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PATIENT NAME: _____ SEX: M F

FIRST NAME MIDDLE INITIAL LAST NAME

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ DATE OF BIRTH: _____ AGE: _____

HOME PHONE: _____ CELL PHONE: _____ EMERG CONTACT PHONE: _____

EMPLOYER: _____ WORK PHONE: _____ SS#: _____

EMPLOYER ADDRESS: _____

REFERRING PHYSICIAN/FRIEND: _____

SPOUSES EMPLOYER: _____

SPOUSES EMPLOYERS ADDRESS: _____

SPOUSES WORK PHONE: _____

IF FULL-TIME STUDENT INDICATE SCHOOL CURRENTLY ATTENDING: _____

PRIMARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ PHONE #: _____

RELATIONSHIP TO INSURED: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

SECONDARY INSURANCE: _____

POLICY #: _____ GROUP #: _____

ADDRESS: _____ PHONE #: _____

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT): _____

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO ORTHOPAEDIC SURGEONS OF L.I., ASSOCIATES FOR SERVICES DESCRIBED. I UNDERSTAND THAT I AM RESPONSIBLE TO PAY FOR SERVICES INCLUDING REASONABLE ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT.

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATIONS OR ITS INTERMEDIARIES OR CARRIERS, OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

SIGNED: _____ DATE: _____

PRINT NAME: _____

PLEASE ADVISE THE FRONT DESK STAFF IF YOU WERE INJURED IN A CAR ACCIDENT OR ON THE JOB

Orthopaedic Surgeons of L.I., Assoc.
Musculoskeletal Orthopaedic Questionnaire

Name _____ Age _____ Occupation _____

Today's date _____ Your date of Birth _____ Social Security# _____

Name of your referring physician _____

Name of your primary care physician _____

What brings you here?

CHIEF COMPLAINT: _____

HISTORY:

Date symptoms started/accident occurred: _____ **Problem: Body part(s)** _____

Describe _____

List any treatments or tests you have had for this problem:

PAST MEDICAL HISTORY: (check if applies and explain)

HeartDisease _____ Diabetes _____

High Blood Pressure _____ Circulation Problems _____

Arthritis (type?) _____ Stomach/intestine problems _____

Neurological _____ Cancer(type?) _____

Bleeding/Clottingproblems _____ Hepatitis _____

Breathing/Lung problems _____ Broken bones _____

Other Problems _____

List all past SURGERIES and dates:

MEDICATIONS: (list all)

ALLERGIES: (meds, environmental)

Have you ever had a Bone Densitometry test? Yes, when: _____ No

Please complete next page

