UCONN | HEALTH CENTER

New England Musculoskeletal Institute

Welcome to the Department of Orthopaedic Surgery in the New England Musculoskeletal Institute at the University of Connecticut Health Center. Thank you for scheduling your appointment with Dr. Katherine Coyner. To learn more about Dr Coyner, feel free to visit her website at www.Drcoyner.com

Enclosed you will find our New Patient Questionnaire, Permission to Treat and Permission to Communicate with family members or other designee. Please complete these forms prior to your visit and bring them with you. **If you've had a MRI, please bring the actual disc with the images and the printed report with you to your appointment.**

Since we are scheduling visits in advance, it is important that you mark your calendar. Kindly call us as soon as possible if you cannot keep this appointment. Please arrive early or on time for your visit to avoid having to reschedule your appointment. The Orthopaedic Department direct number is **(860) 679-6600.**

It is your responsibility to check with your insurance carrier to verify that they will pay for this visit. **Workers Compensation** appointments must be authorized **prior** to your visit. If you fail to mention your injury is Work related, you may be responsible for all fees incurred. If you have sustained a **Motor Vehicle** Injury, we must have a letter from your Auto insurance stating whether you do or do not have "Medpay". Please be sure to bring this letter with you to your visit. If you have not spoken to someone in our Central Registration Department to gather important demographics and insurance information, please contact the registration department prior to your appointment at **860-679-1600 or 800-553-0954**.

Lastly, when you arrive for your appointment, please have with you a **photo ID** and your **insurance cards** for us to scan into your electronic chart. Please note that your co-pay that is designated by your insurance carrier is expected at the time of your visit. The department accepts: Cash / Check / Master Card / Visa and Discover.

We look forward to meeting you and providing you with excellent medical care.

Thank you for choosing the Orthopaedic Department at the New England Musculoskeletal Institute at the UCONN Health Center.

UMG – Ortho

Electronic Medical Record Patient Chart Preparation

Chief Complaint _____

Accident related? □ **Yes** □ **No** **Workers Compensation?** □ **Yes** □ **No**

□**Right** □**Left** □**Bilateral** _____

Duration:_____ **Pain Score: NO PAIN - 0 1 2 3 4 5 6 7 8 9 10 – WORST PAIN (circle one)**

Past treatment / Additional providers:_____

Previous Radiology Studies? □ **Yes** □ **No**

If yes: Dates – Xray_____ **MRI**_____ **CT Scan**_____

Active Medications (list all medication you are currently taking and include herbal, naturopathic or over the counter)

Medication Name	Strength / Directions

Pharmacy 1 Name and Address: _____**Phone:** _____

Pharmacy 2 Name and Address: _____**Phone:** _____

Allergies (Medications, Environmental, Food): □ **No Known Allergies**

Allergy	Reaction	Comments

Past Medical History: check off all medical problems you have had in your lifetime

☐ AIDS / HIV	☐ Congestive Heart Failure	☐ GERD (reflux)	☐ Multiple Sclerosis	☐ Scoliosis
☐ Alcoholism	☐ COPD (emphysema)	☐ Gout	☐ Myocardial Infraction (Heart Attack)	☐ Seizure Disorder
☐ Alzheimer's	☐ Coronary Artery Disease	☐ Hepatitis Type:	☐ Obesity	☐ Sleep Apnea
☐ Anemia	☐ Crohn's Disease	☐ Hyperlipidemia (high cholesterol)	☐ Osteoarthritis	☐ SLE (Lupus)
☐ Angina	☐ Degenerative Joint Disease	☐ Hypertension (high blood pressure)	☐ Osteoporosis	☐ Spinal Stenosis
☐ Arthritis	☐ Depression	☐ Inflammatory Bowel Disease	☐ Parkinson's	☐ Vertebral Joint Disease (Spondyloarthopathy)
☐ Asthma	☐ Diabetes	☐ Juvenile RA	☐ Peptic Ulcer Disease	
☐ Atrial Fibrillation	☐ Drug Abuse	☐ Kidney Disease	☐ Psoriasis	☐ Thyroid Disease
☐ Benign prostatic hypertrophy (prostate enlarged)	☐ DVT	☐ Liver Disease	☐ PVD	☐ Valvular Disease (Heart Valve)
	☐ Fibromyalgia	☐ Lyme Disease	☐ Renal Disease	☐ Other:
☐ CVA / Stroke	☐ Gallbladder Disease	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Other:
☐ Cancer: (date / type / treatment)				

