

**PATIENT INFORMATION**

Doctor you are seeing today: Gregg R. Foos, MD

PATIENT NAME  Appointment Date

PLEASE CHECK  Male  Female ARE YOU:  Right  Left Handed  Ambidextrous

MARITAL STATUS  M  D  S  W  P

BIRTHDATE  AGE  HEIGHT  ft  in WEIGHT  lbs

OCCUPATION

FT /  PT /  Self-Employed /  Unemployed /  Retired /  Disabled /  FT Student /  PT Student

**DOCTOR INFORMATION**

Referring Doctor / Athletic Trainer / Physical Therapist / Friend

Family Medical Doctor

**INJURY INFORMATION**

Date of injury or accident or onset of symptoms

Part of body you are being seen for today  Left  Right  Bilateral

Describe your injury or the onset of your symptoms  Auto Accident?  Work Injury?

Have you been seen for a previous injury or symptoms for this body part?  Yes  No

If yes, by whom

**TREATMENT**

Seen in ER?

When

Where

Treatments?

Injection  Physical Therapy  NSAID / Pain Meds  Brace

Tests/Scans Done?

X-rays  MRI  CAT Scan  Bone Scan  Nerve Test (EMG/NCV)

Where?  Did you bring them with you today?  Yes  No

**PAIN ASSESSMENT**

Please indicate the level of your pain for the injury listed above. Please circle the number below.

0 1 2 3 4 5 6 7 8 9 10

**PAST MEDICAL HISTORY**     None

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Anemia                                   | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Phlebitis/Pulmonary Emboli/Blood clots |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus/SLE               | <input type="checkbox"/> Rheumatoid Arthritis                   |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Lyme's Disease          | <input type="checkbox"/> Skin Rash/Psoriasis                    |
| <input type="checkbox"/> Emphysema/COPD                           | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Stroke                                 |
| <input type="checkbox"/> Gout                                     | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Osteoarthritis          | <input type="checkbox"/> Thyroid Disease                        |
| <input type="checkbox"/> Heart Attack /CAD                        | <input type="checkbox"/> Kidney Problems     | <input type="checkbox"/> Osteoporosis            | <input type="checkbox"/> Ulcers                                 |
| <input type="checkbox"/> Cancer - Please tell us what type: _____ |  |  |   |
| <input type="checkbox"/> Other (please list) _____                |  |  |   |

**PAST SURGICAL HISTORY**     None

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Appendix _____         | <input type="checkbox"/> Bowel/Colon _____ | <input type="checkbox"/> Breast Biopsy _____ |
| <input type="checkbox"/> Gallbladder _____      | <input type="checkbox"/> Gynecologic _____ | <input type="checkbox"/> Heart Surgery _____ |
| <input type="checkbox"/> Hernia Repair _____    | <input type="checkbox"/> Tonsils _____     |  |
| <input type="checkbox"/> Cosmetic Surgery _____ | <input type="checkbox"/> Other _____       |  |
|   | (please list type)                         | (please list body part)                      |
| <input type="checkbox"/> ORTHOPAEDIC _____      |  |  |
| (please list all) _____                         |  |  |
| _____   |  |  |

**MEDICATIONS**     None

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

- Anti-Inflammatory     Aspirin     Birth Control Pills     Coumadin     Tylenol

Please list any prescription medications you are currently taking:

\_\_\_\_\_

**ALLERGIES**     None

Do you have any **allergies** to any medications? (Please list all that apply & your reaction)

\_\_\_\_\_

\*\*Do you have an allergy to Latex?\*\*     Yes     No

**FAMILY HISTORY**     None

Do your parents, siblings, or grandparents have any of the following? Please check all that apply & indicate which family member:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Disease |  |   |

Do you have any deceased family members? Please check all that apply and indicate cause of death.

- Mother     Father     Sibling     Grandparent

Cause: \_\_\_\_\_

## SOCIAL HISTORY

(Please check all that apply)

Do you smoke tobacco?

