SHERBAN ORTHOPAEDICS AND SPINE SURGERY, PLLC

2914 Elmwood Avenue, Kenmore NY 14217---55 Spindrift Drive, Williamsville NY 14221---3673 Southwestern Blvd. Orchard Park NY 14127

PHONE: (716) 447-6310 FAX: (716) 775-6288

PATIENT NAME: _____
ADDRESS: _____
EMAIL:_____TELEPHONE: HOME: _____CELL: _____
DATE OF BIRTH: _____SEX: MALE:_____FEMALE:_____
SOCIAL SECURITY NUMBER: _____
CHIEF COMPLAINT:_____

Workers' Compensation Patients

Understand that without majority of the below information, you or your back-up insurance may be billed in lieu of missing information about your Workers' Compensation claim. The more information we have, the more timely we are able to process any requests for additional testing, surgery, braces, etc that the physician may/may not wish to order at your appointment. If you are unsure how to obtain the below information, before you arrive at our office, contact your Human Resources representative at your company. They will assist you.

WC Carrier Name:	
WC Carrier Address:	
WC Carrier Phone:	
WC Carrier Fax:	
Date of Injury:	
WC Claim Number:	
WC Board Number:	____ ____ ____ ____ ____ ____ ____ ____
WC Claim Examiner/Adjuster:	
Examiner/Adjuster Phone #:	
Examiner/Adjuster Fax #:	
Employer's Name:	
Employer's Address:	
Job Title:	
Employment Status:	
Usual Work Activities:	

I,_____ authorize my physician/Health Care Solutions of WNY, LLC to release any information pertaining to my work related injury to my employer, Workers' Compensation insurance carrier and the Workers' Compensation Board (for the duration of my treatment for this incident)

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered. I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Signature:_____ Date:_____

Physician Office: SHERBAN ORTHOPAEDIC AND SPINE SURGERY, PLLC

For new claims please contact and provide the office with your Workers' Compensation information.

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GENERAL INFORMATION***

***(You do NOT have to fill out GENERAL INFORMATION portion, if this insurance is secondary to NF/WC)**

PATIENT NAME : _____
ADDRESS : _____
TELEPHONE : HOME : _____CELL : _____
EMAIL ADDRESS:_____
DATE OF BIRTH : _____SEX : MALE :_____FEMALE :_____
SOCIAL SECURITY NUMBER : _____
CHIEF COMPLAINT:_____

****

EMERGENCY CONTACT INFORMATION

NAME : _____
RELATION : _____
TELEPHONE : HOME : _____CELL : _____

PRIVATE INSURANCE INFORMATION

PRIMARY INSURANCE : _____
ID# :_____GROUP# :_____
SECONDARY INSURANCE : _____
ID# :_____GROUP# :_____

CORRESPONDENCE INFORMATION

REFERRED BY: _____
Address: _____Telephone: _____

PRIMARY MEDICAL DOCTOR: _____
Address: _____Telephone: _____

ATTORNEY INFORMATION:_____
Address: _____Telephone: _____

INSURANCE AUTHORIZATION:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO AUTHORIZE AND REQUEST PAYMENT OF MEDICAL BENEFITS DIRECTLY TO MY PHYSICIANS. I AGREE THAT THIS AUTHORIZATION WILL COVER ALL MEDICAL SERVICES RENDERED UNTIL SUCH AUTHORIZATION IS REVOKED BY ME. I AGREE THAT A PHOTOCOPY OF THIS FORM MAY BE USED IN LIEU OF THE ORIGINAL.

NO SHOWS:

Please be advised that a fee of $25.00 will be charged to patients who fail to show for a scheduled appointment without giving us one business day's notice by phone {716-447-6310}. The patient must speak with someone in the office to cancel his/her appointment.

*PLEASE NOTE THAT YOUR INSURANCE COMPANY WILL NOT COVER THIS CHARGE –
THIS POLICY IS INTENDED TO FACILITATE BEST SCHEDULING PRACTICES AND ENABLE OUR PROVIDERS AND OUR STAFF TO MAXIMIZE THE TIME AVAILABLE FOR PATIENT CARE

_____ _____
Patient name Printed Date

_____ _____
Patient Signature Date

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DATE: _____

MEDICAL HISTORY QUESTIONNAIRE

Family Physician: _____ Chiropractor_____
Physical Therapy: _____ Cardiologist: _____

Any Other Specialist(s): _____ _____ _____

MEDICATIONS: Please list your most current medications and who prescribes them

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

SOCIAL HISTORY:

ALCOHOL: DO YOU DRINK? **Y OR N** IF YES, HOW MUCH AND HOW OFTEN: SOCIAL / OCCASIONAL / MODERATE

SMOKING AND CHEWING TOBACCO: DO YOU SMOKE? Y or N < PACK A DAY___1-2 PACKS A DAY___ >3 PACKS A DAY___

CHEWING TOBACCO____ PREVIOUS SMOKER: Y or N WHEN DID YOU QUIT? _____

Surgical History & The Date Performed:

_____ _____ _____
_____ _____ _____

PRESENT MEDICAL CONDITIONS: Please check any medical conditions you are being treated for or have been in the past
NO MEDICAL PROBLEMS REPORTED ☐

MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER	MEDICAL PROBLEMS	YOURSELF	FAMILY MEMBER
Asthma			Dialysis or Kidney Failure		
Emphysema			Urinary tract infections		
COPD			Diabetes		
Pneumonia			Thyroid problems		
Tuberculosis			Osteomyolitis		
Pulmonary Embolism			Bleeding disorders		
Respiratory Arrest			Anesthesia problem / Malignant hyperthermia		
Sleep Apnea			Peripheral Vascular Disease (PVD)		
High Cholesterol/Lipids			Deep Vein Thrombosis (DVT)		
High Blood Pressure			Cerebral Palsy		
Stroke / TIA			Polio		
Mitral Valve Prolapse			Parkinson's		
Congestive Heart Failure			Multiple Sclerosis		
Angina (Chest Pain)			Ulcers skin/pressure		
Coronary Heart Disease			Psoriasis		
Heart Attack (Myocardial Infarction)			Tooth abscess		
Arrhythmia (Irregular heart beat)			Gingivitis		
Inflammatory Bowel (Diverticulitis/losis)			Rheumatoid Arthritis		
Acid Reflux (GERD)			Gout		
Gastric / Stomach Ulcer			Lupus		
GI Bleed			Scleroderma		
Hepatitis or liver disease			Depression		
Kidney problems			HIV/AIDS		
Drug OR Alcohol dependency			CANCER		

AUTHORIZATION AND RELEASE:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. **Signature:**_____ **Date:**_____

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DATE: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

General Information:

Information about your treatment and care, including payment for care, is protected by two federal laws:

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Confidentiality Law. Under these laws the practice must obtain your written consent before it can disclose information about you for payment purposes. For example, the practice must obtain your written consent before it can disclose any Personal Health Information (PHI). In addition, you must also sign a written consent before the practice can share information for any and all treatment purposes. However, federal law permits the practice to disclose information in the following circumstances without your written permission:

1. To practice staff for the purposes of maintaining the clinical records
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, your insurance company)
3. For research, audit or evaluations (e.g. State licensing review, or accreditation as required by the State and/or Federal government);
4. To report a crime committed on the practice's premises or against practice staff
5. To medical personnel in a medical/psychiatric emergency
6. To appropriate authorities to report suspected child abuse or neglect
7. To report certain infectious illnesses as required by state law
8. Information that is requested per a court order

Before the practice can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Disclosure of Medical Information

I give my permission to the office of Sherban Orthopaedics and Spine Surgery, PLLC to disclose medical information regarding my treatment/diagnosis to the following family members or friends whom you may speak with:

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Sherban Orthopaedics and Spine Surgery PLLC . (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at any time. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information. I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

Signature:_____ Date: _____

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Narcotic Medication Agreement

I,_____ understand that:

- I will call the office five (5) business days ahead of my refill date. P# 716-447-6310 EXT 3.
- The overuse of narcotic medication can result in serious health risks.
- You should not drive or operate machinery while taking narcotic medications.
- All prescriptions must be filled at one (1) pharmacy only and prescribed by one (1) doctor only, this includes emergency department prescriptions.
- You agree to a random urine drug testing.
- **This medication will be strictly monitored and ALL of the medications will be filled at the SAME pharmacy.**

  The pharmacy I have chosen is: _____

  Phone #: _____ **Address:**_____
- **Early refill requests will not be honored & I will take my medication ONLY as prescribed.**
- I am responsible for MAKING & KEEPING scheduled appointments. I understand that I will need to be seen approximately EVERY month while I am being prescribed narcotic medications.
- I understand that if I am not able to keep my appointments my medications will not be refilled.
- I WILL NOT obtain narcotic medication from any provider while obtaining medications from Sherban Orthopaedics and Spine Surgery and/or associates. If it is found that other providers are prescribing for me, Dr. Sherban and/or his associates reserve the right to discontinue prescribing medications and/or discharge me.**
- Your prescription or medications WILL NOT be replaced if they are lost, destroyed, stolen, get wet, misplaced etc. under any circumstances.
- Notify us immediately if you become pregnant.

I have read the Narcotic Medication Agreement and by signing I affirm that I have read, understand, and accept all of the terms of this agreement.