Prior Surgeries or Procedures: list all operations you have had in your lifetime

Date:	Type of Operation

Family History:

Mother	
Father	
Sister	
Brother	

Tobacco Usage:

□ Never Smoked **□ Chewing Tobacco**

□ Current smoker- _____packs per day for ___yrs **☐Former smoker- _____packs per day ___yrs Year Quit _____**

Alcohol Usage:

□ None **☐ Yes: how many days per week _____how many drinks _____**

Substance Abuse:

□ None **☐ Yes: What substance_____ Last use _____**

Neg	Pos	**Constitutional**	○ All Neg
○	○	Chills	
○	○	Fatigue	
○	○	Fever	
○	○	Malaise (uneasiness)	
○	○	Night sweats	
○	○	Weakness	
○	○	Weight Gain	
○	○	Weight Loss	
○	○	Other	

Neg	Pos	**Heent**	○ All Neg
○	○	Blurred Vision	
○	○	Double vision	
○	○	Dysphagia (trouble swallowing)	
○	○	Ear Drainage	
○	○	Facial Pain	
○	○	Headache	
○	○	Hearing Loss	
○	○	Hoarseness	
○	○	Nasal Congestion	
○	○	Ringing in Ears	
○	○	Vertigo (dizziness)	
○	○	Visual Loss	
○	○	Other	

Neg	Pos	**Respiratory**	○ All Neg
○	○	Chest Pain (with breathing)	
○	○	Cough	
○	○	Dyspnea (shortness of breath)	
○	○	Known TB exposure	
○	○	Resent Infection	
○	○	Wheezing	
○	○	Other	

Neg	Pos	**Gastrointestinal**	○ All Neg
○	○	Abdominal Pain	
○	○	Black Tarry Stools	
○	○	Constipation	
○	○	Diarrhea	
○	○	Heartburn	
○	○	Jaundice	
○	○	Loss of Appetite	
○	○	Nausea	
○	○	Vomiting	
○	○	Other	

Neg	Pos	**Neurological**	○ All Neg
○	○	Difficult Walking	
○	○	Poor Coordination	
○	○	Memory Loss	
○	○	Muscle Weakness	
○	○	Paresthesia (tingling)	
○	○	Seizures	
○	○	Tremors	
○	○	Other	

Neg	Pos	**Cardiovascular**	○ All Neg
○	○	Chest Pain	
○	○	Cyanosis (skin discoloration)	
○	○	Heart Murmur	
○	○	Leg Swelling	
○	○	Palpitations	
○	○	Syncope (fainting)	
○	○	Other	

Neg	Pos	**Genitourinary**	○ All Neg
○	○	Dysuria (urinary discomfort)	
○	○	Frequent urination	
○	○	Hematuria (bloody urine)	
○	○	Urge Incontinence	
○	○	Urinary Incontinence	
○	○	Other	

Neg	Pos	**Metabolic/Endocrine**	○ All Neg
○	○	Cold Intolerance	
○	○	Hair Loss	
○	○	Heat Intolerance	
○	○	Other	

Neg	Pos	**Integumentary**	○ All Neg
○	○	Contact Allergy	
○	○	Itchy Skin	
○	○	Rash	
○	○	Skin Infections	
○	○	Skin Lesions	
○	○	Other	

Neg	Pos	**Psychiatric**	○ All Neg
○	○	Anxiety	
○	○	Depression	
○	○	Insomnia	
○	○	Other	

Neg	Pos	**Musculoskeletal**	○ All Neg
○	○	Back Pain	
○	○	Body Aches	
○	○	Bone/Joint pain	
○	○	Rheumatologic Manifestations	
○	○	Other	

Neg	Pos	**Immunologic**	○ All Neg
○	○	Asthma	
○	○	Bee sting Allergies	
○	○	Contact Dermatitis	
○	○	Environmental Allergies	
○	○	Food Allergies	
○	○	Seasonal Allergies	
○	○	Other	

