

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

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609-927-1991

PATIENT INFORMATION:

Today's Date: _____

Name: _____ Male: _____ Female: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Cell phone: (____) _____

Work phone: (____) _____ Social Security #: _____

Date of Birth: _____ Age: _____ Height: ____ft ____in Weight: _____

Email: _____

Your Employer: _____ Occupation: _____

Pharmacy Name: _____

Pharmacy Address: _____

Mail-Order Pharmacy Name: _____

Mail-Order Address: _____

Body Part to be examined? : _____

Date of onset Illness/Accident/Injury/Condition: _____

Did the above injury occur as a result from a fall? ___ YES ___ NO

Referred to Shore Orthopaedic University Associates by:

Physician: (Name/Address) _____

Insurance Co. Internet Newspaper Emergency Room Radio Friend/Family

Medical Physician Information:

Primary Care Physician:

Current: _____ Address: _____ Phone: _____

Previous: _____ Address: _____ Phone: _____

Cardiologist: (Name) _____

Pulmonologist: (Name) _____

Other Medical Specialists: (Name) _____

Emergency Contact: _____ **Phone:** _____

Relationship to patient: _____ **Authorized to disclose Health/Billing Information* Yes No

PATIENT INJURY/TREATMENT FORM:

Please provide a full description of your condition that requires medical treatment:

What makes symptoms worse? _____

What makes symptoms better? _____

For each, check what BEST applies:

The pain is: RARE INTERMITTENT CONSTANT DULL

The pain is: SHARP ACHY THROBBING BURNING OTHER _____

On a 0-10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Associated Symptoms: Check ALL that apply:

- POPPING LOCKING GRINDING SWELLING STIFFNESS
 WEAKNESS TINGLING NIGHT PAIN

OTHER _____

Have you ever had a previous injury or symptoms involving this body part in the past? YES NO

Have you had any previous treatment for this problem? NONE medication injection

() physical therapy () surgery () chiropractic care Explain: _____

Related testing for above: X-Ray MRI CT Scan Bone Scan Other: _____

Facility/Date test performed: _____

If this is an injury or accident, where did the injury or accident occur?

Property/Location: _____

Address: _____

Did the injury or accident occur on the job? YES NO

Have you or do you intend to file this claim under Workers' Compensation? YES NO

Did the injury occur as result of an auto accident? YES NO If yes, fill in Auto Insurance information

Name of Insurance Co. _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim Number: _____ Adjuster Name: _____

MEDICAL HISTORY: Do you currently or have you ever had any of the following: Check all that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Non-insulin diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Insulin - diabetes |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Gout | Circulatory disease |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoporosis | Anxiety Disorder |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Reflux/heartburn | <input type="checkbox"/> Seizures | U Urinary Infections |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Hyperthyroidism | Hypothyroidism |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | Fibromyalgia |
| <input type="checkbox"/> Other Psych Illness | | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Increased Cholesterol |

Substance Abuse: _____

Cancer:(type)_____

Other/Details of above: _____

NONE

SURGICAL HISTORY: Check all that apply:

NONE

- | | | | | | |
|---------------------|----------------------------|---------------------|---------------------------|-----------------------|------------------------|
| Eyes/ENT: | cataracts | sleep apnea | tonsils | sinus surgery | thyroid |
| Heart: | bypass | valve replacement | stent placement | angioplasty | pacemaker |
| GI: | appendix | gallbladder | hernia | gastric bypass | |
| Gynecologic: | C-section | hysterectomy | tubal ligation | | |
| Urologic: | prostate | bladder | vasectomy | | |
| Orthopaedic: | right hip replacement | | left hip replacement | | right knee replacement |
| | left knee replacement | | right knee arthroscopy | | left knee arthroscopy |
| | right shoulder arthroscopy | | left shoulder arthroscopy | | fracture surgery |
| Spine: | cervical fusion | lumbar fusion | | cervical disk removal | |
| | | lumbar disk removal | | fracture surgery | |
| Vascular: | carotid | aneurysm | | leg bypass | |
| Cancer: | skin | breast | lung | prostate | other: _____ |

Other/details from above: _____

History of surgical infection? YES NO If yes, explain _____

History of failed surgery? YES NO If yes, explain _____

History of anesthesia complication? YES NO If yes, explain _____

FAMILY HISTORY:

Mother: () Living Deceased Cause of death: _____ Age: _____
() anesthesia complications bleeding disorder () arthritis () heart disease () diabetes
() cancer: _____ () malignant hyperthermia: _____
() other: _____

Father: () Living () Deceased Cause of death: _____ Age: _____
() anesthesia complications () bleeding disorder () arthritis () heart disease () diabetes
() cancer: _____ () malignant hyperthermia: _____
() other: _____

SOCIAL HISTORY:

Marital status: () single married () divorced () widowed
Alcohol use: () none () occasionally () daily () _____ times per week
Tobacco use: Have you smoked at least 100 cigarettes in your entire life? () Yes () No
 Previous smoker When quit? _____ Years smoked? _____
 Current smoker Cigarettes/day? _____ Years smoked? _____

OTHER CURRENT SYMPTOMS:

