Richard S. Obedian M.D., F.A.A.O.S., PLLC

Patient Intake Sheet

Name: ____________________________
Address: __________________________
____
Date of Birth:__________ Male Female
Social Security No.:_______________
Home Phone:_____________________
Work Phone:_____________________
Cell Phone:______________________
Marital Status: M S D W
Occupation:______________________

EMERGENCY CONTACT
Name:___________________________
Phone:__________________________
Relationship:_____________________

RESPONSIBLE PARTY'S EMPLOYER INFORMATION
Name:___________________________
Address:_________________________
____
Phone:__________________________

REFERRING PERSON:
Name:___________________________

Reason for Visit:_________________
____
____

Should this injury be filed under no fault insurance or worker's compensation?
Yes No

Primary Insurance Information:
Policy Holder____________________
Policy Holder's Social:____________
Date of Birth:____________________
Relationship to Patient:____________
Name of Insurance:_______________
Address:________________________
____
ID No:_________________________
Group No:_______________________

Secondary Insurance Information:
Policy Holder____________________
Policy Holder's Social:____________
Date of Birth:____________________
Relationship to Patient:____________
Name of Insurance:_______________
Address:________________________
____
ID No:_________________________
Group No:_______________________

"I verify the accuracy of the above information and I authorize the release of information as provided on this form. I also authorize the assignment of benefits directly to Richard S. Obedian, M.D., PLLC. I understand that I am financially responsible for the treatment rendered. I hereby authorize Richard S. Obedian, M.D., PLLC to submit a claim to the insurance carrier or its intermediaries for all covered services rendered for radiology and orthopaedic care and authorize and direct the insurance carrier or its intermediaries to issue payment check(s) directly to Richard S. Obedian, M.D., PLLC"

SIGNATURE____________________________ **DATE:**____________________

PATIENT AGREEMENT

I. Individual's Responsibility for Non-Covered Services:

In consideration of services rendered by Richard S. Obedian, M.D., PLLC to the undersigned patient, the undersigned promise(s) to pay to Richard S. Obedian, M.D., PLLC any co-payment, co-insurance, deductible or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services that are not covered by my health insurance plan. In case of denial or termination of benefits, or in the event I fail to inform you of any changes in my insurance coverage, I, the undersigned understand that I am responsible for payment in full for services rendered.

In case of denial from No-Fault, the Workers' compensation Board, Workers' Compensation Carrier or termination of my orthopedic benefits, I, the undersigned, am responsible for payment in full of any and all services rendered.

II. Assignment of Benefit Proceeds:

I hereby assign to Richard S. Obedian, M.D., PLLC all monies and/or benefits to which I am entitled from my insurer/HMO/third-party payer, No-Fault, Workers' Compensation policy, government agencies, or those who are financially liable for my medical care.

III. Authorization to Release Records:

I hereby authorize Richard S. Obedian, M.D., PLLC to release to my insurer/HMO/third-party payer, government agencies, or to whomever is financially responsible for my medical care, all information needed to substantiate payment for such medical care and, if required, of pre-certification/prior approval purposes.

It is, however, understood that there will be no obligation of the undersigned to pay for any services, which are improperly billed.

IV. Authorization for Use and Disclosure of Protected Health Information {PHI}:

I hereby authorize Richard S. Obedian, M.D., PLLC to use and disclose my individually identifiable Protected Health Information ("PHI") in the manner described. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI for Richard S. Obedian, M.D., PLLC and that it then may no longer be protected by federal privacy regulations. State law may or may not prohibit such re-disclosure by the person or entity receiving my PHI from Richard S. Obedian, M.D., PLLC I voluntarily sign this authorization. I have been provided the opportunity to review the PHI agreement in full.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Phone: ____________________
- ☐ Work Phone: ____________________
- ☐ Other Phone: ____________________
- ☐ I authorize you to leave a detailed message at my home or work phone number.
- ☐ I authorize you to contact or speak to the following individuals regarding my care:

____

____

ADDITIONAL AUTHORIZATION WILL BE NEEDED FOR RELEASE OF MEDICAL RECORDS

____________________	____________________	__________
Print	Sign	Date

NAME:________________________________ DATE:__________

1. RATE YOUR PAIN: 0= NO PAIN 10= EXTREME PAIN

A. AT ITS BEST 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)
B. AT ITS WORST 0 1 2 3 4 5 6 7 8 9 10 (CIRCLE ONE)

