Louis W. Catalano, III, MD
Roosevelt Hand to Shoulder Center
485 Madison Avenue, 8th Floor
New York, N.Y. 10022
T:212-658-1122
F:212-826-4107

Patient Information **Date**:_____

Legal Name: _____ Date of Birth:_____ Sex: M / F
Address_____
City:_____ State:_____ Zip:_____
Social Security:_____ Email:_____
Phone: Home: _____ Cell:_____ Work:_____
Emergency Contact : Name:_____ Contact #:_____
Relationship:_____

Occupation:_____ Employer's name: _____

Pharmacy 1) Name:_____
Address: _____
Tel: _____

Referring Physician: First _____ Last_____ Tel:_____
Primary Physician: First_____ Last_____ Tel:_____

Optional Authorization for Release of Medical Information to Others
_____ Do not release information
_____ I authorize Dr. Louis W. Catalano, III, MD and his staff to use the additional contact information listed below to discuss or disclosed information regarding my appointments, billing information and/or medical care, including labs/radiology results. This authorization will remain in effect until I provide written notification to Dr. Louis W. Catalano, III, MD of changes or update.

Name:_____ Relationship_____ Tel:_____
Name:_____ Relationship_____ Tel:_____

Insurance Information
Primary Insurance:_____ Member ID #_____
Policy Holder Name:_____ Policy Holder DOB: _____
Secondary Insurance:_____ Member ID #_____
Policy Holder Name: _____ Policy Holder DOB:_____

Is this a Workers Compensation or No Fault case?
Date of Injury: _____ Job title:_____
Employer:_____Address:_____
Insurance Company:_____ Case#_____

Patient's name:_____ Signature:_____ Date:_____

Medical History Questionnaire

Name: First _____ Middle:_____Last:_____

What is your height? _____ weight?_____ Dominant Hand: Left Right Both

Date of injury:_____ Injury resulted from: work car accident sports accident other

How did the injury occur? Body Part: _____
_____
_____
_____
_____

Please rate your pain on a scale from 1 (least) to 10(most)_____
Are you taking any medications for the pain? yes ___ no _____
If yes, what medication _____ dosage_____
What makes it better? _____ What makes it worse?_____
Any prior treatment? yes_____ no___ If yes, please list prior Doctors or Physical/Occupational Therapy?
_____
_____

Have you had any radiology images/reports, if yes where and when
1._____Tel:_____
2._____Tel:_____
3._____Tel:_____

Surgery History/ and or hospitalizations Year
1._____
2._____
3._____
4._____

Any previous fractures/injuries? yes no If yes, Which part body and when
_____
Any history of anesthesia complications? yes no If yes, please describe _____
_____

Medications and dosage -if you have a list please provide the list.
1._____
2._____
3._____
4._____

Please list any known allergies_____
_____
_____
_____

Patient's signature:_____ Date:_____

Social History:

List all regular activities/hobbies _____

_____

1) Alcohol: Never_____ Monthly or less___ 2-4 x month_____ 2-3x a week___ 4+ a week ____

2) How many drinks of containing alcohol do you have a typical day when you are drinking?
1-2___ 3-4___ 5-6___ 7-9___ 10+more_____

3) How often do you have six or more drinks on occasion?
Never_____ Less than monthly___ Monthly____ Weekly___ Daily or almost daily_____

4) How often during the last year have you found you that you were not able to stop drinking once you have started?
Never_____ Less then monthly___ Monthly_____ Weekly___ Daily or almost daily_____

5) How often during the last year have you found that you failed to do what was normally expected from you because of drinking?
Never_____ Less then monthly___ Monthly_____ Weekly___ Daily or almost daily_____