**PAIN MANAGEMENT PROVIDER:_____

Patient Signature:_____ Date:_____

Witness Signature: _____ Date:_____

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Dr. Ross Sherban
Fellowship Trained Orthopaedic
Spinal Surgeon

Email: **scheduling@drsherban.com**
Website: **www.drsherban.com**

American Academy of Orthopaedic Surgeons
American Osteopathic Academy of Orthopaedics
North American Spine Society
American Osteopathic Association
American Medical Association
Association of Orthopaedic Surgeons
AOSpine

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

The undersigned hereby consents to and authorizes the release of all medical reports, hospital records, and X-ray films concerning my physical condition, past and present by _____ and their employees.

The information to be disclosed shall be limited to the following:

	(Please check appropriate box :)
Office Reports	( )
Other	(X) Please list: **ALL MEDICALS ON FILE**

This disclosure is made for the following purpose:

	(Please check appropriate box :)
Continued Care	(X)
Legal	( )
Other	( ) Please specify: _____

I specifically authorize the release of this information to: **Ross Sherban D.O.** and his employees, or any person authorized by him/her to examine any of the aforesaid records. This Authorization is subject to written revocation at any time except to the extent that action has been taken in reliance thereon.

Phone: 716-447-6310 **Fax: 716-775-6288**

This Authorization is limited to the furnishing of the above records only and shall not be construed as authorizing you to communicate orally or in writing concerning my medical condition other than for the purpose of furnishing records.

Signature: _____

Date: _____

CERVICAL SPINE FUNCTIONAL REPORT

PATIENT NAME: _____ DOB: _____

DATE_____ OP DATE_____

OSWESTRY RATING
CHOOSE ONE ANSWER FROM EVERY CATEGORY

1. Pain Intensity
   - ( ) I have no pain at the moment
   - ( ) The pain is very mild at the moment
   - ( ) The pain is moderate at the moment
   - ( ) The pain is fairly severe at the moment
   - ( ) The pain is very severe at the moment
   - ( ) The pain is the worst imaginable at the moment

2. Personal Care (washing, dressing, etc)
   - ( ) I can look after myself without causing extra pain
   - ( ) I can look after myself normally, but it causes extra pain
   - ( ) It is painful to look after myself and I am slow and careful
   - ( ) I need some help but manage most of my personal care
   - ( ) I need help everyday in most aspects of self care
   - ( ) I do not get dressed, wash with difficulty and stay in bed

3. Lifting
   - ( ) I can lift heavy weights without extra pain
   - ( ) I can lift heavy weights but it causes extra pain
   - ( ) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (ex: on a table)
   - ( ) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned (ex: on a table)
   - ( ) I can only lift very light weights
   - ( ) I cannot lift or carry anything at all

4. Reading
   - ( ) I can read as much as I want with no pain in my neck
   - ( ) I can read as much as I want with slight pain in my neck
   - ( ) I can read as much as I want with moderate pain in my neck
   - ( ) I cannot read as much as I want because of moderate pain in my neck
   - ( ) I cannot read as much as I want because of severe pain in my neck
   - ( ) I cannot read at all

5. Headache
   - ( ) I have no headache at all
   - ( ) I have slight headache which come infrequently
   - ( ) I have moderate headache which come infrequently
   - ( ) I have moderate headache which come frequently
   - ( ) I have severe headaches which come frequently
   - ( ) I have headaches almost all the time

6. Concentration
   - ( ) I can concentrate fully when I want to with no difficulty
   - ( ) I can concentrate fully when I want to with slight difficulty
   - ( ) I have a fair degree of difficulty in concentrating when I want to
   - ( ) I have a lot of difficulty in concentrating when I want to
   - ( ) I have a great deal of difficulty in concentrating when I want to
   - ( ) I cannot concentrate at all

7. Work
   - ( ) I can do as much work as I want to
   - ( ) I can only do my usual work, but no more
   - ( ) I can do most of my usual work, but no more
   - ( ) I cannot do my usual work
   - ( ) I can hardly do any work at all
   - ( ) I cannot do any work at all

8. Driving

( ) I can drive my car without any neck pain
( ) I can drive my car as long as I want with slight pain in my neck
( ) I can drive my car as long as I want with moderate pain in my neck
( ) I cannot drive my car as long as I want because of severe pain in my neck
( ) I can hardly drive at all because of the severe pain in my neck
( ) I cannot drive my car at all

9. Sleeping

( ) I have no trouble sleeping
( ) My sleep is slightly disturbed (less that 1 hour of sleep loss)
( ) My sleep is mildly disturbed (1-2 hours sleep loss)
( ) My sleep is moderately disturbed (2-3 hours sleep loss)
( ) My sleep is greatly disturbed (3-5 hours sleep loss)
( ) My sleep is completely disturbed (5-7 hours sleep loss)

10. Recreation

( ) I am able to engage in all my recreational activities with no neck pain at all
( ) I am able to engage in all my recreational activities with some pain in my neck
( ) I am able to engage in most but not all of my usual recreational activities because of pain in my neck
( ) I am able to engage in a few of my usual recreational activities because of the pain in my neck
( ) I can hardly do any recreational activities because of pain in my neck
( ) I cannot do any recreational activities at all

VISUAL ANALOG SCALE (VAS) FOR PAIN - CERVICAL

Patient Name:_____

Today's Date:_____

DOB: _____Surgery Date:_____

Place a **circle on the number** indicating the **total** amount of neck pain you have felt for the last week.