2. WHAT MAKES THE PAIN WORSE? (PLEASE CHECK ALL THAT APPLY)

_________BENDING _________PROLONGED SITTING

_________TWISTING _________PRLONGED STANDING

_________COUGHING _________STRAINING AT STOOL

_________SNEEZING _________WALKING

_________CALF CRAMPING WHILE WALKING

TURING HEAD: ___RIGHT ___LEFT ___UP ___DOWN

3. WHAT MAKES THE PAIN BETTER?

_________REST _________MEDICATIONS

_________ LYING DOWN _________HEAT

_________BRACE _________COLLAR

_________ LYING ON SIDE WITH HIPS AND KNEES CURLED UP

4. IS THE PAIN USUALLY WORSE: (CHECK ALL THAT APPLY)

_________ IN THE MORNING WHEN YOU FIRST GET UP

_________AS THE DAY PROGRESSES

_________AT NIGHT IN BED

_________DOES IT WAKE YOU UP FROM SLEEPING?

5. ANY OTHER JOINTS HURT? (DESCRIBE)______________________

6. HAVE YOU LOST ANY WEIGHT? ___YES ___NO HOW MUCH?______

7. HAVE YOU HAD ANY BOWEL OR BLADDER PROBLEMS? ___YES ___NO

8. ANY TROUBLE WALKING? ___LEG PAIN ___LEG UNSTEADINESS

9. ANY NUMBNESS OR TINGLING? ___NO ___YES WHERE?

10. ANY WEAKNESS? ___NO ___YES WHERE?

11. HAVE YOU EVER HAD NECK OR BACK PAIN IN THE PAST? ___NO ___YES ___BACK ___NECK

HOW MANY TIMES? __________ WHEN WAS THE LAST EPISODE?_______

12. PLEASE LIST ANY PRIOR INJECTIONS OR SURGERIES.

PROCEDURE______________________________ HOSPITAL____________________
PROCEDURE______________________________ HOSPITAL____________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________, acknowledge receipt of written Notice of
[print patient name]

Privacy Practices from Richard S. Obedian M.D. PLLC

[ ] Patient chose not to sign acknowledgement

Reason:

____

______________________________ ______________
Office staff acknowledging of patient's refusal to sign Date

______________________________ ______________
Patient Signature Date

Name________________________________ Date__________

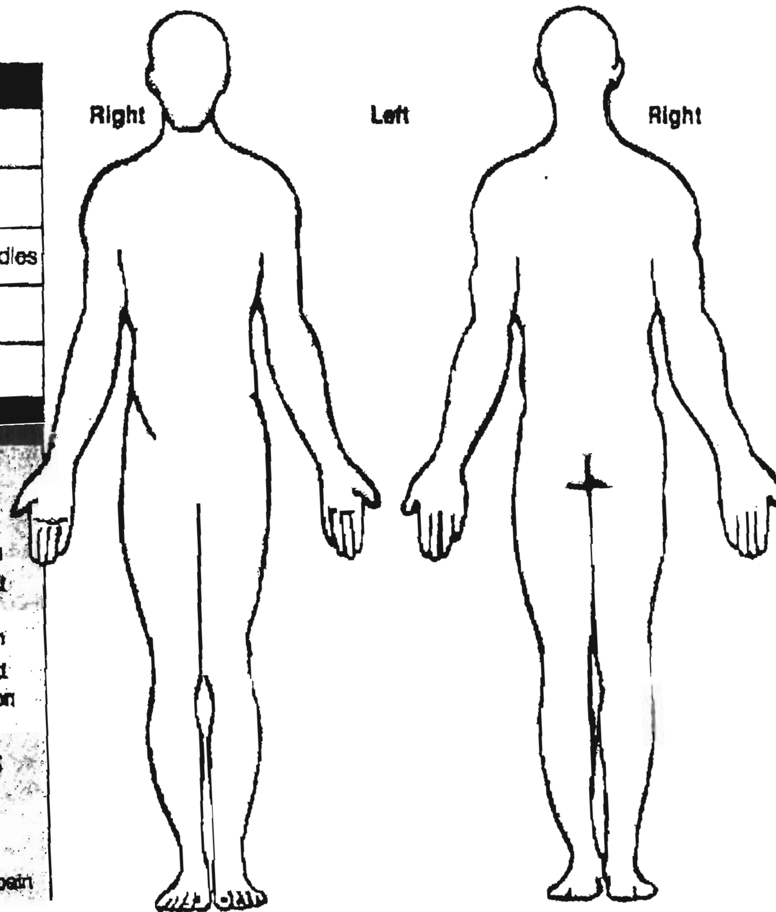
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL	
0	No pain
1	Mild pain; you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4-5	More severe pain; you begin to feel antisocial
6	Severe pain
7-9	Intensely severe pain



