Name:
Chart:
Date:

PATIENT INFORMATION

NAME _____ SEX _____ AGE _____ STATUS M S D W

STREET _____

CITY _____ STATE _____ ZIP CODE _____

BIRTHDATE _____ SS # _____

HOME PHONE _____ OTHER PHONE _____

EMAIL ADDRESS: _____ REFERRING DOCTOR _____

PRIMARY CARE DOCTOR _____ ADDRESS _____

PHONE NUMBER _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO.: SECONDARY INSURANCE CO.:

CO. NAME: _____ CO. NAME: _____

ADDRESS: _____ ADDRESS: _____

GROUP OR PLAN: _____ GROUP OR PLAN: _____

PLAN NO.: _____ PLAN NO.: _____

MY RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER _____

IF THE INSURANCE IS IN SOMEONE ELSE'S NAME, PLEASE FILL IN:

NAME OF INSURED PERSON HIS ADDRESS HIS PHONE RELATIONSHIP

_____

INSURED'S BIRTHDATE _____ INSURED'S SS # _____

EMPLOYMENT INFORMATION

MY EMPLOYER: _____ SPOUSE OR PARENT'S EMPLOYER: _____

ADDRESS: _____ ADDRESS: _____

TELEPHONE NO.: _____ TELEPHONE NO.: _____

OCCUPATION: _____ OCCUPATION: _____

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I AUTHORIZE DAVID M. DINES, M.D. AND JOSHUA S. DINES, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.

DATE: _____ SIGNATURE: _____

Name:
Chart:
Date:

40467-12

DAVID M. DINES, M.D., F.A.C.S., P.C.
JOSHUA S. DINES, M.D.
ORTHOPEDIC SURGERY

333 Earle Ovington Blvd.
Suite 106
Uniondale, NY 11553
(516)-482-1037
FAX: (516)-482-9217

I authorize David M. Dines, M.D., P.C./Joshua S. Dines, M.D. to release my personal health information to the following person(s): (list name and relationship):

_____

_____

_____

Further, 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.

Signed: _____ **Date:** _____

Name:
Chart:
Date:

40467-12

DAVID M. DINES, M.D., F.A.C.S., P.C.
JOSHUA S. DINES, M.D.
ORTHOPEDIC SURGERY

333 Earle Ovington Blvd.
Suite 106
Uniondale, NY 11553
(516)-482-1037
FAX: (516)-482-9217

NAME _____ AGE ___ _____ BIRTH DATE _____

ADDRESS _____

HOME TEL # _____ BUS TEL # _____ OCCUPATION _____

PRESENT CHIEF COMPLAINT _____ DURATION _____

OTHER HEALTH PROBLEMS _____

IS THIS THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IS A LAWSUIT PENDING? ☐ YES ☐ NO

PAST MEDICAL HISTORY

ALLERGIES:	YES	NO	REACTION TYPE
PENICILLIN	☐	☐	
NOVACAINE	☐	☐	
ENVIRONMENTAL	☐	☐	
OTHER: _____			

MEDICATIONS:

HEART PILLS	☐	☐
BLOOD	☐	☐
DIABETIC PILLS	☐	☐
DIABETIC SHOTS	☐	☐
CORTISONE	☐	☐
COUMADIN	☐	☐
OTHER _____		

FAMILY HISTORY:	YES	NO
DIABETES	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
GOUT	☐	☐
MUSCLE/NERVE DISORDER	☐	☐

PREVIOUS ILLNESSES: (SUCH AS TUBERCULOSIS, DIABETES, RHEUMATIC FEVER, ETC)

_____

LIST ALL PREVIOUS OPERATIONS _____

_____

REVIEW OF SYSTEMS

PULMONARY:	YES	NO
ARE YOU A SMOKER?	☐	☐
# OF PACKS/DAY		
DURATION OF HABIT		
CARDIOVASCULAR/RESPIRATORY		
CHRONIC COUGH	☐	☐
COUGH PRODUCTIVE OF SPUTUM, COLOR		
CHEST PAIN	☐	☐
PALPITATIONS	☐	☐
HISTORY OF HEART ATTACK	☐	☐
HISTORY OF PNEUMONIA	☐	☐
HIGH BLOOD PRESSURE	☐	☐