Currently:  Every day? Or  Some days?  
 Former Smoker?  Never smoked?

Do you drink alcohol?

No  Yes If Yes, how often? \_\_\_Daily \_\_\_Other \_\_\_/ week

Have you ever been treated for chemical dependence?  No  Yes

Education (highest level achieved):  High School  College  Technical School  Advanced Degree

Are you pregnant?

No  Yes

### REVIEW OF SYMPTOMS

None

(Please check all that apply)

GI	<input type="checkbox"/> Heartburn, ulcers	<input type="checkbox"/> Nausea, Vomiting	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Liver Disease
ENDO	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Heat or Cold Intolerance			
CON	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Loss of Appetite			
EYE	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Vision Loss		
ENT	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Trouble Swallowing		
CV	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations			
RS	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath			
GU	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Kidney Problems		
SK	<input type="checkbox"/> Frequent Rashes	<input type="checkbox"/> Skin Ulcers	<input type="checkbox"/> Lumps	<input type="checkbox"/> Psoriasis	
NEU	<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures		
PSY	<input type="checkbox"/> Depression	<input type="checkbox"/> Drug/Alcohol Addiction	<input type="checkbox"/> Sleep Disorder		
HEM	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Anemia		
ALL	<input type="checkbox"/> Seasonal Allergy	<input type="checkbox"/> Other (please list): _____			
LYMP	<input type="checkbox"/> Leg Swelling				
MSK	<input type="checkbox"/> Fracture	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Sprains	<input type="checkbox"/> Dislocation	
VASC	<input type="checkbox"/> Claudication				
MISC	<input type="checkbox"/> Vitamin D/Calcium Supplements		<input type="checkbox"/> Bone Density Test		

ARE YOU HIV POSITIVE?

Yes  No

**PATIENT DEMOGRAPHICS**

Patient Name \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
Phone #'s: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

\*\*\*\*\*

Email address \_\_\_\_\_ How would you like us to contact you? Phone: \_\_\_home \_\_\_cell \_\_\_work  
How did you hear about our practice?: Family/Friend Brochure Yellow Pages Website Other \_\_\_\_\_

\*\*\*\*\*

Patient Employer \_\_\_\_\_  
Employer's Address/Phone # \_\_\_\_\_

Please list your attorney's information (if applicable to this injury):  
Name/Address/Phone#: \_\_\_\_\_

\*\*\*\*\*

**PRIMARY INSURANCE**

**Will the primary insurance subscriber/insured party be responsible for the account? Y N**

Name of Insurance Plan \_\_\_\_\_  
Claim Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**SUBSCRIBER /INSURED PARTY INFORMATION:**

Name \_\_\_\_\_ Address \_\_\_\_\_  
Home phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
Please circle one Male Female Employment Status: FT / PT / Retired / Disabled  
Is this insurance coverage through the subscriber's employer? YES NO  
Employer \_\_\_\_\_  
Employer address \_\_\_\_\_ Employer phone # \_\_\_\_\_  
Effective date of Insurance \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insurance Plan \_\_\_\_\_

Claim Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**SUBSCRIBER/INSURED PARTY INFORMATION:**

Name \_\_\_\_\_ Address \_\_\_\_\_

Home phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

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

Employer \_\_\_\_\_

Employer address \_\_\_\_\_ Employer phone # \_\_\_\_\_

Effective date of Insurance \_\_\_\_\_

**GUARANTOR INFORMATION** - Please list who will be responsible for the account.

SELF  SAME AS PRIMARY INSURANCE  OTHER

Name \_\_\_\_\_ Address \_\_\_\_\_

Home phone # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Please circle one Male Female Employment Status: FT / PT / Retired / Disabled

Employer \_\_\_\_\_

Employer address \_\_\_\_\_ Employer phone # \_\_\_\_\_

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

Please circle one WORKERS COMP MOTOR VEHICLE

Insurance Company \_\_\_\_\_

Adjuster/Case Manager \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_ Claim # \_\_\_\_\_

Employer \_\_\_\_\_

**PHARMACY INFORMATION**

Please list your **complete** pharmacy information.

