Alice Chen, MD/IP CT, LLC
Hospital for Special Surgery
1Blachley Rd; Stamford, CT 06902
(203) 705 2087 (O) (877) 363-0849 (F)

Date: _____

MR#: _____

Patient Information:

Name: _____ I prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Date of Birth: _____ Sex: _____ How did you hear of us? _____

Email address: _____ Preferred Pharmacy: _____

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

Employer: _____ _____ ☐FT ☐ PT ☐Retired

If Student, Name of School: _____ City/ State: _____ ☐FT ☐ PT

Emergency Contact: _____ Relationship: _____ Phone: _____

Past Medical History:

Please circle any conditions that you have been treated for: ☐ High Blood Pressure ☐ Heart Disease ☐COPD

☐ High Cholesterol ☐ Congestive Heart Failure ☐ Heart Attack ☐Stroke ☐Diabetes

Neurological Disease: _____

Other: _____

_____

Have you ever had any problems with anesthesia? **NO / YES** If so, please describe:

_____

Surgeries/ Hospitalizations:	**Year:**

MEDICATIONS:

Please list all medications that you are currently taking, including over the counter medications such as aspirin, Tylenol, herbal preparations, etc.

Medication:	**Dosage (mg):**	**Times Taken:**
	mg	
	mg	
	mg	
	mg	
	mg	

Are you currently taking any blood thinners? _____

Name of doctor(s) prescribing medications:

_____ _____

Office Use Only:

Height: _____ Weight: _____ BP: _____ HR: _____ Temp: _____ Initials: _____

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Chief Complaint:

Chief Complaint/ Problem: ☐Right ☐Left _____

_____

When did you first begin to notice symptoms (approximate): _____

Who has been treating you for this problem? _____

Has any imaging been performed (X-ray, MRI, etc): _____

What types of treatments have been given for this problem? _____

_____

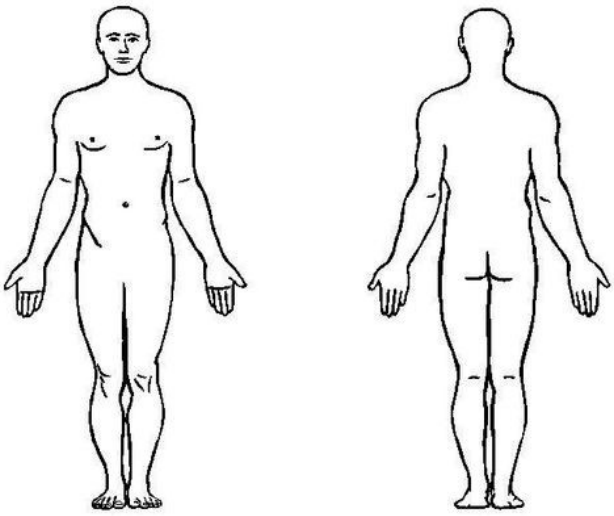
Is the current problem a result of (check all that apply): Car Accident: _____ Work Accident: _____ Injury: _____

Explain: _____

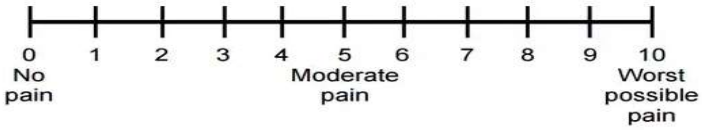
Have you had any similar symptoms in the past? _____ _____

_____

Please indicate where your symptoms are located:



Rate the intensity of your symptoms:



Lowest pain intensity: _____

Highest pain intensity: _____

What activities or positions make your symptoms **worse**? _____

_____

_____

What activities or positions make your symptoms **better?** _____

_____

The pain is: ☐**CONSTANT** ☐ **INTERMITTENT**

Have you had recent physical therapy for **THIS** injury? If so, where?

_____

ALLERGIES:

Please list any known allergies and reactions you have, if known

Medication:	**Reaction:**

Are you currently being treated by any other doctor besides your primary care doctor?

Physician Name: **Specialty:**

_____ _____

_____ _____

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Review of Systems:

Have you had any of the following conditions within the past year? (Please mark all that apply)

Constitutional	Skin	Respiratory	Cardiovascular
Chills	Dryness	Asthma	Chest Pain
Fever	Easy Bruisability	Shortness of Breath	High Blood Pressure
Unexpected weight loss	Itching	Pain	Heart Murmur
Fatigue	Rash	Cough	Palpitations
Nausea/ Vomiting	Hair texture change	Wheezing	Recent EKG
Weakness			Sleep apnea
Recurrent infections			History of Heart Attack

Genitourinary	Musculoskeletal	Psychiatric	Neurologic
Infections	Arthritis	Behavioral Change	Blackouts/ Fainting
Stones	Gout	Disturbing Thoughts	Strokes
Change in urine frequency	Muscle Cramps	Memory Loss	Unsteady gait
Change in urine urgency	Restricted Motion	Psychiatric Disorders	Numbness/ Tingling
Blood in Urine	Back Problems	Depression	Memory Loss
Pelvic Pain	Joint Pain	Excessive Stress	Speech Disorders
Irregular Menses	Muscle Stiffness	Mood changes	Tremors
Sexual Problems	Weakness	Anxiety/ Nervousness	Difficulty Walking
Incontinence	Leg Pain	Disorientation	
	Arm Pain	ADD/ ADHD	