GASTROINTESTINAL:	YES	NO
RECENT WEIGHT LOSS	☐	☐
CHANGE IN BOWEL HABITS	☐	☐
DIARRHEA	☐	☐
CONSTIPATION	☐	☐
DIVERTICULITIS	☐	☐
BLOOD IN STOOL	☐	☐
ABDOMINAL PAIN	☐	☐
NAUSEA/VOMITING	☐	☐
HISTORY: ULCERS	☐	☐
" JAUNDICE	☐	☐
" GALLSTONES	☐	☐
" HERNIA	☐	☐
FREQUENT VOIDING	☐	☐
BLOOD IN URINE	☐	☐

Name:
Chart:
Date:

RECENT CHANGE IN
VISION ☐ ☐
HOARSENESS ☐ ☐

GENITORINARY:	YES	NO
HISTORY BLADDER INFECTIONS	☐	☐
HISTORY KIDNEY INFECTION	☐	☐
PAIN ON URINATION	☐	☐
DIFFICULTY CONTROLLING URINATION	☐	☐

BLEEDING HISTORY:

HISTORY BLEEDING PROBLEMS	☐	☐
FREQUENT NOSE BLEEDS	☐	☐
EASY BRUISING	☐	☐
FAMILY HISTORY OF EASY BLEEDING	☐	☐

SPECIFIC ORTHOPAEDIC PROBLEM
PAIN LOCATION LEFT ☐ RIGHT ☐
DURATION OF PAIN _____

	YES	NO
PAIN INCREASED BY ACTIVITY	☐	☐
DECREASED BY REST	☐	☐
ABLE TO WORK	☐	☐
ABLE TO DO HOUSEWORK	☐	☐
FEVER, SWEATS OR CHILLS	☐	☐
NIGHT PAIN	☐	☐
SWELLING	☐	☐
PREVIOUS INJURY TO SAME AREA	☐	☐
REDNESS	☐	☐
WARMTH TO SITE	☐	☐
PRIOR HISTORY OR EVALUATION OF THIS COMPLAINT	☐	☐

CHANGE IN
SWALLOWING ☐ ☐

NEUROLOGICAL:	YES	NO
HEADACHES	☐	☐
LOCATION _____		
FREQUENCY _____		
HISTORY FAINTING	☐	☐
" NUMBNESS	☐	☐
" NUMBNESS SITE	☐	☐
" WEAKNESS	☐	☐
" WEAKNESS SITE	☐	☐
" SEIZURES	☐	☐

EXTREMITIES:

JOINT STIFFNESS IN AM	☐	☐
STIFFNESS SITE _____		
DURATION _____		
DOES ASPIRIN HELP?	☐	☐

KNEE PROBLEMS:	YES	NO
LOCKING, UNABLE TO STRAIGHTEN KNEE	☐	☐
FEELING OF GIVING WAY	☐	☐
PAIN ON SQUATTING	☐	☐
PAIN ON KNEELING	☐	☐
PAIN GOING UPSTAIRS	☐	☐
PAIN GOING DOWNSTAIRS	☐	☐

FEMALE PATIENTS:	YES	NO
ARE YOU TAKING BIRTH CONTROL MEDICATION	☐	☐
LAST PAP SMEAR DATE: _____		
ARE YOU PRESENTLY PREGNANT?	☐	☐
LAST MENSTRUAL DATE _____		
MENOPAUSE (IF YES, AGE _____)		
VAGINAL BLEEDING SINCE MENOPAUSE	☐	☐

BRIEFLY DESCRIBE THE NATURE OF YOUR COMPLAINT: _____

Name:
Chart:
Date:

40467-12

DAVID M. DINES, M.D., F.A.C.S., P.C.
JOSHUA S. DINES, M.D.

