

PATIENT INFORMATION

Today's Date _____

Patient Name Please click one Male Female
E-mail
Address City
State Zip Birth Date Age
Height Weight
Social Security # Marital status M S D W P
Home Phone Work Phone Cell Phone
Employment Status
F/T P/T F/T student P/T student
Self-Employed Disabled Unemployed Retired

DOCTOR INFORMATION

Which doctor are you seeing today?

Referring Doctor/Athletic Trainer/ Physical Therapist/etc.

Name Address Phone#

Family Medical Doctor

Name Address Phone#

Have you been seen for this injury previously? Yes No

If yes, by whom

INJURY INFORMATION

Date of injury or accident or onset of symptoms

Part of body you are being seen for today

click one Right Left Both

Describe your injury or the onset of your symptoms

Do you have any of the following medical problems? Please click all that apply.

Asthma	Anemia	Stroke	High Blood Pressure
Heart Murmur	Irregular Heartbeat	Heart Attack	Lupus
Ulcers	Gout	Skin Rashes/Psoriasis	Emphysema
Kidney Problems	Hepatitis	Diabetes	Irritable Bowel
Rheumatoid Arthritis	Osteoarthritis	Pulmonary Emboli	Phlebitis
Multiple Sclerosis	Osteoporosis	High Cholesterol	Liver Disease
Cancer			

If you checked off Cancer, please tell us what type:

SURGERY

Have you ever had surgery? Please click and give dates to all that apply.

Appendix	Tonsils	Gallbladder	Gynecologic
Breast Biopsy	Heart Surgery	Hernia Repair	Bowel/Colon
Orthopaedic Surgery		Other	

MEDICATIONS

Do you take any of the following medications on a regular basis? Please click all that apply.

Aspirin	Birth Control Pills	Tylenol	Coumadin	Anti-Inflammatory
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Please list any prescription medications:

**Do you have any allergies to any medications?*

FAMILY HISTORY

Do your parents, siblings, or grandparents have any of the following? Please click all that apply.

High Blood Pressure	Heart Disease	COPD/Emphysema	Stroke
Pulmonary Embolism	Rheumatoid Arthritis	Liver Disease	Diabetes
Crohns Disease	Osteoarthritis	Osteoporosis	Cancer
Ulcerative Colitis	Thyroid Disease	Asthma	

SOCIAL HISTORY

Please click all that apply.

Smoke Tobacco Drink Alcohol Been treated for chemical dependence

Education (highest level achieved)

High School Technical School College Advanced Degree

PRIMARY INSURANCE

Please click one

Managed Care	Private Insurance	Medicare	School Insurance
Self Pay	PPO	POS	HMO

Name of Insurance plan

Claim address

Policy #

Group #

Subscriber's name

Subscriber's address

Name of employer

Employer's address

Subscriber's work phone #

Cell phone #

Date of birth

Social Security #

Please circle one

Male

Female

Is this insurance coverage through the subscriber's employer? YES NO

Effective date of insurance

SECONDARY INSURANCE

Please click one

Managed Care

Private Insurance

Medicare

School Insurance

Self Pay

PPO

POS

HMO

Name of Insurance plan

Claim address

Policy #

Group #

Subscriber's name

Subscriber's address

Name of employer

Employer's address

Subscriber's work phone #

Cell phone #

Date of birth

Social Security #

Please circle one

Male

Female

Is this insurance coverage through the subscriber's employer?

YES

NO

Effective date of insurance

****If this is a workers comp or motor vehicle related injury please complete the information below****

Please click one

Workers Comp

Motor Vehicle

Insurance Company

Adjuster/Case Manager

Phone #

Address

Claim #

Employer

Name

Date

Patients with no insurance: payment is expected at the time of service. A specific payment plan acceptable to both you and the office may be arranged.

Patients with insurance: deductibles and all co-payments are expected at the time of service. Your co-payment is not covered by your insurance and is not always an exact percentage. You will be sent a statement showing both your account balance and your anticipated responsibility. If a patient balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney for collection.

We extend to our patients, the courtesy of allowing you to assign your insurance benefits directly to our office. This policy may reduce your out of pocket expense.

Please note the following:

1. The privilege of insurance assignment begins when you insurance is qualified and the insurance forms are received. Until that time you must pay for all services rendered.
2. Since we do not own your insurance policy we are limited in our efforts to collect from your insurance company. We expect that you act on your own behalf with your insurance carrier. Frequent calls on the status of your claim often help speed this process.
3. Due to recent changes in our status with most insurance companies, it will be your responsibility to turn over to our office any checks and related explanations of benefits that your insurance company issues to you for services rendered with Professional Orthopaedic Associates in a timely manner.
4. This office does not promise that an insurance company will pay the usual and customary charges to this office, nor does this office enter into any dispute with any insurance companies over that amount of the reimbursement.

It is the goal of this office to provide you with the finest quality of care available. If you have any questions regarding your health care or any of our office policies, please do not hesitate to let us know.

By typing your name below, it verifies that you have reviewed these office policies and accept the responsibilities as detailed above.

I have reviewed these office policies and accept my responsibilities as detailed above.

Signature

Date

I authorize my insurance company to make payments for my unpaid balance directly to: Professional Orthopaedic Associates. I hereby authorize the release of information relating to my care directly to my insurance company, attorney, school or any other treating specialist.

Signature

Date

Authorization to Use or Disclose Health Information

Professional Orthopaedic Associates, P.A.

Date of Request

Patient Name

Date of Birth

Address

**As required by the Privacy Regulations, Professional Orthopaedic Associates, P.A. may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization. **

I, _____, give permission for Professional Orthopaedic Associates, P.A. and any of its employees to release any or all of my Patient Health Information to the following relatives, friends or acquaintances.

Patient information to be disclosed: All

For the specific purpose of: Any Effective date for authorization:

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, this information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. I understand I have the right to:

1. Revoke this authorization by sending written notice to this office that revocation will not effect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

Signature of Patient or Patient's authorized representative

Date

Authorized signature of Professional Orthopaedic Associates Staff

Date

Please provide your pharmacy information

Patient Name

Date

Pharmacy Name

Pharmacy Address

City

State

Zip Code

Phone Number

Fax Number

If your injury does warrant surgery, please be advised that your ambulatory surgery may be scheduled at the

Shrewsbury Surgery Center

655 Shrewsbury Ave. - Shrewsbury, New Jersey

Toms River Surgery Center

1430 Hooper Ave. - Toms River, New Jersey

The physicians at Professional Orthopaedic Associates

have an ownership interest in the Surgery Centers.

Patients that wish to have their ambulatory surgery performed

elsewhere may do so at a hospital where the physician maintains privileges.

Thank you

Professional Orthopaedic Associates

Office Locations

Tinton Falls Office

776 Shrewsbury Ave. Suite #105 - Tinton Falls, NJ 07724 - P: 732-530-4949 - F: 732-530-3618

Toms River Office

1430 Hooper Ave. Suite# 101 - Toms River, NJ 08753 - P: 732-341-6777 - F: 732-349-7722

Freehold Office

303 West Main Street - Freehold, NJ 07728 - p: 732-577-0027 - f: 732-577-0036