

Ranawat Orthopedics HSS

- ☐ Chitranjan S. Ranawat, M.D.
- ☐ Amar S. Ranawat, M.D.
- ☐ Anil S. Ranawat, M.D.

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

As your treating physician(s) and as a member(s) of the Medical Staff of Hospital for Special Surgery (HSS), we would like you to know that we have several financial relationships with orthopedic device companies whose products we may use in your care at HSS. The following will provide you with information about our current financial relationships for Ranawat Orthopedics HSS:

Dr. Amar Ranawat:

Dr. Amar Ranawat is a consultant for Ceramtec, LTD, Convatec and DePuy Orthopedics, Inc. Dr. Ranawat also receives research support from Ceramtec, LTD.

Dr. Anil Ranawat:

Dr. Anil Ranawat is a consultant on the unicompartmental knee team for Stryker - MAKO Surgical Corp. Dr. Ranawat is Editor-in-Chief for which receives salary support from Springer, and receives royalties from Elsevier, Inc.

Dr. Chitranjan Ranawat:

Dr. Chitranjan Ranawat is a consultant and product designer for DePuy Orthopedics, Inc. on the Sigma[®] and Attune[™] total knee prosthesis systems for which he receives royalty payments.

WE DO NOT RECEIVE ANY PAYMENTS FROM THESE COMPANIES FOR USE OF THEIR 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 us, you may either contact 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 disclosed to you, you choose to refuse a particular treatment, 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 you understand the financial interest or relationship described above. You also confirm that you have the right to ask any questions to your providing physician.

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

For Office Use Only: If the patient does not sign this acknowledgment form, record here the good faith efforts made to obtain this acknowledgement.

PATIENT REGISTRATION FORM

HOSPITAL FOR SPECIAL SURGERY

Patient Label

PATIENT DEMOGRAPHICS

NAME (AS LISTED ON IDENTIFICATION)		PREFERRED NAME		DATE OF BIRTH	SOC. SEC. NUMBER
SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE ☐ INTERSEX	SEX LISTED WITH HEALTH INSURANCE ☐ FEMALE ☐ MALE	WHAT IS YOUR GENDER IDENTITY? ☐ SAME AS SEX LISTED WITH INSURANCE ☐ OTHER: _____		PREFERRED PRONOUNS ☐ She/Her ☐ Ze/Hir ☐ He/His/Him	
PERMANENT STREET ADDRESS			CITY	STATE	ZIP CODE
COUNTRY	HOME PHONE	CELL PHONE	E - MAIL ADDRESS	☐ MYCHART ☐ DISCHARGE INSTRUCTIONS ☐ DECLINE	
TEMPORARY ADDRESS (IF APPLICABLE)			CITY	STATE	ZIP CODE

GENERAL INFORMATION

HISPANIC ETHNICITY? ☐ YES ☐ NO ☐ UNKNOWN ☐ DECLINE		RACE	ADDITIONAL RACE	ETHNICITY
FURTHER DESCRIPTION OF ETHNICITY # 1	FURTHER DESCRIPTION OF ETHNICITY # 2	RATE YOUR ABILITY TO SPEAK AND UNDERSTAND ENGLISH ☐ VERY WELL ☐ WELL ☐ NOT WELL ☐ NOT AT ALL ☐ DECLINED ☐ UNAVAILABLE		
WHAT IS YOUR PREFERRED SPOKEN LANGUAGE FOR HEALTH CARE INSTRUCTIONS?		IN WHAT LANGUAGE WOULD YOU PREFER READING HEALTH CARE INSTRUCTIONS?		
WOULD YOU LIKE AN INTERPRETER FREE OF CHARGE? ☐ YES ☐ NO	RELIGION	WOULD YOU LIKE RELIGIOUS SERVICES DURING INPATIENT STAY? ☐ YES ☐ NO		
MARITAL STATUS	VISUALLY IMPAIRED? ☐ YES ☐ NO	PLEASE LIST ANY VISUAL OR HEARING NEEDS		