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, David M. Dines, M.D., and Joshua S. Dines, M.D., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices & Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that David M. Dines, M.D., and Joshua S. Dines, M.D. not require to agree to the restrictions requested.
I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that David M. Dines, M.D., and Joshua S. Dines, M.D., deserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should David M. Dines, M.D., and Joshua S. Dines, M.D., change their notice, they will send a copy of any revised notice to the address I've provided.
I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.
I fully understand and accept / decline the terms of this consent.

_____ / / _____
Patients Signature

_____

Consent Received by _____ on _____.

☐ Consent refused by patient, and treatment refused as permitted.

☐ Consent added to the patient's medical record on _____.

Name:
Chart:
Date:

DAVID M. DINES, M.D., F.A.C.S., P.C.
JOSHUA S. DINES, M.D.
ORTHOPEDIC SURGERY

333 Earle Ovington Blvd.
Suite 106
Uniondale, NY 11553
(516)-482-1037
FAX: (516)-482-9217

IT IS UNDERSTOOD AND AGREED THAT MY PURPOSE OF REQUESTING EXAMINATION AND TREATMENT IS FOR MEDICAL PURPOSES ONLY AND NOT IN CONNECTION WITH PENDING OR PROPOSED LITIGATION. SHOULD SUCH LITIGATION ARISE, IT IS FURTHER UNDERSTOOD AND AGREED THAT THE TREATING PHYSICIAN WILL NOT PARTICIPATE IN ANY WAY IN LITIGATION EXCEPT TO PROVIDE A TRUE AND ACCURATE COPY OF ANY MEDICAL RECORDS AND X-RAYS IN THE POSSESSION AND CONTROL OF THIS OFFICE PURSUANT TO AN AUTHORIZATION BY THE UNDERSIGNED. *

SIGNED: _____

DATE : _____

*UPON PAYMENT OF THE USUAL COPYING CHARGES

Name:
Chart:
Date:

40467-12

Acct #: _____ Name: _____

ePrescribing

David M. Dines, M.D., and Joshua S. Dines, M.D. are in the process of implementing ePrescribing.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your preferred pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- Less confusion caused by handwritten prescriptions and unclear phone calls
- Reduced possibility of medical errors
- Less chance of adverse drug reactions
- Fewer trips to the pharmacy
- A safer, faster, easier way to get your prescription filled

Patient Preferred Pharmacy
Complete Pharmacy information below to indicate which pharmacy your electronic prescriptions will be sent.

_____
Preferred Pharmacy Name / Phone Number

_____
Preferred Pharmacy Address / Street, City, State, Zip

Patient Consent

I agree that David M. Dines, M.D., and Joshua S. Dines, M.D. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
Patient Signature Date

Patient Decline

I decline that David M. Dines, M.D., and Joshua S. Dines, M.D. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes. This does not prevent David M. Dines, M.D., and Joshua S. Dines, M.D. from ePrescribing.

_____ _____
Patient Signature Date

Name:
Chart:
Date:

40467-17

HOSPITAL
FOR
SPECIAL
SURGERY

Dear Patients:

Attached is a disclosure that needs to be signed from David M. Dines, M.D. and Joshua S. Dines, M.D. This disclosure is to inform you of our industry support with Biomet, Inc., Tornier Inc., and Arthrotec Inc. We are required by The Hospital for Special Surgery to inform you that we receive support for our orthopedic research to injured orthopedic patients for treatment of various orthopedic problems and research.

Thank you for your consideration in this matter. If you have any questions, please feel free to contact the doctors or the support staff.

Sincerely,

David M. Dines, M.D.

Joshua S. Dines, M.D.