Name Address Phone	
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**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-insurances are expected at the time of service. Your co-insurance 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's balance remains unpaid for more than 90 days, the patient's account may be turned over to an attorney/collection agency for collections. If your account is sent to collections, you will be responsible for all collection fees generated.**

**INSURANCE POLICY**

**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 your insurance is qualified and the insurance forms received. Until that time you must pay for all services rendered.**
- 2. All deductibles must be made prior to submitting your insurance claims.**
- 3. 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 up this process.**
- 4. Due to the 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.**
- 5. It is our goal of this office to provide you with the finest quality of care available. If you have any questions regarding your healthcare or any of our office policies, please do not hesitate to let us know.**
- 6. If it becomes necessary to utilize a collection agency due to nonpayment of your bill, you will be responsible for all fees charged by that agency as well as your balance.**

**Please sign below:**

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

**Print Name: \_\_\_\_\_  
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 to and from my insurance company, attorney, school, pharmacy or any other entity involved as it is related to my care and treatment.**

**Print Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**I hereby authorize my motor vehicle insurance carrier to release information to Professional Orthopaedic Associates regarding the PIP benefits that have been paid to date on my claim.**

**Print Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**We welcome your referrals and look forward to a Doctor-Patient relationship.**

# PROFESSIONAL ORTHOPAEDIC ASSOCIATES

## Authorization of Designated Representative to Appeal a Determination

**Date:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_

**Insured ID #:** \_\_\_\_\_

I hereby authorize Professional Orthopaedic Associates, as my designated representative, to appeal to my insurance company, \_\_\_\_\_, on my behalf, in the  
(please print name of insurance company here)

determination of services rendered by \_\_\_\_\_, and, as part of the appeal, I hereby  
(doctor you are seeing today)

authorize \_\_\_\_\_ to disclose and furnish to my  
(please print name of insurance company here)

designated representative, Professional Orthopaedic Associates, the following information:

**All medical and financial information contained in my insurance file. I understand this information is  
privileged and confidential.**

**Patient Name:** \_\_\_\_\_  
(please print)

**Legal Guardian's name:** \_\_\_\_\_  
(please print)

**Signature of Patient or Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Professional Orthopaedic Associates Representative**

**ASSIGNMENT OF BENEFITS/APPOINTMENT OF ATTORNEYS**

I hereby assign all rights and benefits due me from my insurance carrier to Professional Orthopaedic Associates (“POA”) and authorize and empower POA to appeal a determination by a carrier to deny, reduce or terminate my benefits including, but not limited to, the filing of a lawsuit or fee arbitration. Furthermore, I authorize and direct my insurance carrier to pay the proceeds of any benefits due me directly to POA. A copy of this can be considered as an original for insurance purposes. \_\_\_\_ (initials)

I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid within a reasonable amount of time. If for any reason any portion of the bill is not paid by my insurance carrier, I further agree to make arrangements for prompt payment of the bill. \_\_\_\_ (initials)

If I receive any payment from an insurance carrier relating to services rendered, I agree that I will hold such payment in trust for POA and I agree to send any such payment to POA within one week after I receive same. In the event my account is turned over to an attorney for collection, I agree to pay a legal and collection fee equal to 33 1/3% of the outstanding balance, plus court costs. \_\_\_\_ (initials)

I understand that should I not turn over the proceeds, an action for collection may be filed against me in which I agree to be responsible for payment of any court costs and attorney fees involved in efforts to collect the entire fee billed by the doctor, not just what has been paid to me by my insurance carrier. \_\_\_\_ (initials)

I agree that if POA treats me for any problem that is involved in litigation or involves a claim for personal injuries, I will immediately notify the Billing Department for my POA provider. At the time any settlement funds are disbursed or received, I promise to pay any and all of my provider’s and POA’s bills. \_\_\_\_ (initials)

