SHORE ORTHOPAEDIC GROUP – NEW PATIENT INFORMATION FORM

DATE: _____

LAST NAME: _____ **FIRST NAME (LEGAL):** _____ **M.I.** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

SOCIAL SECURITY #: _____ **DATE OF BIRTH:** _____ **AGE:** _____

HOME#: _____ **CELL#:** _____

WORK #: _____ **EMAIL:** _____

SEX: ☐ **M** ☐ **F** **MARITAL STATUS:** ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

RACE: _____ **ETHNICITY:** _____ **PREF LANGUAGE:** _____

EMERGENCY CONTACT

NAME: _____ **RELATIONSHIP:** _____ **PHONE#:** _____

IF PATIENT IS A MINOR – PARENT'S SOCIAL SEC# _____

REFERRED BY: ☐ **PRIMARY PHYSICIAN** ☐ **OTHER PHYSICIAN** ☐ **FRIEND** ☐ **OTHER** _____

YOUR PRIMARY CARE PHYSICIAN: _____ **CITY:** _____ **STATE:** _____

REFERRING PHYSICIAN: _____ **ADDRESS:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ **PHONE#:** _____

EMPLOYER INFORMATION

NAME: _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____ **PHONE#:** _____

OCCUPATION: _____

CURRENT PROBLEM

PLEASE BRIEFLY DESCRIBE: _____

_____

IS PROBLEM ON YOUR: ☐ **RIGHT SIDE** ☐ **LEFT SIDE** **DATE OF ONSET:** _____

HEALTH INSURANCE INFORMATION

PRIMARY

CARRIER: _____ **NAME OF INSURED (POLICY HOLDER):** _____

ADDRESS: _____ **ID NUMBER:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

INSURED'S EMPLOYER: _____ **SS#:** _____ **DOB (MM/DD/YEAR):** _____

SECONDARY

CARRIER: _____ **ID NUMBER:** _____

NAME OF INSURED (POLICY HOLDER): _____ **SS#:** _____ **DOB (MM/DD/YEAR):** _____

INSURED'S EMPLOYER: _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

IF APPLICABLE, COMPLETE THE FOLLOWING

☐ **WORKMAN'S COMPENSATION OR** ☐ **AUTO RELATED INJURIES**

INSURANCE CO: _____ **DATE OF ACCIDENT:** _____

ADDRESS (NOT AGENT): _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____ **PHONE#:** _____

CLAIM#: _____ **ADJUSTER'S NAME:** _____

NAME OF INSURED (POLICY HOLDER): _____

ATTORNEY'S NAME (IF APPLICABLE): _____ **PHONE #:** _____ **EXT:** _____

EMPLOYER AT TIME OF INJURY: _____ **PHONE#:** _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP CODE:** _____

MEDICAL HISTORY FORM

ARE YOU: ☐ **RIGHT HANDED** ☐ **LEFT HANDED**

DESCRIBE ANY MEDICAL TREATMENT YOU HAVE ALREADY RECEIVED FOR THIS PROBLEM: _____

_____

LIST ANY PREVIOUS SURGERIES AND DATES (NOT NECESSARILY RELATED TO PRESENT PROBLEM)

DATE	SURGERY	DATE	SURGERY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING

_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST ANY ALLERGIES TO MEDICATIONS

