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:

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Rheumatoid Arthritis
☐ Emphysema	☐ Blood clots	☐ Lyme Disease	☐ Non-insulin diabetes
☐ Depression	☐ High blood pressure	☐ Irregular heartbeat	☐ Insulin - diabetes
☐ Heart disease	☐ Hepatitis A / B / C	☐ Gout	☐ Circulatory disease
☐ HIV/AIDS	☐ Kidney disease	☐ Osteoporosis	☐ Anxiety Disorder
☐ COPD	☐ Reflux/heartburn	☐ Seizures	☐ Urinary Infections
☐ Stomach ulcers	☐ Parkinson's disease	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Sleep Apnea	☐ Glaucoma	☐ Stroke	☐ Fibromyalgia
☐ Other Psych Illness		☐ Bleeding disorder	☐ 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 ☐ weight gain ☐ fever ☐ night sweats ☐ fatigue

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

Medication	Dosage	Times per day

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