Gastrointestinal	Endocrine	Hematologic	Head/ ENT
Abdominal Pain	Cold Intolerance	Anemia	Dizziness
Nausea	Excessive Urination	Easy bruising/ bleeding	Headaches
Change in BM frequency	Neck Pain	Swollen Glands	Fainting
Constipation	Weight gain		Blurry/ Double vision
Diarrhea	Goiter		Glaucoma
Heartburn/ GERD	Sweats		Cataracts
Decreased appetite	Thyroid trouble		Sinus Infections

OTHER CONDITIONS NOT LISTED: _____

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Family Medical History:

Please list **immediate** relatives (parents, siblings, grandparents, children) who have/had the following:

Please indicate if Maternal or Paternal

Heart Disease/ Heart attack: _____ High Blood Pressure: _____

Stroke: _____ Diabetes:_____

Cancer (what type?): _____ Neurological Disorders: _____

Other: _____

Social History:

Employer: _____ Usual activities required: _____

Do you have children? **YES / NO** If so, how many? _____ Do they live with you? _____

Are you exclusively responsible for anyone's care? **YES / NO** If so, who? _____

Do you have anyone to help you at home if you have surgery? **YES / NO** If so, who? _____

Do you smoke?

_____ No, I have never smoked _____ Yes, I have smoked _____ packs of cigarettes per day for _____ years

_____ No, I quit smoking _____ years ago. I smoked _____ packs a day for _____ years

_____ Yes, I smoke cigars or a pipe, _____ a day for _____years

Do you drink alcohol? _____ NO _____ YES, _____ drinks per **day / week / month** (circle one)

Do you use any street drugs? _____ NO _____ YES, please list: _____

Please answer the following questions with regard to future testing:

Are you pregnant? **YES / NO / NA**

Are you claustrophobic? **YES / NO**

Are you a welder/ metal worker? **YES / NO**

Have you worked with metal in the past? **YES / NO**

Please circle any of the following that you have:

Cardiac Pacemaker Cardiac valve prosthesis Vena Cava Umbrella Implanted pump

Automated internal cardiac defibrillator Aneurysm clip Neurostimulator Any metal in your body

The information provided on this form is accurate to the best of my knowledge:

_____ _____

Patient Signature *Date*

I have reviewed the above information with the patient.

_____ _____

Dr. Chen's Signature *Date*

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PATIENT FINANCIAL POLICY & CONSENT FOR RELEASE OF INFORMATION

I hereby authorize payment of medical benefits billed to my insurance company. I hereby accept responsibility for payment for any service(s) provided to me that are <u>not covered</u> by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Physician does not participate with my insurance; I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

_____ _____

Signature of patient or patient's representative *Date*

I, _____, hereby authorize ALICE CHEN, MD/IP CT, LLC. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, ALICE CHEN, MD/IP CT, LLC. can refuse to treat me.

I have been informed that ALICE CHEN, MD/IP CT, LLC. has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying ALICE CHEN, MD/IP CT, LLC. in writing, but if I revoke my consent, such revocation will not affect any actions that ALICE CHEN, MD/IP CT, LLC. took before receiving my revocation.

I understand that ALICE CHEN, MD/IP CT, LLC. has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that ALICE CHEN, MD/IP CT, LLC. restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that ALICE CHEN, MD/IP CT, LLC. does not have to agree to such restrictions, but that one such restrictions are agreed to, must adhere to such restrictions.

_____ _____

Signature of Patient or Patient's Representative *Date*
(Form MUST be completed before signing.)

_____

Printed Name of Patient or Patient's Representative

_____

Relationship to the Patient

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As **required** by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, New York and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606 - 1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of this Notice and have therefore been notified of how health information about me may be used and disclosed by the Hospital, and how I may obtain access to and control this information. I also acknowledge and understand special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and/or disclosure of my health information as described in this Notice, including treating me and arranging for my medical care, to seek and receive payment for services given me, and for the business operations of the Hospital and its staff.

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

For any questions about this Notice or would like further information
Please contact the Privacy Officer at (212) 774-7500.

AUTHORIZATION FOR RELEASE OF MEDICAL TREATMENT/RECORDS

I am writing to authorize the person or persons listed below to obtain/speak on my medical treatment/records on my behalf. Please release/speak of my medical records related to treatment for _____ (all or specific medical conditions) rendered by Dr. Alice Chen.

Specific Medical Information: _____
Name of Advocate: _____
Phone Number of Advocate: _____ Fax: _____
Address of Advocate: _____

_____ _____

Signature of Patient or Personal Representative *Date*

Office Use Only:

If the patient does not sign this acknowledgement form, record here the good faith efforts made to obtain this acknowledgement and consent.

_____
_____