Check all that apply: NONE

General Health:	weight loss fatigue	weight gain	fever	night sweats
ENT:	headaches	difficulty swallowing	nose bleeds	
Cardiovascular:	chest pain	palpitations	fainting	
Respiratory:	shortness of breath	wheezing	coughing	snoring
Gastrointestinal:	heartburn	nausea	constipation	diarrhea
Urinary:	urinary frequency	urgency	pain	incontinence
Musculoskeletal:	joint pains	swelling	stiffness	muscle pain
Skin:	skin changes	poor healing	rash	itching
Neurological:	numbness/tingling	unsteady gait	dizziness	tremors
Hematologic:	easy bleeding	bruising		

Other: _____

MEDICATION ALLERGIES: (rash, swelling, shortness of breath, etc.) **NONE**
Penicillin Sulfa Latex Iodine (IV contrast) Shellfish Poultry products
~ other: _____

MEDICATION SIDE EFFECTS: (heartburn, nausea, vomiting) () **NONE**
() NSAIDS () Codeine () Percocet () Vicodin/Lortab () other: _____

MEDICATIONS: () **NONE** () additional sheet attached

<u>Medication</u>	<u>Dosage</u>	<u>Times per day</u>

Check all that apply:
Race: Asian Black Hispanic White
Language: English Spanish Sign Language Other: _____
Ethnicity: Latino Not Latino

Have you ever had a DEXASCAN? YES NO If yes, Date: ____/____/____

Are you: right-handed left-handed

Do you have an advanced care plan? YES NO

Do you have a healthcare proxy? YES NO

***Patient or Responsible Party Signature** _____ **Date** ____/____/____

INSURANCE INFORMATION:

My Insurance requires a referral to a Specialist: YES NO
Is patient minor/dependent? YES NO
Child’s Parent/Guardian Name: _____ Date of Birth: _____
Parent/Guardian Social Security # _____

Subscriber for Primary Insurance: (Name the insurance policy is listed under)

Subscriber Name: _____ Relation to Patient: _____
Address: _____ Social Security # _____
City: _____ State: _____ Zip: _____ Phone: _____
Employer: _____ Date of Birth: _____
Name of Primary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Claim/Policy # _____ Group # _____ ID# _____

Subscriber for Secondary Insurance: (Name the insurance policy is listed under)

Subscriber Name: _____ Relation to Patient: _____
Address: _____ Social Security # _____
City: _____ State: _____ Zip: _____ Phone: _____
Employer: _____ Date of Birth: _____
Name of Secondary Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Claim/Policy # _____ Group # _____ ID# _____

THIS FORM MAY BE SENT TO YOUR INSURANCE COMPANY

I authorize Shore Orthopaedic University Associates to furnish information to insurance carriers concerning my illness, condition, accident, or injury and treatment. I hereby assign to Shore Orthopaedic University Associates all payments for medical services rendered to me or my dependent(s) which I have not already paid. I acknowledge that all of the above information is true and correct and that it has been furnished to Shore Orthopaedic University Associates with full knowledge that I, the patient, or my dependent, will be liable for all said services rendered and that I, the patient, or my dependent will be contractually bound to pay for said services including all costs of collection and a reasonable attorney’s fee should collection become necessary.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

You agree, in order for us to service your account or to collect monies you may owe, Shore Orthopaedic University Associates and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that Shore Orthopaedic University Associates, its employees and/or our agents may contact me/us as described above.

Print Name *Signature Date

Parent or Guardian’s Name *Signature Date

**SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES
PF-2000 Consent to Use and Disclosure of Protected Health Information**

Use and Disclosure of your Protected Health Information

Your protected health information will be used by Shore Orthopaedic University Associates or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Shore Orthopaedic University Associates may or may not agree to restrict the use or disclosure of your protected health information.

If *Shore Orthopaedic University Associates* agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation or consent is received will not be affected.

Reservation of Right of Change Privacy Practices

Shore Orthopaedic University Associates reserved the right to modify the privacy practices outlined in this notice.

“Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his patients of any significant financial interest he may have in a health care services. Accordingly, I wish to inform you that I do have a financial interest in the following health care service(s) to which I refer my patients:

Shore Ambulatory Surgical Center, LLC d/b/a Jersey Shore Ambulatory Surgery Center

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading. NJSA 45:9-22.6”

Signature

I have reviewed this consent form and give my permission to *Shore Orthopaedic University Associates* to use and disclose my health information in accordance with it.

Name of Patient

***Signature of Patient**

***Signature of Patient Representative**

Relationship to Patient

Date

Project Medicine Drop: SAFE and SECURE MEDICINE DISPOSAL

Unused medications that remain in your medicine cabinet are susceptible to theft and misuse. To prevent medications from getting into the wrong hands, New Jersey's Office of the Attorney General and Division of Consumer Affairs urge you to properly dispose of your expired and unwanted prescription medicine at a nearby Project Medicine Drop location. DROP OFF IS SIMPLE, ANONYMOUS AND AVAILABLE 24 HOURS A DAY – 365 DAYS A YEAR, NO QUESTIONS ASKED. Simply bring in your prescription and over-the-counter medications and discard them in an environmentally safe manner. Always scratch out the identifying information on any medicine container you are discarding.

*For a list of Project Medicine Drop locations, please visit <http://www.njconsumeraffairs.gov/meddrop>