PATIENT CONTACTS

PRIMARY CARE PROVIDER (PCP)	PCP TELEPHONE NUMBER	NOTIFY PCP OF ADMISSION? ☐ YES ☐ NO	NOTIFY PCP OF RESULTS? ☐ ALL ☐ ABNORMAL ☐ NONE
REFERRING PROVIDER	REFERRING PROVIDER TELEPHONE		
PATIENT'S EMPLOYER	PATIENT OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT	RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)			EMPLOYER PHONE

EMERGENCY CONTACT

FULL NAME CONTACT #1		ADDRESS (no., street, apt#, city, state, zip code)			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO
FULL NAME CONTACT #2		ADDRESS			
HOME PHONE	WORK NUMBER	CELL PHONE	RELATIONSHIP TO PATIENT	LEGAL GUARDIAN? ☐ YES ☐ NO	SUPPORT PERSON? ☐ YES ☐ NO

PATIENT REGISTRATION DOWNTIME FORM HOSPITAL FOR SPECIAL SURGERY

GUARANTOR (The person responsible for the bill)

GUARANTOR FULL NAME			ADDRESS (no., street, apt#, city, state, zip code)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER	HOME PHONE	CELL PHONE
EMPLOYER		OCCUPATION	☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ STUDENT		RETIREMENT DATE
EMPLOYER ADDRESS (no., street, city, state, zip code)					EMP PHONE

VISIT INFORMATION

VISIT RELATED TO AN ACCIDENT OR INJURY? ☐ YES ☐ NO		INJURED BODY PART: ☐ RIGHT ☐ LEFT	HOW DID YOUR INJURY OCCUR?
DATE OF INJURY	TIME OF INJURY	PLACE OF INJURY	

INSURANCE INFORMATION

PRIMARY INSURANCE					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER		CLAIM NUMBER (if applicable)		CASE NUMBER
SECONDARY INSURANCE					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			POLICY NUMBER		GROUP/PLAN NUMBER
TERTIARY INSURANCE					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			POLICY NUMBER		GROUP/PLAN NUMBER
WORKER'S COMPENSATION/NO FAULT INSURANCE					
SUBSCRIBER NAME		RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH	EMPLOYER
INSURANCE COMPANY NAME			PHONE NUMBER		
INSURANCE COMPANY ADDRESS			NAME OF CLAIMS ADJUSTER (if applicable)		
POLICY NUMBER	GROUP/PLAN NUMBER		CLAIM NUMBER (if applicable)		CASE NUMBER

New Patient Questionnaire

Orthopedic Sports Medicine and Shoulder

Name:		DOB:	Date:
Height:	Weight:		Age:

What is your dominant hand? Right Left Ambidextrous

Chief Complaint

What is the reason for your visit? _____

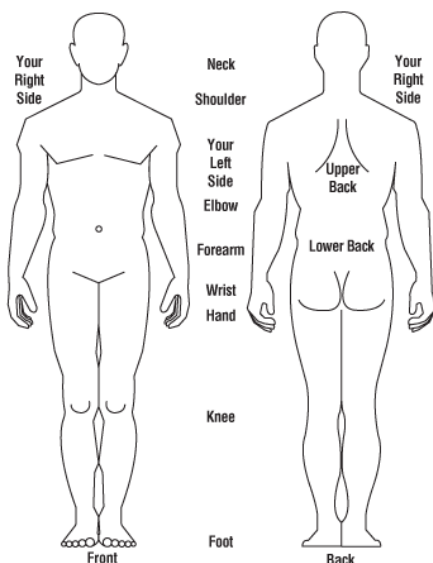
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Catching	Clicking	Other:	

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10
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Please mark on the body diagram where you are experiencing pain:



When did this condition start? _____

Onset: Gradual Sudden

Pain Frequency: Constant Intermittent Rarely

Quality: Sharp Dull Burning
Tingling Throbbing Other

Night Pain: Yes No

Swelling: Yes No

Feels unstable/gives way: Yes No

Range of Motion: Normal Decreased

Everyday Activities: No Restrictions Limited Unable

Recreational Activities: No Restrictions Limited Unable

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play: Professional College High School Recreational

Have you had or tried any of the following (please select and describe)?