Neg	Pos	**Hematologic Lymphatic**	○ All Neg
○	○	Bleeding	
○	○	Bruising	

UCONN HEALTH

UConn John Dempsey Hospital
UConn Medical Group

(Patient Identification)

CONSENT TO TREATMENT AND USE AND DISCLOSURE OF HEALTH INFORMATION

CONSENT TO TREATMENT: I consent to clinical care and treatment by UConn Health* (*see reverse for locations). I consent to any routine diagnostic procedures (including voluntary testing for HIV), examination and any other service provided to me by or at the direction of my physician/dentist. I consent to the use of audiovisual technology for purposes of my clinical care. UConn Health is an academic medical center, so residents/students may be involved in my care.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI"): I consent to UConn Health's use of my PHI, including drug and/or alcohol abuse information, psychiatric information, and HIV-related information, for treatment, payment and health care operations. UConn Health may disclose or allow electronic access to my PHI so that my primary care provider, referring physician(s), and other health care providers have this information when treating me and coordinating my healthcare. UConn Health will communicate with me using the email address I provide and update from time to time allowing me to electronically access my available PHI, complete surveys, and communicate with my care team. I also allow UConn Health to disclose my PHI to the health insurance plan or payer financially responsible for my care. To avoid disclosure to my health insurance plan, I must agree in writing that I will self-pay for my care. If I have agreed to self-pay for care at UConn John Dempsey Hospital, I may receive a copy of those charges by contacting Patient Accounts at 860-679-2000.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: Before signing this consent, I had opportunity to receive and/or review UConn Health's Notice of Privacy Practices (NoPP), and consent to the use and disclosure of my PHI for treatment, payment and health care operations. I may receive notification of any future changes to these privacy practices by contacting UConn Health's Privacy Officer. While I may request restrictions to how UConn Health uses and/or discloses PHI about me for treatment, payment or health care operations, UConn Health is not required to agree to my restrictions and in these circumstances may refuse to provide non-emergency care. However, if I refuse to disclose my psychiatric information, this will not affect my right to obtain treatment, except when UConn Health reasonably determines that failing to disclose information could adversely impact my healthcare. If UConn Health does agree to a restriction I request, they will follow our agreement. The NoPP is available for reading or listening via audio file at http://health.uconn.edu/disclaimersprivacy/

FOR STAFF USE ONLY: If unable to obtain patient's consent or provide Notice of Privacy Practices, indicate the reason:
□ Emergency; □ Patient refusal; □ Other: _____

ASSIGNMENT AND AUTHORIZATION MEDICARE/MEDICAID/COMMERCIAL INSURANCE CERTIFICATION: I certify that the insurance information given by me to pay my bills is correct. I authorize UConn Health to release to my insurance company any information needed for payment and request that payment of authorized benefits be made on my behalf. I assign the benefits payable for UConn Health (physicians or other ordering providers) furnishing services to me, and authorize UConn Health to submit claims to potential third-party payers for me. I request that this consent form apply to all services related to my care. This consent will be valid for one year. I have the right to revoke this consent by contacting UConn Health's Information Management Department, except when they have already taken steps relying on this consent.

_____ _____ _____

Patient Signature or Authorized Representative** **Date** **Time □ AM □ PM**

_____

Print Name

****Note: if signing on behalf of the patient, I am:**
□ Parent; □ Guardian; □ Representative (specify):

_____

HCH901

(Patient Identification)

* "UConn Health" includes all locations of the following: UConn John Dempsey Hospital, UConn Medical Group (UMG), University of Connecticut School of Medicine, University Dentists, University of Connecticut School of Dental Medicine.

Information that UConn Health releases is subject to these notices:

Psychiatric Information: In the event that information released constitutes confidential psychiatric information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

Drug and Alcohol Abuse Information: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV-Related Information: In the event that information released constitutes confidential HIV-related information protected under Connecticut law:
This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

UCONN HEALTH

UConn John Dempsey Hospital
UConn Medical Group

(Patient Identification)

Permission to Communicate with Family and/or Others Involved in Your Care

As a patient at UConn Health you have a right to restrict who you want us to communicate with regarding your health information. If you would allow us to routinely communicate with any family, friends or others involved in your care please let us know their names and contact information. We will only communicate with those individuals that you note below.