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

PATIENT HISTORY

Name ______________________________ Date______________________

Height____________Weight____________

PAST MEDICAL HISTORY	YES	NO	YEAR	COMPLICATIONS/COMMENTS
Cardiovascular/Heart Disease				
High Blood Pressure				
Heart Attack (MI)				
Pacemaker				
Arrhythmia (i.e. fibrillation)				
Edema (Leg/Ankle Swelling)				
Endocrine				
Diabetes				
Hypothyroid				
Hyperthyroid				
Gastrointestinal				
Ulcer				
Heartburn (Dyspepsia)				
Bloody or Tarry Stool				
Neurological				
Seizures				
Stroke (CVA)				
Asthma				
Cancer (where?)				
Kidney Disease				
Liver Disease				
Rheumatic Disease				
Osteoporosis				
Skin Problems				
Psychiatric problems				
Hepatitis				
HIV / AIDS				

MEDICATIONS	AMOUNT PER DAY

ALLERGIES	REACTION

HABITS	YES	NO	HOW MUCH (PER DAY/PER WEEK)
Cigarettes/Cigars			
Alcohol			
Drugs (Specify)			

ILLNESS/SURGERY	YEAR	COMPLICATIONS	COMMENTS

RICHARD S. OBEDIAN, M.D., PLLC

81 North Broadway, Hicksville, New York 11801- Phone: (516) 933-4350 Fax: (516) 933-4352

ATTENTION PATIENTS

This office now participates in E-prescribing. We require the following information for all prescriptions written:

Patient Name:_______________________________________

Primary care physician:_______________________________
Phone number:____
Address:____

Pharmacy:____
Phone number:____
Address:____

Preferred Language:___________________________________

Race: select one or more:
American Indian Asian Black Hispanic White

Ethnicity: select one:
Hispanic Non-Hispanic

E-mail address_______________________________________

Richard S Obedian, M.D. PLLC
81N. Broadway, Hicksville, NY 11801, 516-933-4350

WE HAVE A PARKING LOT CONVIENTLY LOCATED BEHIND OUR BUILDING.

FROM LONG ISLAND EXPRESSWAY

- TAKE LIE TO EXIT 41S.
- CONTINUE SOUTH PAST THE BROADWAY MALL.
- STAY TO THE LEFT AT THE FORK TO GO ONTO ROUTE 107 TOWARDS MASSAPEQUA.
- TURN LEFT ONTO THORMAN AVENUE. (OPPOSITE DUNKIN DONUTS AND NEXT TO PELLA WINDOWS.)
- **AND YOU WILL SEE ON YOUR RIGHT IS OUR LARGE PARKING LOT.**

FROM NORTHERN STATE PARKWAY

- EXIT 35 SOUTH
- CONTINUE SOUTH PAST THE BROADWAY MALL.
- STAY TO THE LEFT AT THE FORK TO GO ONTO ROUTE 107 TOWARDS MASSAPEQUA.
- TURN LEFT ONTO THORMAN AVENUE. (OPPOSITE DUNKIN DONUTS AND NEXT TO PELLA WINDOWS)
- **AND YOU WILL SEE ON YOUR RIGHT IS OUR LARGE PARKING LOT.**

FROM SOUTHERN STATE PARKWAY

- EXIT 28A NORTH - SEAFORD/OYSTER BAY EXPRESSWAY (135)
- CONTINUE NORTH TO EXIT 10 - OLD COUNTRY RD.
- MAKE A LEFT AT THE LIGHT GOING WEST ON OLD COUNTRY RD.
- CONTINUE WEST UNTIL YOU REACH 107/BROADWAY
- MAKE A RIGHT ONTO 107/BROADWAY (NORTH)
- CONTINUE ABOUT ¾ MILE AND MAKE A RIGHT ONTO THORMAN AVE.(Pella Windows is on the corner)
- **AND YOU WILL SEE ON YOUR RIGHT IS OUR LARGE PARKING LOT.**

FROM WOODBURY ROAD

- TAKE WOODBURY ROAD WEST TO BAY AVENUE
- MAKE A RIGHT ON BAY AVENUE
- MAKE THE THIRD LEFT ON THORMAN AVENUE
- MAKE THE FIRST LEFT AFTER THE STOP SIGN ON DESMOND PLACE
- **AND YOU WILL SEE ON YOUR RIGHT IS OUR LARGE PARKING LOT.**