I understand that my provider and POA may each bill for services rendered independently. I authorize this office to submit their bills to any insurance company with which I (or my spouse) have an insurance policy or any company against which I may proceed for medical expense benefits. \_\_\_\_ (initials)

In the event that the doctor elects to bring a lawsuit or petition for arbitration against the insurance carrier, I assign my rights, title and interest under any section of any insurance policy under which I am entitled to proceed for benefits. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim for any unpaid bills for treatment rendered. My provider and POA may designate such attorney beginning thirty-one (31) days after any bill for services rendered becomes due. I agree to fully cooperate with them in the collection of any benefits from the insurance carrier including full cooperation with the chosen attorney. \_\_\_\_ (initials)

In the event this assignment is held invalid for any reason, I hereby authorize POA to appoint an attorney of its choice to represent me directly against an insurer from which I may collect any & all benefits and to bring a claim in a forum of the attorney’s choice. This appointment is intended to enable the attorney to collect the bills of POA and this appointment does not authorize the selected attorney to represent me in any third-party action. Further, this appointment will not conflict with any other attorney who currently represents me. \_\_\_\_ (initials)

By consenting to having a law firm of POA’s choosing represent me, I understand that in such lawsuits my confidentiality may not be protected and personal information may be revealed. I authorize my provider and POA to release any and all information concerning my injury or illness and its treatment to the attorney designated by the assignee or third person that are involved in the action to collect benefits. \_\_\_\_ (initials)

I have read, understand and agree to the above. \_\_\_\_ (initials)

\_\_\_\_\_  
Patient Name – please print

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient’s Signature or Signature of Parent/Legal Guardian



**ANTI-INFLAMMATORY MEDICATION**

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Your doctor may prescribe a non-steroidal anti-inflammatory (NSAID) medicine to help alleviate your symptoms of pain, swelling or inflammation.

The most frequent side effects of this medication include, stomach upset, nausea and diarrhea. Ulcers or bleeding may occur without warning. It is recommended that this medicine be taken with food, which may reduce the appearance or magnitude of these side effects. Do not drink alcoholic beverages while taking this medication.

For best results, this medicine should be taken at the prescribed dose for the period of time recommended by your physician. If you take any other medications prescribed by other physicians, you should consult your pharmacist prior to filling this prescription to check for drug interactions.

Should you develop any side effects with this medication, stop taking it immediately and contact your physician or this office. Patients with active ulcer disease or who are taking daily medicines for bronchial asthma; must be aware that use of this medicine may result in an exacerbation of these problems. This medicine should not be taken in combination with other NSAID or aspirin containing medications. **Please note that commonly used over the counter medicines such as Ibuprofen, Advil, and Aleve contain non-steroidal medications that could increase the risk of stomach side effects of prescribed medication. Tylenol, however, would not increase this risk.**

For your protection, periodic blood work, within 6-8 weeks after taking this medication will be necessary to monitor any possible liver or kidney irritation.

If you are pregnant, have the flu, fever or any viral illness; do not take this medication. Consult your physician.

I have read and understand the above information.

PATIENT 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:

\_\_\_\_\_

I, \_\_\_\_\_, give permission to the practitioner/facility listed below to release any or all of my Patient Health information to Professional Orthopaedic Associates, P.A. as part of my medical care.

\_\_\_\_\_

I, \_\_\_\_\_, give permission for Professional Orthopaedic Associates, P.A. and any of its employees to leave information related to any or all of my care at the following number:

\_\_\_\_\_                      **Home                      Cell                      Work**  
(please indicate what kind of number you have listed)

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, the information described above may be disclosed to other individuals or institutions and is no longer protected by these regulations.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

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 a written notice to this office and that revocation will not affect 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

# **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: 732-530-4949 - F: 732-349-7722

### **Freehold Office**

303 West Main Street - Freehold, NJ 07728 - P: 732-530-4949 - F: 732-577-0036

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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

### **SurgiCare**

901 West Main St. – Freehold, 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