PATIENT INFORMATION

Doctor you are seeing today: Mark W Gesell, MD

PATIENT NAME _____ Appointment Date _____

PLEASE CHECK ☐ Male ☐ Female ARE YOU: ☐ Right ☐ Left Handed ☐ Ambidextrous

BIRTHDATE _____ AGE _____

DOCTOR INFORMATION

Referring Doctor / Athletic Trainer / Physical Therapist / Friend

Family Medical Doctor

INJURY INFORMATION

Date of symptoms or accident _____

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

Briefly describe below the reason for your visit: ☐ 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

MEDICAL HISTORY ☐ None

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

☐ Anemia	☐ Heart Murmur	☐ Liver Disease/Hepatitis	☐ Phlebitis/Pulmonary Emboli/Blood clots
☐ Asthma	☐ High Blood Pressure	☐ Lupus/SLE	☐ Rheumatoid Arthritis
☐ Diabetes	☐ High Cholesterol	☐ Lyme's Disease	☐ Skin Rash/Psoriasis
☐ Emphysema/COPD	☐ Irregular Heartbeat	☐ Multiple Sclerosis	☐ Stroke
☐ Gout	☐ Irritable Bowel	☐ Osteoarthritis	☐ Thyroid Disease
☐ Heart Attack /CAD	☐ Kidney Problems	☐ Osteoporosis	☐ Ulcers

☐ Cancer - Please tell us what type: _____

☐ Other (please list) _____

PAST SURGICAL HISTORY ☐ None

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

☐ Appendix _____ ☐ Bowel/Colon _____ ☐ Breast Biopsy _____
☐ Gallbladder _____ ☐ Gynecologic _____ ☐ Heart Surgery _____
☐ Hernia Repair _____ ☐ Tonsils _____
☐ Cosmetic Surgery_____ _____ ☐Other_____ _____
(please list type) (please list body part)
☐ 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:
☐ Cancer ☐ High Blood Pressure ☐ Rheumatoid Arthritis
☐ Diabetes ☐ Osteoporosis ☐ Stroke
☐ 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)

Marital Status ☐ M ☐ D ☐ S ☐ W ☐ P

Do you smoke tobacco? ☐ Every day? ☐ Some days? ☐ Former Smoker? ☐ Never smoked?

Do you drink alcohol? ☐ No ☐ Yes If Yes, how often? ___Daily ____/ week ____Other

Have you ever been treated for chemical dependence? ☐ No ☐ Yes

SOCIAL HISTORY-CONT'D

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

Are you pregnant? ☐ No ☐ Yes

OCCUPATION _____

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

HEIGHT ☐ FT ☐ IN **WEIGHT** ☐ LBS

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

CURRENT SYMPTOMS ☐ None

(Please check all that apply)

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

****

Are you currently being treated for Osteoporosis or have you had any testing for Osteoporosis?

☐ NO ☐ YES If **YES**, please list the treatment and/or testing you have received and when:

_____

Are you HIV Positive? ☐ NO ☐ YES

Have you received a FLU vaccination within the current flu season? **(FLU SEASON IS OCTOBER – MARCH)**

☐ No If **NO**, please circle a reason: declined allergy not available other

☐ Yes If **YES**, please list approximately the date you received it: _____

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#: _____

****

EMERGENCY CONTACT INFORMATION

Relationship to patient: _____
Name: _____
Phone #: _____ _____ _____
HOME CELL WORK

****

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 _____

LOCAL PHARMACY INFORMATION

Please enter the pharmacy's name, address and phone number in the box below:

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

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 Dr. Mark W. Gesell (the "provider(s)"), as my designated Authorized Representative(s), 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 assignor; (2) submitting evidence; (3) making statements about facts 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

_____

Print Name of Insured/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; such as the following:

Advil	Mobic
Aleve	Naproxen
Celebrex	Naprosyn
Diclofenac-Sodium	Oxaprotin (Daypro)
Ibuprofen	Piroxicam (Feldene)
Indomethacin (Indocin)	Voltaren

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 physican 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 physican.

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 : <u>All</u> **For the specific purpose of : <u>Any</u>**

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