Neck Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of arm pain you have felt for the last week.

Left Arm Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the total amount of arm pain you have felt for the last week.

Right Arm Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

LUMBAR SPINE FUNCTIONAL REPORT

PATIENT NAME:_____ DOB:_____

DATE:_____OP DATE:_____

OSWESTRY RATING
CHOOSE **ONE** ANSWER FROM **EVERY** CATEGORY

1.) Pain Intensity:
( ) I have no pain at the moment
( ) The pain is very mild at the moment
( ) The pain is moderate at the moment
( ) The pain is fairly severe at the moment
( ) The pain is very severe at the moment
( ) The pain is the worst imaginable at the moment

2.) **Personal Care**: (*Washing, Dressing, ect.)*
( ) I can look after myself without causing extra pain
( ) I can look after myself normally, but it causes extra pain
( ) It is painful to look after myself and I am slow and careful
( ) I need some help but manage most of my personal care
( ) I need help everyday in most aspects of self care
( ) I do not get dressed, wash with difficulty and stay in bed

3.) Lifting:
( ) I can lift heavy weights without extra pain
( ) I can lift heavy weights but it causes extra pain
( ) Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (Ex. On a table.)
( ) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned (Ex. On a table.)
( ) I can only lift very light weights
( ) I cannot left or carry anything at all

4.) Walking:
( ) Pain does not prevent me walking any distance
( ) Pain prevents me from walking more than one (1) mile.
( ) Pain prevents me from walking more than a half (½) a mile.
( ) Pain prevents me from walking more than a quarter (¼) mile.
( ) I can only walk using a cane or crutches.
( ) I am in bed most of the time, I can only walk to the toilet.

5.) Sitting:
( ) I can sit in a chair as long as I like.
( ) I can only sit in my favorite chair as long as I like.
( ) Pain prevents me sitting for more than one (1) hour.
( ) Pain prevents me sitting for more than half (½) an hour.
( ) Pain prevents me sitting for more than ten (10) minutes.
( ) Pain prevents me from sitting at all.

6.) Standing:
( ) I can stand as long as I want without extra pain.
( ) I can stand as long as I want, but it gives me extra pain.
( ) Pain prevents me standing for more than one (1) hour.
( ) Pain prevents me standing for more than half (½) hour.
( ) Pain prevents me standing for more than ten (10) minutes.
( ) Pain prevents me for standing at all.

7.) Social Life:
( ) Social life is normal, with no extra pain.
( ) Social life is normal, but increases degrees of pain.
( ) Pain has no significant effect of my social life apart from limiting more energetic interest. (ex dancing)
( ) Pain has restricted my social life and I do not get out often.
( ) Pain has restricted my social life at home
( ) I have no social life because of pain.

8.) Sleeping:

( ) I have no trouble sleeping
( ) My sleep is slightly disturbed (less than one (1) hour of sleep loss)
( ) My sleep is mildly disturbed (One to two (1-2) hours of sleep loss)
( ) My sleep is moderately disturbed (Two to three (2-3) hours of sleep loss)
( ) My sleep is greatly disturbed (Three to five (3-5) hours of sleep loss)
( ) My sleep is completely disturbed (Five to seven (5-7) hours of sleep loss)

9.) Traveling:

( ) I can travel anywhere without extra pain
( ) I can travel anywhere, but is causes extra pain
( ) Pain is bad, but I manage journeys over two (2) hours
( ) Pain restricts me to journeys of less than one (1) hour
( ) Pain restricts me to short necessary journeys under a half (½) hour
( ) Pain prevents me from traveling except to the doctor or hospital.

10.) Changing Degree of Pain

( ) My pain is rapidly getting better
( ) My pain fluctuates but overall is definitely better
( ) My pain seems to be getting better but improvement is slow
( ) My pain is neither getting better or worse
( ) My pain is gradually getting worse
( ) My pain is rapidly getting worse

VISUAL ANALOG SCALE (VAS) FOR PAIN – LUMBAR

Patient Name:_____

Today's Date:_____

DOB: _____Surgery Date:_____

Place a **circle on the number** indicating the **total** amount of back pain you have felt for the last week.

Low Back Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of leg pain you have felt for the last week.

Left Leg Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain

Place a **circle on the number** indicating the **total** amount of leg pain you have felt for the last week.

Right Leg Pain

No Pain 1 2 3 4 5 6 7 8 9 10 Extreme Pain