Ranawat Orthopaedics HSS

- □ **Chitranjan S. Ranawat, M.D.**
- □ **Amar S. Ranawat, M.D.**
- □ **Anil S. Ranawat, M.D.**

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff, Residents and Fellows

As your treating physician(s) and as a member of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopaedics HSS:

Dr. Amar Ranawat:
Dr. Amar Ranawat holds stock options and receives royalties from ConforMis, Inc. Dr. Ranawat is also a consultant and a member of the Hip Advisory Board of MAKO Surgical Inc. for which he receives royalties for software development. In addition, he is also a consultant for Convatec, DePuy, Medtronic, Nova Surgical, Pacira and Pipeline Orthopedics for product development. Dr. Ranawat also receives research support from Stryker and Ceramtec. He is a member of the editorial board of CORR, JOA, COP, BJJ, and the HSS journal. He is on the AAOS Adult Hip Committee, Co-Director of the AAOS Adult Knee Webinar: Management of Complication in TKR, and the Program Chairman for the Eastern Orthopaedic Association.

Dr. Anil Ranawat:
Dr. Anil Ranawat holds stock options and receives royalties from ConforMis, Inc. He is also a consultant and member of the Hip Advisory Board of MAKO Surgical Inc. Dr. Ranawat is also a consultant for Mitek, Pipeline Orthopedics, Conmed Linvatec and Nova Surgical. In addition, he is Editor-in-Chief of "Current Trends in Musculoskeletal Medicine" where he receives salary support from Springer-Verlag and royalties from Elsevier. He is on the Sports Committee of AAOS and Chairman Member of Eastern Orthopaedic Association.

Dr. Chitranjan Ranawat:
Dr. Chitranjan Ranawat is a product designer for DePuy on the Sigma® total knee prosthesis for which he receives royalty payments. In addition, he is a product designer on the Accolade® hip system for Stryker and receives royalty payments. Dr. Ranawat receives education support for the Ranawat Orthopaedic Research Foundation from Depuy.

Please be aware that under no circumstances do we receive payments from these companies for use of their products for your care at HSS or for the care of any other patients at HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with us, you may either contact the Chief of Service, (212-606-1852), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of financial interest or relationship disclosed to you, you choose to refuse a particular treatment, operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

Signature

_____

Patient/Parent/Guardian/Health Care Agent **Date**

Print Name _____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

PATIENT REGISTRATION

Chitranjan Ranawat **Amar Ranawat** **Anil Ranawat**

Last Name_____First Name_____Date_____

Address_____Apt. #_____

City_____ State_____ Zip_____

Sex M F Date of Birth_____ SS# _____-_____-_____

Home Phone_____ Work_____Cell _____

Occupation_____ presently working_____ Yes _____ No

May we contact you via email regarding:
Your Appointment, Billing, Research Y_____ N_____ Email:_____

Is your current problem related to
a claim for worker's compensation or a current or potential lawsuit? Y_____ N_____

Emergency Contact

Name_____Phone_____ Relationship_____

Primary Care Physician

Name_____Phone_____Fax number_____

Address_____ City_____ State_____ Zip Code_____

Referring Physician

Name_____Phone_____ Fax number_____

Address_____ City_____ State_____ Zip Code_____

<u>Primary Insurance Information</u>

(*Please present your insurance card to the front desk staff*)

Primary Insurance Carrier_____
Policy #_____ Group #_____
Name of insured_____

<u>Secondary Insurance (Circle one)</u>

Medicare, Private Insurance, Workmen's Compensation, NO-Fault

Insurance Carrier_____

Policy # _____ Group #_____

WCB# (worker's comp) _____ Date of Accident_____

PATIENT REGISTRATION

Chitranjan Ranawat Amar Ranawat Anil Ranawat

Assignment and Release

I, the undersigned, have insurance coverage with_____and assign all medical benefits to: Ranawat Orthopaedics or Anil Ranawat. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian_____ Date _____

Referral

I realize that my particular insurance plan might require a referral for me to be seen by any of the physicians employed by Ranawat Othropaedics or Anil Ranawat. If at any time I fail to obtain a referral for a particular visit, I will be responsible for obtaining a valid referral from my primary care physician (PCP). If a valid referral is not possible, I will be solely responsible for all charges.