_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE COMPLETE THE FOLLOWING TO THE BEST OF YOUR ABILITY

HEIGHT: _____ **WEIGHT:** _____ **BLOOD PRESSURE:** _____

DO YOU SMOKE: ☐ **YES** ☐ **NO** **HOW MUCH?** _____ **DO YOU DRINK? :** ☐ **YES** ☐ **NO** **FREQUENCY:** _____

LIST ALL PRESENT MEDICAL PROBLEMS

_____	_____	_____
_____	_____	_____
_____	_____	_____

HAVE YOU EVER HAD PROBLEMS WITH

ASTHMA	☐ YES	☐ NO	**HEPATITIS**	☐ YES	☐ NO
BLADDER	☐ YES	☐ NO	**HIATAL HERNIA**	☐ YES	☐ NO
BLEEDING TENDENCIES	☐ YES	☐ NO	**HIGH BLOOD PRESSURE**	☐ YES	☐ NO
BOWELS	☐ YES	☐ NO	**KIDNEYS**	☐ YES	☐ NO
BREATHING DIFFICULTIES	☐ YES	☐ NO	**LIVER DISEASE**	☐ YES	☐ NO
CANCER	☐ YES	☐ NO	**LUNGS**	☐ YES	☐ NO
CIRCULATION	☐ YES	☐ NO	**OSTEOPOROSIS**	☐ YES	☐ NO
COORDINATION	☐ YES	☐ NO	**PROSTATE PROBLEMS**	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO	**SHORTNESS OF BREATH**	☐ YES	☐ NO
DIGESTION	☐ YES	☐ NO	**SUBSTANCE ABUSE**	☐ YES	☐ NO
DIZZINESS	☐ YES	☐ NO	**THYROID**	☐ YES	☐ NO
EMOTIONAL PROBLEMS	☐ YES	☐ NO	**ULCER DISEASE**	☐ YES	☐ NO
EPILEPSY	☐ YES	☐ NO	**VISION**	☐ YES	☐ NO
GALL BLADDER	☐ YES	☐ NO	**WATER RETENTION**	☐ YES	☐ NO
GOUT	☐ YES	☐ NO	**OTHER:** _____		
HEARING PROBLEMS	☐ YES	☐ NO	_____		
HEART PROBLEMS	☐ YES	☐ NO			
• **CHEST PAINS**	☐ YES	☐ NO			
• **PALPITATIONS**	☐ YES	☐ NO			

MEDICAL RELEASE - PLEASE SIGN

I HEREBY AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO MY PHYSICIAN ON ALL INSURANCE SUBMITTED BY SHORE ORTHOPAEDIC GROUP FOR COVERED SERVICES RENDERED. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY NON-REIMBURSED AMOUNTS OF MY BILL. I AUTHORIZE RELEASE OF ANY PERTINENT MEDICAL RECORDS AND/OR X-RAYS CONCERNING MY CARE TO INSURANCE COMPANIES, AND/OR MY ATTORNEY OF RECORD, AND/OR SHORE ORTHOPAEDIC GROUP. I ALSO AUTHORIZE RELEASE OF MEDICAL DATA THAT INCLUDES REDISCLOSURE OF MEDICAL INFORMATION OBTAINED FROM OTHER PROVIDERS. I PERMIT A PHOTOSTAT COPY OF THIS AUTHORIZATION BE USED IN PLACE OF THE ORIGINAL.

I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

SIGNATURE: _____ **DATE:** _____

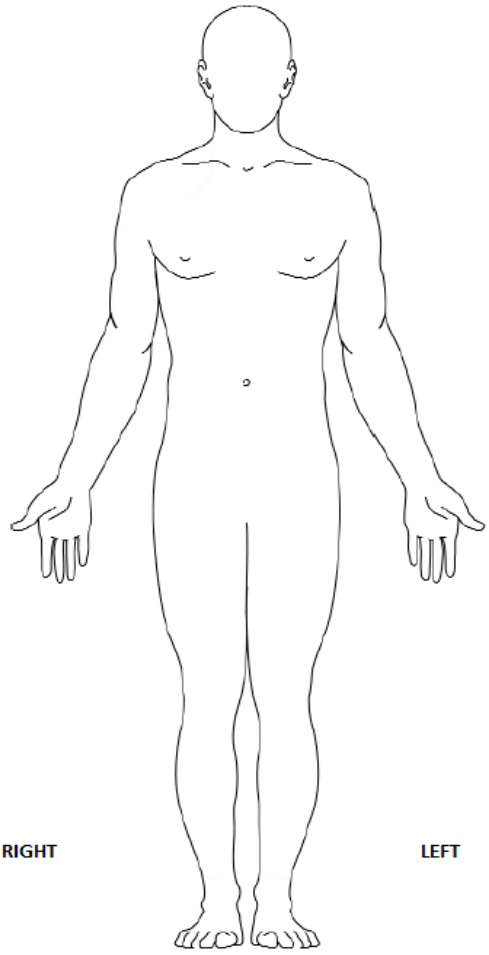
PATIENT PAIN DRAWING

NAME: _____ DATE: _____

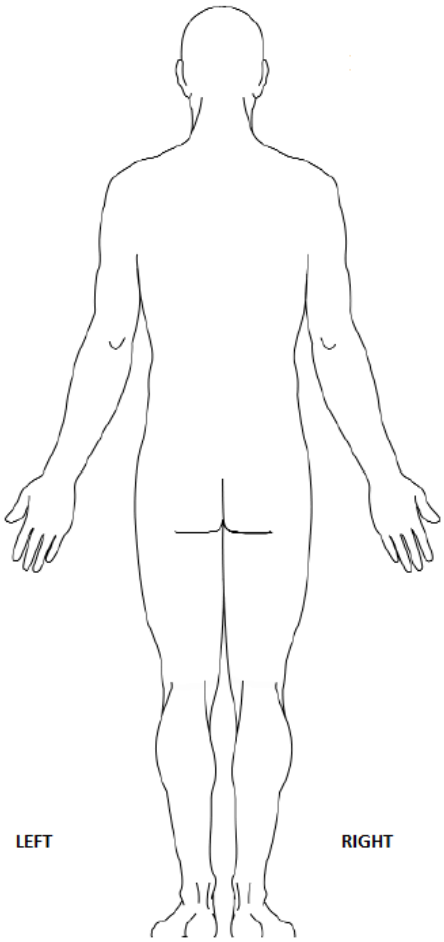
Where is pain now? _____

Mark the area on your body where you feel the sensations described below using:

Aching	Numbness	Pins & Needles	Burning	Stabbing
▽▽▽	========	OOOOOO	xxxxxxx	////////



FRONT



BACK

How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line below how bad your pain is now:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Pain imaginable)

SHORE ORTHOPAEDIC GROUP - OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment.

All patients must complete our information form in its entirety before seeing the doctor.

IF WE ARE NOT PARTICIPATING WITH YOUR INSURANCE PLAN, FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, OR ATM/CREDIT CARDS.

REGARDING YOUR INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You are responsible to know your insurance policy. In the event that we do accept assignment of benefits, we require that you provide a credit card with authorization to bill that account for the balance. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your responsibility. Please be aware that some and perhaps all of the services that are provided may be uncovered services, and not considered reasonable and necessary under the Medicare program and/or other medical insurance if doctor is non-participating with the insurance company. I authorize the insurance company to forward payment directly to the physician. Should payment be sent directly to me, it is my responsibility to forward payment directly to physician. This office does not accept any and all medicaid insurances. By signing this waiver you are aware that you are responsible.

I AUTHORIZE MY INSURANCE CARRIER TO FORWARD PAYMENT TO MY PHYSICIAN'S OFFICE.

A CURRENT REFERRAL IS REQUIRED FOR OUR MANAGED CARE PATIENTS AT TIME OF SERVICE.

Insurance plans, where we are a participating provider, co-payments are due prior to treatment. You will be billed for any deductible and co-insurance amounts. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Patients involved in worker's compensation or motor vehicle injuries must provide this office with an open claim number, name and address of insurance company, adjuster's name and phone number, in addition to your health insurance information. In the event that your claim is denied, you will be held responsible for all charges incurred. In accordance to New Jersey state laws, patients involved in motor vehicle accidents are responsible for their deductible and co-insurance amounts which may vary depending on your policy. Please refer to the above paragraph concerning your health insurance coverage for any outstanding balances.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS

Adult patients are responsible for full payment according to their plan at the time of service.

MINOR PATIENTS

A minor must be accompanied by a parent or guardian. The adult accompanying the minor is responsible for full payment. Unfortunately we cannot get involved in divorce and custody matters.

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, we reserve the right to charge at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THESE TERMS.

_____	_____	_____
Please Print Name	Signature of patient or responsible party	Date

SHORE ORTHOPAEDIC GROUP L.L.C

www.shoreortho.com

35 Gilbert Street South • Tinton Falls, New Jersey 07701 • (732) 530-1515 • Fax (732) 747-5433
1255 Route 70 • Lakewood, New Jersey 08701 • (732) 942-2300 • Fax (732) 942-2311
Interventional Pain Medicine • 1255 Route 70 • Lakewood, 08701 • New Jersey (732) 942-2020 • Fax (732) 942-2021

+ * CARY D. GLASTEIN, M.D., F.A.C.S., F.A.A.S.S., F.A.A.O.S.
* CHARLES C. RIZZO, M.D., F.A.C.S., F.A.A.O.S.
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Orthopaedic Surgery
Sports Medicine
Scoliosis
Spinal Reconstruction Surgery
Total Joint Replacement and Revision
Foot and Ankle Surgery
Laser Surgery
Shoulder & Elbow Surgery
Interventional Pain Medicine
Electrodiagnostic Testing

_____

PATIENT'S NAME (PLEASE PRINT)

Shore Orthopaedic Group may leave messages at my home/cell. _____
Initials

I do not wish to have messages left at my home/cell. _____
Initials

An alternative number to reach me at is: _____ _____
Initials

Shore Orthopaedic Group may call me at my work/office. _____
Initials

I authorize the following person(s) to speak to Shore Orthopaedic Group on my behalf:

_____ _____
Initials

Shore Orthopaedic Group may speak to my spouse. _____
Initials

_____ _____
Patient's Signature Date

* Fellow of the American Board of Orthopaedic Surgeons
+ Clinical Assistant Professor of Orthopaedic Surgery Drexel University

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Initials:_____ Reason:_____

* Fellow of the American Board of Orthopaedic Surgeons
+ Clinical Assistant Professor of Orthopaedic Surgery Drexel University

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OWNERSHIP DISCLOSURE STATEMENT

This is to advise you that the doctors have ownership interests in treatment or surgery Centers to which you may be referred. This is to further advise you that you may choose any facility available for the purpose of obtaining the particular procedure or test being performed and to let the physician know if you wish to choose a certain facility or center other than the one which you have been referred. The facilities or centers whereby the physicians have ownership interest may include, but are not limited: Lakewood Surgery Center.

