SUCH CLAIM OR CAUSE OR ACTION AS I MAY HAVE, REGARDLESS OF WHO MAY BE IN POSSESSION OF SUCH FUNDS.

I HEREBY AUTHORIZE AND DIRECT MY ATTORNEYS, OR ANY OTHER PERSON OR PERSONS INTO WHOSE HANDS OR POSSESSION ANY OF THE PROCEEDS SHALL COME, TO HOLD IN TRUST AND TO PAY OVER TO MAXIM TYORKIN, M.D. SUCH SUMS AS ARE CLAIMED BY HIM FOR MEDICAL SERVICES RENDERED.

IN WITNESS THEREOF, I HAVE HEREUNTO SET MY HAND AND SEAL THIS_____DAY OF _____.

X_____
PATIENT SIGNATURE

I HAVE FULL KNOWLEDGE OF ABOVE ASSIGNMENT AND LIEN.

_____
ATTORNEY'S SIGNATURE

Here

AUTHORIZATION FOR EMAIL CORRESPONDENCE AND TEXT MESSAGES

Date _____

My preferred language to be contacted in is: ☐ English ☐ Spanish

☐ Please check this box to receive emails and text messages from Maximum Orthopedics.

I _____, authorize Maximum Orthopedics to send me email correspondence
(Print your name)

and text messages pertaining but not limited to, appointment reminders, courtesy emails, and follow-ups.
I understand that I am going to receive emails and text messages, and this is an acknowledgement to my agreement.

Email : _____ Cellphone number: _____

Signature X_____

☐ Please check here if you do not want to receive emails or text messages from Maximum Orthopedics.

AUTORIZACIÓN PARA CORRESPONDENCIA POR CORREO ELECTRONICO Y MENSAJES DE TEXTO

Date _____

Mi idioma de preferencia para ser contactado/a es: ☐ Inglés ☐ Español

☐ Porfavor indique aqui si deseas receibir mensajes y correos electronicos de parte de Maximum Orthopedics.

Yo _____, autorizo que Maximum Orthopedics
(Nombre en letra de molde)

me mande mensajes pertenientes per no limitados a, recuerdos de cita, cortesia y seguimientos.

Yo entiendo que yo voy a ser contactado/a por estos medios y esto es reconocimiento de mi acuerdo

Correo electronico: _____ Numbero de cellular: _____

Firma X_____

☐ Porfavor indique aqui si no deseas receiver correos electronicos y mensajes de texto de parte de Maximum Orthopedics.