Type	Date Range	Location/Results	Effective?	
Acupuncture Treatment			Yes	No
Anti-Inflammatory Medications			Yes	No
Chiropractic Treatment			Yes	No
Injections			Yes	No
Physical Therapy			Yes	No
Massage Therapy/Deep Tissue			Yes	No
MRI				
CT				
X-Ray				

Referring Physician: _____

Phone Number: _____

Screening Questions (Coordination of Care)

Are you currently on any blood thinners? Yes No

Have you ever had a MRSA Infection? Yes No

Have you had Deep Vein Thrombosis (DVT)? Yes No

Have you had a Pulmonary Embolism (PE)? Yes No

Have you ever had any problems with anesthesia? Yes No Problem: _____

Have you ever had complications from prior surgery? Yes No Problem: _____

Have you had surgery for this same condition before? Yes No

Do you have any of the following medical devices? (Mark all that apply)

Pain Pump	Neurostimulator	Pacemaker and/or Defibrillator	Shunt for hydrocephalus
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Do you have diabetes? Yes No

If yes, do you have an insulin pump? Yes No

Have you been taking opioids for 6 months or more (e.g. codeine, percocet, morphine, Vicodin, etc.)? Yes No

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	Yes No	Date:
Do you use birth control?	Yes No	Type:
Have you experienced menopause?	Yes No	When:
Have you had a hysterectomy?	Yes No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	
Age you began your first period:		
When was your most recent menstrual period?	Date:	
How many periods have you had during the last 12 months?		
Number of pregnancies:		

Please list any allergies below (including medications, foods, and environment):

Allergy	Reaction
1.	
2.	
3.	
4.	
5.	

Medication	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Medical and Family History

Please select any past medical conditions and list any family members (mother, father, etc.) below:

Condition	Yourself?	Family Member?	Condition	Yourself?	Family Member?
Anxiety	Yes	Yes	Open Wounds/Ulcers	Yes	Yes
Arrhythmia (Irregular heartbeat)	Yes	Yes	Osteoarthritis	Yes	Yes
Asthma	Yes	Yes	Osteoporosis	Yes	Yes
Bleeding Problems	Yes	Yes	Peripheral Vascular Disease	Yes	Yes
Blood Clots (DVT)	Yes	Yes	Pneumonia	Yes	Yes
Cancer	Yes	Yes	Psychiatric Illness (Depression)	Yes	Yes
Diabetes	Yes	Yes	Pulmonary Embolus	Yes	Yes
Heart Attack	Yes	Yes	Reflex Sympathetic Dystrophy	Yes	Yes
Heart Disease	Yes	Yes	Reflux	Yes	Yes
High Blood Pressure	Yes	Yes	Rheumatoid Arthritis	Yes	Yes
High Cholesterol	Yes	Yes	Seizures	Yes	Yes
Infection	Yes	Yes	Stroke	Yes	Yes
Kidney Disorders	Yes	Yes	Ulcers	Yes	Yes
Lung Disease	Yes	Yes	Other:	Yes	Yes

Please list the family member (father, mother, etc.) to any of the positive responses you listed above:

Surgical and Hospitalization History

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	

Social History

Are you a tobacco user? Yes No

Do you consume alcohol? Yes No

If yes, how many drinks per week? _____

Occupation: _____ Employer: _____

Immunizations and Falls Screening:

Have you received the pneumonia vaccine? Yes No

If yes, date? _____ If not, why? _____

In the past year, did you received the Influenza (flu) vaccine between October 1st and March 31st? Yes No

If yes, date? _____

Have you fallen 2 or more times within the past year, or fallen with injury in the past year? Yes No

If yes, do you have vision problems that may have contributed to your fall? Yes No

Review of Systems

Are you currently having, or have you had problems in the past year with (select all that apply):

Constitutional	ENT	Eyes	Respiratory
Activity Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing
Weight Change			
None	None	None	None

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		
None	None	None	None

Musculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness
None	None	None	None

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	