Signature of Insured/ Guardian_____ Date _____

HIPPA Privacy Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that Ranawat Orthopaedics, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Insured/Guardian_____ Date _____

CONFIDENTIAL MEDICAL HISTORY

Chitranjan Ranawat **Amar Ranawat** **Anil Ranawat**

Last Name_____ **First Name**_____

Age _____ **Occupation** _____

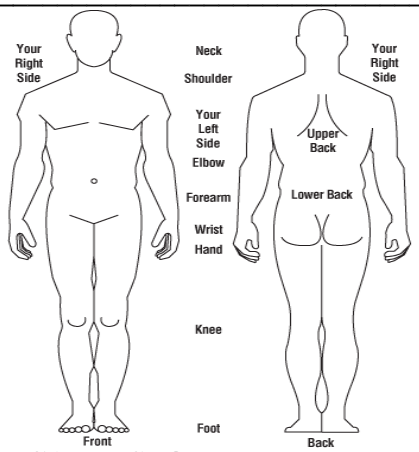
Referring Physician: _____

Chief Complaint: _____

Date of injury or onset of symptoms: _____

Describe the injury or problem: _____

_____



Where is your pain? Please Mark the Drawing
Rate your pain:
0= No Pain **10= Extreme pain**
Right now: **0 1 2 3 4 5 6 7 8 9 10**

What makes it better? _____
_____
What makes it worse? _____
_____

YOUR MEDICAL HISTORY

Have you ever been hospitalized? Yes _____ **No**_____ **(If yes, why?)**_____

_____

Have you ever had surgery? Yes_____ **No** _____ **(If yes, when?)**_____

_____

Do you think you might be pregnant at this time? Yes _____ **No** _____

Have you ever had a blood clot? Yes _____ **No** _____

Does anyone in your family have any of the following problems? Please Circle

Heart Disease	**High Blood Pressure**	**Anesthesia complications**
Cancer	**Nerve problems**	**Blood problems (anemia, abnormal bleeding)**
Stroke	**Diabetes**	**Other:** _____

Medical Profile

Name:_____

Current Medications:

Medications	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Medical History: Please **circle** appropriate response(s) and **write in answer where appropriate**

General Health: Excellent Good Fair Poor

Head: Headaches History of Injury Other (Please Describe): _____

Neck: Any Issues (Please Describe): _____

Skin: Any Issues (Please Describe): _____

Eyes: Loss of Vision Glasses Cataract Other (Please Describe): _____

Ears: Hearing Loss Other (Please Describe): _____

Nose/Throat: Bleeding Sinus Trouble Other (Please Describe): _____

Respiratory: Asthma Other (Please Describe): _____

Heart: Chest Pain Heart Disease Irregular Heartbeat High Blood Pressure Other__

Bleeding: Any Issues (Please Describe): _____

Metabolic: Diabetes Hypothyroid Other (Please Describe): _____

Stomach/Bowel: Constipation Nausea/Vomiting Bleeding Other (Please Describe): _____

Urinary: Leakage Discharge/Drainage Other (Please Describe): _____

Neurological: Headaches Seizures(epilepsy) Stroke Numbness Other: _____

Prior Diseases: Hepatitis AIDS Herpes Infection Involving Joint Other: _____

Prior Surgeries: Thyroid Surgery Heart Bypass Appendectomy Back Surgery Arthroscopy Other___

Allergies: Penicillin Food (list): Other: _____

Do you Smoke? Yes No If yes, number of packs per day? Number of years?_____

Do you Drink? Yes No If yes, number of drinks per week? Number of years?_____

Current Height: _____ **Current Weight:** _____

FAI / HIP Labral Tear Treatment History

Name: _____DOB:_____Date:_____

1. **Onset of Pain/ Symptoms: _____ Date: _____**

   Did you see another doctor for your pain? Yes _____ No _____

   Name of MD: _____Date: _____
   Address: _____Phone: _____

2. **Did you receive any medical treatment? Yes _____ No _____**

   Anti-Inflammatory Medications Yes _____ No _____
   (Ex. Naproxen, Ibuprofen, Celebrex, etc.) Type _____ Date: _____

   Intra-articular Injection Yes _____ No _____
   "Blind" in-office injection Date _____
   Ultrasound or Fluroscope Guided Date _____

   Previous Surgeries: _____ Date: _____

3. **Did you have any previous radiology imaging?**

   X- Rays Yes _____ No _____ Date: _____
   MRI Yes _____ No _____ Date: _____
   CT Scan Yes _____ No _____ Date: _____

4. **Have you previously had any physical therapy for your hip pain?**
   Yes _____ No _____

   If yes, what is the name of the facility? _____
   Address: _____ Phone: _____

   Date you began physical therapy: _____

TO BE COMPLETED BY CLINICAL STAFF/MD/PA:

PROSPECTIVE TREATMENT PLAN:

Physical Therapy: Yes _____ No _____ _ Date: _____

Duration & Frequency of PT: _____ x week for _____weeks

Medications Prescribed: _____

MRI Yes _____ No _____ Date:_____
Dx/Findings:_____

CT Scan Yes _____ No _____ Date: _____
Dx/Findings:_____

Intial Inj: Date _____ Duration of pain relief: _____

2nd injection Date _____ Duration of pain relief: _____

Failure of Conservative Therapy: Yes_____ Duration of pain relief: _____

Ranawat Orthopaedic Center

PATIENT ADMINISTERED QUESTIONNAIRE - HIP

Name: _____ **(Please circle your responses)** **Date:** _____

1-Have you had hip pain within the last 3 months?