Please print below the name(s) of persons with whom we may discuss your health information. Also provide their relationship to you and their contact information.

- Name of family member or friend:_____
  Relationship to you: _____
- Phone number: _____

- Name of family member or friend:_____
  Relationship to you: _____
- Phone number: _____

Hospital visitation ONLY: You also have the right to identify a support person for this purpose.

Support Person (for visitation):_____

_____
Print Patient Name

_____
Print Patient Name

_____ _____
Date Time □ AM □ PM

STAFF USE ONLY:
Inpatients (exception Psychiatry and CMHC): Complete a form for each inpatient at every admission. Retain paper copy in chart.
Outpatients in JDH and UMG clinics: Assure a form is completed for each new patient to UConn Health. Enter information into GE (IDX). Registration staff update annually and front desk staff update at the patient's request.
Outpatients in Psychiatry: Assure a form is completed for each patient. Retain paper copy in chart. Registration staff update annually and department staff update at the patient's request.
Dental locations: Complete a form for each new dental patient. Enter information into axiUm. Check for updates at each visit and enter any changed information into axiUm.

HCH1397

Address
Old Avon Orthopaedics, LLC
2 Simsbury Road
Avon, CT 06001

From I-84 West Bound

Take exit 43 (Park Road/West Hartford Center). Turn left at light at end of ramp. At second light turn right onto South Main Street for 2.2. miles. Take a left at light onto Route 44 West (Albany Avenue). Go over Avon Mountain approximately 4.3 miles. Stay straight through light onto Route 10/44 West for .5 miles. Turn right onto Route 10 North/202 (Simsbury Road). Old Avon Orthopaedics, LLC is on the right. (Post Office entrance)

From I-84 East Bound

Take exit 39 (Farmington/ Route 4) and proceed straight through the light at the intersection of Route 4. Proceed into Farmington and at the light (Farmington Golf Club is on the right) take a right on to Route 10. Follow Route 10 until it intersects with Route 44 at Avon Old Farms. Take a left and stay straight through light onto Route 10/44 West for .5 miles. Turn right onto Route 10 North/202 (Simsbury Road). Old Avon Orthopaedics, LLC is on the right. (Post Office entrance)

Address
Musculoskeletal Institute (MSI)
UConn Health
3RD Floor, Suite 2
263 Farmington Avenue
Farmington, CT 06030

From Bradley International Airport
Follow Route 20 to I-91 South to I-84 West in Hartford. Follow I-84 West about 7 miles to Exit 39 which is after 39A. Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the UConn Health campus.

From Farmington Center
Stay on Route 4 East/Farmington Avenue. As you drive up the hill toward I-84, stay in the right lane and follow the signs as Route 4 East/Farmington Avenue loops to the right and crosses the I-84 access road. At the fourth traffic light, turn right to enter the UConn Health campus.

From West Hartford Center
Stay on Farmington Avenue/Route 4 West. The UConn Health is about 3.3 miles on the left.

From Route 44 Canton/Avon
Proceed on Route 44 eastbound through Avon. Turn right onto Route 10 South/Waterville Road. Turn left onto Talcott Notch Road and continue to Farmington Avenue/Route 4 West. Turn right; the UConn Health is a 1/4 mile on the left.

From I-84
Take Exit 39 (if coming from I-84 West, Exit 39 is after 39A). Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the UConn Health campus.

From Northbound Route 9
Take Exit 32 (left exit) onto I-84 West and stay in the right lane. Take Exit 39 (first exit). Turn right at the first traffic light onto Route 4 East (Farmington Avenue). At the third traffic light, turn right to enter the UConn Health campus.

From the entrance, proceed to the roundabout and follow the signs to the UConn Musculoskeletal Institute. A patient drop off lane is available at the ground level entrance. Parking is available in Garage 1. There is a ground-level entrance to the garage directly past the UConn Musculoskeletal Institute building on the right.
Parking and entrance to the physicians' offices are accessible via a pedestrian bridge located on level 3.