I have read and understand the above.

_____
(Patient signature)

_____
(Date)

Legal Assignment of Benefits & Designation of Authorized Representative

I, _____ represent that I have valid and in-force insurance and/or employee health care benefits coverage, and hereby assign and convey directly to Shore Orthopaedic Group, LLC (the "provider(s)"), as my Statutory Derivative Beneficiary (SDB), commonly known as a Designated Authorized Representative, and a Claimant under the "patient Protection and Affordable Care Act" (PPACA), existing ERISA and other applicable federal and state laws, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from the provider(s), regardless of the provider's managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to the provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from the provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including but not limited to, (1) obtaining information about the claim to the same extent as the assigner; (2) submitting evidence; (3) making statements about factors or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by the provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including if necessary, to bring suit by the provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date

_____

Please Print name of Insured/Guardian

IF YOU WERE INVOLVED IN A WORKERS COMPENSATION INJURY, PLEASE COMPLETE THIS FORM

DATE OF INJURY: _____

DESCRIBE THE INJURY: _____

_____

_____

_____

DESCRIBE YOUR TREATMENT SO FAR:
1ST DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? □ YES / □ NO
TREATMENT PROVIDED: _____

2ND DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? □ YES / □ NO
TREATMENT PROVIDED: _____

3RD DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? □ YES / □ NO
TREATMENT PROVIDED: _____

4TH DOCTOR SEEN: DR. _____ WHEN? _____ STILL SEEING? □ YES / □ NO
TREATMENT PROVIDED: _____

HAVE YOU HAD PHYSICAL THERAPY? □YES OR □ NO HOW LONG? _____ STILL GOING? Y / N HELFPUL? Y / N

DID YOU HAVE AN MRI? □ YES / □ NO WHICH BODY PART? _____

DID YOU HAVE ANY INJECTIONS? □ YES / □ NO WHAT KIND? _____

OTHER TREATMENT: _____

HOW MUCH TIME DID YOU TAKE OFF FROM WORK FOLLOWING THE ACCIDENT? _____

WERE YOU ABLE TO RETURN TO WORK? □ YES / □ NO WHEN? _____

ANY DOCTORS RESTRICTIONS? _____

ARE YOU ON SHORT TERM DISABILITY? □ YES / □ NO ARE YOU ON LONG TERM DISABILITY? □ YES / □ NO

WHAT IS YOUR OCCUPATION? _____

EMPLOYER: _____

HOW LONG HAVE YOU BEEN AT THIS JOB? _____

LIST PRIOR EMPLOYMENT AND HOW LONG YOU WERE THERE

_____ _____

_____ _____

DESCRIBE YOUR CURRENT JOB AND ANY PHYSICAL DEMANDS:
HOURS/DAY: _____ DAYS A WEEK: _____ LENGTH OF COMMUTE: _____

ANY LIFTING? □ YES / □ NO HOW MANY POUNDS? _____ HOW FREQUENTLY? _____

REACHING? □ YES / □ NO PULLING? □ YES / □ NO PUSHING? □ YES / □ NO OVERHEAD ACTIVITY? □ YES / □ NO

KNEELING? □ YES / □ NO BENDING? □ YES / □ NO CROUCHING? □ YES / □ NO DRIVING? □ YES / □ NO

OTHER PHYSICAL DEMANDS: _____

_____

_____

DESCRIBE ANY PRIOR ACCIDENTS OR INJURIES. GIVE DATES, BODY PART INJURED, TREATMENT AND WHETHER OR NOT IT RESOLVED.

_____

_____

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Please complete the following information to help expedite your check-in process

Patient Name: _____

Date of Birth: _____

Pharmacy: _____

Pharmacy Address/Town: _____

Pharmacy Phone #: _____

Height: _____

Weight: _____

Smoking Status

Tobacco Usage: Never _____ Current Smoker_____ Former _____

Type: Cigarettes _____ Cigars_____ Chewing ____ Other _____

Years Used: _____

Frequency: Daily_____ Packs per Day_____ Occasionally _____

Do you have a family history of any of the following?

	Mother	Father	Sister	Brother
Arthritis	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cardiac Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____