Left Hip:	Location: (as many as apply)	Buttock	Groin	Thigh	Side	Lower Back
No **Yes:**	Severity:	Mild	Moderate	Severe	Excruciating	
	Frequency:	Rarely	Occasionally	Frequently	Always	
Right Hip:	Location: (as many as apply)	Buttock	Groin	Thigh	Side	Lower Back
No **Yes:**	Severity:	Mild	Moderate	Severe	Excruciating	
	Frequency:	Rarely	Occasionally	Frequently	Always	

2- How often do you limp?

Never	Rarely	Occasionally	Frequently	Always
	Because of your:	**Left** Hip	**Right** Hip	**Both** Hips

3-How much difficulty do you have with the following activities? Please check one box for each activity.

	None	Slight	Moderate	Great	Unable
• putting on socks/shoes	☐	☐	☐	☐	☐
• personal care (such as toilet, bathing)	☐	☐	☐	☐	☐
• household activities (such as cleaning)	☐	☐	☐	☐	☐
• getting in and out of a car	☐	☐	☐	☐	☐

4-How much assistance do you need with going up and down stairs?

None	Cane/crutch/banister	2 crutches	Walker/someone's assistance	Unable

5-How far can you walk?

Unlimited	More than 10 blocks	4-10 blocks	1-3 blocks	Housebound

6-How often do you participate in recreational/sports activities? Please check one box for each activity.

	Never	Rarely	Occasionally	Frequently	Always
• Walking more than 1 mile	☐	☐	☐	☐	☐
• Running	☐	☐	☐	☐	☐
• Swimming	☐	☐	☐	☐	☐
• Gym workout	☐	☐	☐	☐	☐
• Tennis	☐	☐	☐	☐	☐
• Golf	☐	☐	☐	☐	☐
• Gardening	☐	☐	☐	☐	☐
• Biking	☐	☐	☐	☐	☐
• Skiing	☐	☐	☐	☐	☐
• **Other:** _____	☐	☐	☐	☐	☐

7-How often does your affected hip influence or prohibit the performance of recreational/sports activities?

Never	Rarely	Occasionally	Frequently	Always

8-How often does your affected hip influence your social activities?

Never	Rarely	Occasionally	Frequently	Always

9-How often does your hip pain influence your sense of well-being?

Never	Rarely	Occasionally	Frequently	Always

10-Please rate your degree of satisfaction with your ability to use your hip:

Unsatisfied	0	1	2	3	4	5	6	7	8	9	10	**Fully Satisfied**

WOMAC Survey Form Name: _____

Instructions: In Sections A, B, and C, questions will be asked about your hip or knee pain. Please mark each response with an X. If you are unsure about how to answer a question, please give the best answer you can. A.

Think about the pain you felt in your hip/knee during the last 48 hours.

Question: How much pain do you have?	None	Mild	Moderate	Severe	Extreme
1. Walking on a flat surface	☐	☐	☐	☐	☐
2. Going up and down stairs	☐	☐	☐	☐	☐
3. At night while in bed, pain disturbs your sleep	☐	☐	☐	☐	☐
4. Sitting or lying	☐	☐	☐	☐	☐
5. Standing upright	☐	☐	☐	☐	☐

B. Think about the stiffness (not pain) you have in your hip/knee during the last 48 hours. Stiffness is a sensation of decreased ease in moving your joint.

	None	Mild	Moderate	Severe	Extreme
6. How severe is your stiffness after first awakening in the morning?	☐	☐	☐	☐	☐
7. How severe is your stiffness after sitting, lying, or resting in the day?	☐	☐	☐	☐	☐

C. Think about the difficulty you had in doing the following daily physical activities due to your hip/knee during the last 48 hours. By this we mean your ability to move around and look after yourself.

Question: What degree of difficulty do you have?	None	Mild	Moderate	Severe	Extreme
8. Descending stairs	☐	☐	☐	☐	☐
9. Ascending stairs	☐	☐	☐	☐	☐
10. Rising from sitting	☐	☐	☐	☐	☐
11. Standing	☐	☐	☐	☐	☐
12. Bending to the floor	☐	☐	☐	☐	☐
13. Walking on flat surfaces	☐	☐	☐	☐	☐
14. Getting in and out of a car, or on or off a bus	☐	☐	☐	☐	☐
15. Going shopping	☐	☐	☐	☐	☐
16. Putting on your socks or stockings	☐	☐	☐	☐	☐
17. Rising from the bed	☐	☐	☐	☐	☐
18. Taking off your socks or stockings	☐	☐	☐	☐	☐
19. Lying in bed	☐	☐	☐	☐	☐
20. Getting in or out of the bath	☐	☐	☐	☐	☐
21. Sitting	☐	☐	☐	☐	☐
22. Getting on or off the toilet	☐	☐	☐	☐	☐
23. Performance heavy domestic duties	☐	☐	☐	☐	☐
24. Performing light domestic duties	☐	☐	☐	☐	☐