6) Tobacco Use: yes___ no____ how many a day/week?_____

Any history of substance abuse? yes__ no___ If yes, describe: _____

_____

_____

Do you take recreational drugs? if yes, specify_____

Personal History: Please check any that apply

Chest pain		**Loss of appetite**		**Constipation**		**Insomnia**		**HIV/AIDS**	
Heart attack		**Swollen glands**		**Diarrhea**		**Loss of feeling**		**Hepatitis**	
Heart murmur		**Night sweats**		**Heartburn**		**Migraines**		**Tuberculosis**	
Known CAD		**Weight gain**		**Nausea**		**Pain**		**Blood clots**	
Heart stent		**Weight loss**		**Vomiting**		**Seizures**		**Emphysema**	
Pacemaker		**Nail changes**		**Blood transfusion**		**Stroke/CVA**		**Diverticulitis**	
Heart disease		**Psoriasis**		**Anemia**		**Tremor**		**Osteoporosis**	
High blood pressure		**Skin changes,rash**		**Easy bruising**		**Vertigo**		**Ulcers**	
Irregular heartbeat		**Tick bite**		**Easy bleeding**		**Neuro disorder**		**Steroids**	
Peripheral Vascular disease		**Reynaud Symptoms**		**Enlarge lymph**		**Peripheral neuropathy**		**Bone/joint infections**	
Aorta Widening		**Cold Intolerance**		**Arthritis**		**Autoimmune disease**		**Dental infections**	
Coronary bypass or angioplasty		**Thyroid Disorder**		**Morning Stiffness**		**Burning pain Upper body**		**Rheumatoid Arthritis**	
CHF		**Acid Reflux**		**Joint stiffness**		**Anxiety**		**Gout**	
Chills/ Fatigue		**Black stools**		**Joint pain**		**Depression**		**Stress fracture**	
Kidney problem		**Blood in stool**		**Neck pain**		**Eating disorder**		**Sleep apnea**	

If yes, explain:

_____

_____

Family History: Please indicate which family member, if any have a history of the following.

Stroke		**High blood pressure**		**colitis**	
Seizure		**Heart attack**		**Kidney disease**	
emphysema		**High cholesterol**		**arthritis**	
asthma		**ulcer**		**diabetes**	
Thyroid		**Cancer**			
		Anesthesia complication			

Do you have any medical problems that is not listed, If yes, please specify

_____

Patient's signature:_____ **Date:**_____

Assignment and Release

I, the undersigned, certify that I(Or my dependent) have insurance coverage and assign, Louis W. Catalano, III MD all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. This may include any deductible, co-pay or insurances for which I am responsible, all charges, whether or not paid by insurance. I hereby authorize, Louis W. Catalano, III MD to release all information to secure the payment of benefits. I authorize the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all insurance submissions.

Signature_____ Date:_____

Acknowledgement Of Receipt Of Notice Of Privacy Practice

I, the undersigned have been informed that the U.S Government requires I sign this Notice Of Privacy Practices. The privacy regulations were created by the HIPPA ACT of 1996 to protect patient privacy. I understand that the full text of the Act is available to me upon request.

Signature_____ Date:_____

Cancellation Policy and Patient No show Agreement

We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of orthopedic care. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to an appointment. As a courtesy, our automated system will call you two days before the scheduled appointment date to remind you of your appointment. You may also call us at 212-658-1122 option 1 to confirm. Cancellations of appointments are not accepted outside our office business hours. There will be a $50.00 fee applied to your account for a missing appointment without providing notice at least one business day. If an emergency arises and you have forgotten about the appointment. Please do still call the office, so we may document it.

Signature_____ Date:_____

Workers compensation only

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 acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Signature_____ Date:_____

New York "Surprise Law" April 2015 (For patients who are out of network health insurance)

I have reviewed the information provided and understand that:

- **I understand that if I choose to use a non-participating health care professional, such services may not cover under my plan, if my health insurance plan does not have out-of -network benefits.**
- **If my insurance health plan has out-of-network benefits, I understand that by using my out-of-network benefits. I may incur greater costs for which I will be financially responsible from a in network provider.**

( )I wish to obtain services from Louis W. Catalano, III, MD. I understand he is NOT a "Health Plan" participating health care professional. I also acknowledge that I am utilizing my out of network benefits, if I have out-of- network benefits. I acknowledge the information was given to me prior to my appointment and I agree.

Signature:_____ Date:_____

Please print name:_____