

**Department of Orthopaedics, Doctors Office Center, 90 Bergen St. Suite 1200, Newark,
NJ 07103**

MR #: _____
CPI _____

Today's Date: _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ DOB _____ Age _____
(Last Name First)

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

Phone #: (H) _____ (W) _____ Social Sec. #: _____

Place of Birth: _____ Sex: M ___ F ___ Marital Status: M S W D

Occupation _____ Employer: _____
(Name) (Address)

Referred by: _____
(Name) (Address) Dr.'s UPIN #

Primary/Family Physician: _____
(Name) (Address) (Tel. #)

NJ Driver's License No.: _____ **How did you hear about us?** _____

Spouse's Name: _____ DOB _____ SS #: _____

Parents if under 18: _____

Mother's SS #: _____ Father's SS #: _____

Spouse's Employer: _____ Address: _____

Emergency Contact: _____ Tel. #: _____

INSURANCE INFORMATION

See reverse for Auto and Workers Compensation

Primary Ins.: _____ Address: _____

Name of Insured: _____ Relationship to Patient: _____

ID #: _____ Group #: _____ Medicare #: _____

Secondary Ins.: _____ Address: _____

ID #: _____ Group #: _____

Name of Insured: _____ Relationship to Patient: _____

PLEASE COMPLETE REVERSE

AUTOMOBILE OR OTHER ACCIDENT RELATED INJURIE

Date of Accident: _____ Location of Accident: _____

How did accident occur: _____

Automobile Insurance Co.: _____

Address: _____ Tel: _____

Name of Adjuster: _____ Claim #: _____

Attorney: _____ Tel #: _____

Address: _____

WORKERS COMPENSATION INJURY

How did the accident occur: _____

Please note: The patient is liable for the bill, unless we receive authorization from your employer or workers compensation carrier to treat you. Do you have approval? _____

Date of Accident: _____ Insurance Co.: _____

Address: _____ Tel #: _____

Name of Adjuster: _____ Claim #: _____

Attorney: _____ Tel. #: _____

Address: _____

GUARANTEE TO PAY

I understand that payment is expected at the time of services unless payment will be made directly by either a worker's compensation or auto insurance carrier for the injuries sustained in an accident.

I authorize and request payment of my medical benefits for treatment and /or surgery directly to the Doctors Office Center. I further authorize my attorney to pay the Doctors Office Center directly any monies due them on accounts the same to be deducted from any settlement made on my behalf. I will direct my attorney to pay the Doctors Office Center directly any outstanding balance immediately upon settlement or judgment in my case.

I understand that any outstanding balance not covered or paid by my insurance will be my responsibility to pay. If my accounts are turned over to an attorney or collection agency to obtain payment, I shall be responsible for the attorney's fee. Court costs, and any other costs incurred by the collection agency.

Patient's Signature: _____ **Date:** _____

Copy of my signature shall have the same force and effect as the original.

RELEASE OF RECORDS

I hereby authorize the Orthopaedic Department of the DOC to release any necessary Medical Information.

Patient's Signature: _____ Date: _____

GENERAL MEDICAL HISTORY

Referring Doctor: _____
(Name) (Address) (Telephone#)

Private General M.D. – Name: _____

(Address) (Telephone #)

PLEASE CHECK ANY MEDICAL PROBLEMS YOU HAVE OR HAVE HAD IN THE PAST. FOR THOSE CHECKED, BRIEFLY EXPLAIN IN THE SPACE PROVIDED, IF NECESSARY.

_____ High Blood Pressure _____

_____ Heart Attack (myocardial infarction) _____

_____ Arrhythmia (Abnormal heart beat) _____

_____ Angina (chest pain) _____

_____ CHF (congestive heart failure) _____

_____ Asthma (breathing difficulties) _____

_____ Emphysema _____

_____ Bronchitis (chronic) _____

_____ Sinus problems _____

_____ Pneumonia _____

_____ Stomach problems _____

_____ Kidney or liver problems _____

_____ Seizures _____

_____ Strokes _____

_____ Thyroid problems (hyper/hypothyroid) _____

_____ Arthritis _____

_____ Lupus (Systemic Lupus Erythematosus) _____

_____ Gout _____

_____ Lyme Disease _____

_____ Cancer _____

_____ Diabetes _____

_____ Poor Circulation _____

_____ Poor wound healing _____

_____ Other problems _____

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I _____ authorize the offices of North Jersey Orthopaedic Institute
(patient name)

to disclose to _____
(person to whom disclosure is made)

my medical records to the following extent: _____

_____ (treatment dates, name of health care unit of UMDNJ in which treatment was provided, types of records to be excluded, if any)

for _____
(purpose of disclosure)

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes University of Medicine and Dentistry of New Jersey to release that information.

I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.

This consent may be revoked at any time by writing to – North Jersey Orthopaedic Institute, except to the extent that the North Jersey Orthopaedic Institute has already taken action in reliance on it. If not previously revoked, this consent will terminate upon _____.
(indicate date or an expiration event.)

North Jersey Orthopaedic Institute will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Date: _____

Signature of patient or guardian: _____