New England Orthopaedic Center

Mariam Hakim-Zargar, MD
538 Litchfield Street Suite 204
Torrington, CT 06790
P 860.489.6363

Consent to receive email/text and retrieval of prescription history

Date: _____

Name: _____

Date of Birth: _____

Email and/or text message consent:

Email Address: _____

Cell phone number: _____

I give consent for the New England Orthopaedic Center to send me e-mail and/or SMS text messages to remind me of appointments.

_____
(Patient Signature)

Consent to allow prescription history retrieval:

I give consent for the New England Orthopaedic Center to retrieve prescription history from prescription benefit managers (PBMs), payers, and pharmacies.

_____
(Patient Signature)

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Patient Injury Questionnaire

Date _____

Name_____

Date of Birth _____

Please tell us the reason for your visit today:

☐ **Due to a work injury**
This was an injury that I sustained while I was at work.
Date it occurred: _____
Did this occur in CT? [ ] yes [ ] no If not in CT, in what state did it occur? _____

I have filed a claim with my employer: [ ] yes [ ] no
Please confirm office staff has worker's compensation information for all work-related injuries

☐ **Due to injury that occurred while in an automobile or as a pedestrian?**
Date it occurred: _____
Please present your motor vehicle insurance declaration page with your health insurance card

☐ **Due to a fall or injury, but NOT while operating an automobile**

☐ **None of the above**

I authorize New England Orthopaedic Center to release this information and any other pertinent information related to this information to my insurance company in order to process claims for payment.

Signature _____Date_____

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HIPAA Release

Date: _____

Name: _____

Date of birth: _____

Assignment and Release:

I, _____, authorize treatment and the release of any medical information, acquired in my treatment, to process claims to my insurance company. I authorize direct payment from my insurance company to my physician. At any time I decide, that I want to file my own claims, I understand that payment in full will be required at the time of service. I understand that I will be financially responsible for all charges incurred. I had received and understand the office policies.

X_____
Signature and date

Acknowledgement and Receipt of Privacy Notice:

Hipaa Regulations: I have been presented with a copy of the NEOC Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply. I understand the contents of the Notice, and further understand, that I can request restrictions concerning the use of my personal medical information.

X_____
Signature and Date

If not signed by patient, please indicate relationship to patient and print your name.

Medicare Part B:

Benefits Assignment: I request, that payment of authorized Medicare benefits be made on my behalf to Dr. Hakim-Zargar, New England Orthopaedic Center, LLC for any services furnished. I authorize any holder of medical information about me to release to CMS, the Centers for Medicare and Medicaid Services, and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____
Signature and Date

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Height: _____ Weight: _____ **Pharmacy** (and town)**:**_____

Date_____ **Primary Care Physician** (and town)**:** _____

Name_____ **Age**_____ DOB_____

Reason for your visit (*body part and date of injury*) _____

Have you had any medical imaging for this problem? (CAT Scan, X-Ray, MRI, or Ultrasound) _____

Medical History - *Please check all that apply*:
[]Diabetes, Age at diagnosis_____, [] Diabetic neuropathy, []Insulin Dependent, []Dialysis
[]High Blood Pressure, []Heart Attack (MI), []Coronary Artery Disease, []Peripheral Vascular Disease,
[]Asthma, []Emphysema, []Liver disease, []Hepatitis____, []Reflux or Heartburn, []Ulcers,
[]Thyroid problems, []History of DVT, [] Osteoporosis, []History of Pulmonary Embolism (PE)
[]Any Cancers *(type and year of diagnosis)* _____
[]Previous Fractures *(what and when)* _____
[]Other medical problems_____
_____
[] Seasonal Allergies _____
[] Medication Allergies *(please include what your reaction was)* _____
_____

Past Surgical History – *Please check all that apply and provide dates:*
[]Appendectomy, []Tonsils & Adenoids, []Cholecystectomy (gall bladder), []Hysterectomy,_____,
[]Orthopaedic Surgeries *(what and when)* _____
[]Other surgeries *(what and when)*_____
_____
_____

Social History
Smoking: [] Yes []No. How many packs per day?____How many years?____When did you quit?____
Alcohol use: How much_____ How often: (daily) (weekly) (monthly)
Occupation_____, []Right or [] Left hand dominant

Family History – Do any of the following conditions run in your immediate family:
[]Diabetes_____, []High Blood Pressure_____, []Heart Attack_____,
[]Bone Disease_____, []Cancer_____ [] DVT/PE_____

Medication List – Please write down ALL your medications AND doses on the back. Include all non-prescription supplements.

Signature_____ Date: _____
If minor (relation to patient): _____