DMD/JSD/mcb

David M. Dines, MD, FACS, PC
Joshua S. Dines, MD
Orthopedic Surgery & Sports Medicine
333 Earle Ovington Blvd.
Suite 106
Uniondale, NY 11553
tel 516-482-1037
fax 516-482-9217

Name:
Chart:
Date:

David M. Dines, MD

Financial Interest Disclosure Form
Medical Staff, Allied Health Professional Staff,
Residents and Fellows

As your treating physician and as a member of the Medical Staff of the Hospital for Special Surgery (HSS), I would like you to know that I have a financial relationship with Biomet, Inc. and Tornier, Inc., orthopedics device companies whose products I may use, or prescribe, for you in your care at HSS. The following will provide you with information about my financial relationship with these companies:

I am a consultant for Biomet, Inc., for which I receive royalties for the design and invention of bi-modular, total and comprehensive shoulder replacement system devices. I also have a consultant agreement with Tornier, Inc. for which I receive monetary compensation.

I DO NOT RECEIVE ANY PAYMENTS FROM THE COMPANY FOR USE OF THE COMPANY'S PRODUCTS FOR YOUR CARE AT HSS OR FOR THE CARE OF ANY OTHER PATIENTS AT HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact David W. Altchek, MD, Chief of Service, (212-606-1513), the Hospital's Office of Corporate Compliance (212-774-2398), or the Hospital's Office of Legal Affairs (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit to which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

Signature _____
Patient/Parent/Guardian/Health Care Agent Date

Print Name _____
Patient/Parent/Guardian/Health Care Agent

_____
Relationship to Patient

PLACE THE ORIGINAL SIGNED FORM IN THE PATIENT'S MEDICAL RECORD

David M. Dines, MD., FACS
Joshua S. Dines, MD
Hospital for Special Surgery
333 Earle Ovington Blvd.-Ste. 106
Uniondale, NY 11553
Phone: 516 482-1037
Fax: 516 482-9217

FORM FEE

-Please be advised there is a fee for all forms to be completed.

-Fees range from $10.00-$35.00.

-We thank you in advance for your cooperation.

*Please fill out your portion as best as you can to help expedite the process.

Effective Date: April 14, 2003
Revision Date: September 23, 2013

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 to treat me and arrange 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

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date

If you have any questions about this Notice or would like further information, please contact the Privacy Officer at (212) 774-7500.

For 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.

_____

_____

_____

HOSPITAL
FOR
SPECIAL
SURGERY

Joshua S. Dines, MD
Orthopaedic Surgery & Sports Medicine

Associate Professor of Orthopaedic Surgery
Weill Medical College of Cornell University

Cancellation/Rescheduling Policy for Surgery

In an effort to serve our patients better, we have instituted a cancellation/rescheduling policy for scheduled surgery dates.

Scheduling surgery is a time consuming and complicated process, and the office understands that it is very disruptive to patient's normal lives. Likewise, when surgery is indicated, the office invests a considerable amount of time and effort beforehand to ensure that the day of surgery goes as smoothly as possible. Ahead of your surgery, the office commits many hours of work to ensure that all aspects of your care are prepared for-including, but not limited to: pre-certification and follow up with your insurance plan, coordination of your care with related other physicians when indicated and post-operative DME (durable medical equipment) items related to your surgical care.

From time to time, extenuating circumstances cause a surgery to be cancelled/rescheduled. However, in situations when the patient electively cancels/reschedules a procedure within 10 business days of the scheduled surgery, **a non-refundable cancellation/rescheduling fee of $500.00 will be charged to the patient**.

If your surgery is cancelled/rescheduled for a medical reason, documentation is required and this charge does not apply. Please keep this in mind when scheduling your surgery date.

I, _____ have received and reviewed the surgery cancellation/rescheduling policy of Drs. David and Joshua Dines. I hereby accept and agree to adhere to the above policy.

_____

Patient Signature or Parent/Guardian (if patient is a minor)

_____

Date

Omni Building (Mailing Address)
333 Earle Ovington Blvd., Suite 106
Uniondale, NY 11553
tel 516.482.1037
fax 516.482.9217

Hospital for Special Surgery
519 East 72nd St., Suite 203A
New York, NY 10021
tel 212.744.2474

www.joshuadinesmd.com