

Today's Date _____

NEW PATIENT INTAKE FORM

Patient ID _____

Patient's First Name _____ Middle Initial _____ Last Name _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home# _____ Cell _____ Work # _____

Date of Birth _____ Age _____ SS# _____

Marital Status S / M / Other _____ Sex _____ Occupation _____

Employers Name & Address (or if patient is minor, parents employer) _____

Family Doctor _____ Phone # _____ Fax _____

Address _____

Referred By [Physician / Friend / Insurance Directory / Yellow Pages / Website / Nursing Home]

<p>Referring Physician (Unless listed on referral, the following information must be filled out for Consultation or report to be faxed to your referring physician)</p> <p>Name _____ Phone # _____ Fax # _____</p> <p>Address _____</p>

Primary Insurance

Must Be Completed If Insurance Is Not In Patient's Name

Ins. Name _____ Insured's Name _____

Ins. Address _____ Insured's Address _____

ID# _____ Insured's Date of Birth _____

Group# _____ Insured's SS # _____

Secondary Insurance

Must Be Completed If Insured Is Not In Patient's Name

Ins. Name _____ Insured's Name _____

Ins. Address _____ Insured's Address _____

ID# _____ Insured's Date of Birth _____

Group# _____ Insured's SS # _____

ACCIDENT INFORMATION

Is this visit due to a work-related Injury? Yes No If yes, please complete the following:

Date of injury : _____ Body parts : _____

Adjuster's Name: _____ Phone: (____) _____ - _____

Is this visit due to an auto accident? Yes No If yes, please complete the following:

Have you contacted an attorney regarding this accident? Yes No If yes, please complete the following:

Attorney's Name: _____ Phone: (____) _____ - _____

Attorney's Address: _____

FINANCIAL POLICY

- All co-pays, deductible and co-insurance (where applicable) are due at the time of service.
- We will collect an estimated fee on office visit on self-pay patients on check in. Ancillary charges such as orthotics, x-rays and injections are not included in the office visit. Patients have to pay for the differences or receive refunds after they are seen by the physicians.
- If you miss or cancel your appointment with less than 24 hr prior notice, our office reserves the right to bill you \$50.00 for each no-show and late cancellation. This fee will be your responsibility and will not be billed to your insurance.

INSURANCE

Patient s are responsible to make sure that we are a participating provider for their insurance plans. Please be aware that some or all of the services provided may be considered by your insurance to be "non-covered" services and may not be considered medically necessary under your plan's provisions. You will be responsible for these charges. Please check with your carrier or your handbook for information regarding your covered and non-covered services.

You are responsible for obtaining and presenting a referral as required by your insurance plan. You will be responsible to pay for services or penalties that are denied for lack of referral or prior authorization.

<p>* I have read the above policies and agree to them * I authorize payment of benefits directly to Edison-Metuchen Orthopaedic Group for services provided. * I acknowledge receipt of HIPPA compliance forms * I authorize Edison-Metuchen Orthopaedic Group to release my medical records and all information to appropriate parties as may be necessary for the processing or appealing of my medical bills.</p>	<p align="right">Signature _____ Date _____</p>
<p>I authorize EDISON-METUCHEN ORTHOPAEDIC GROUP to release / / disclose my health information & billing information to my attorney conce my injuries and treatment.</p>	<p align="right">Signature _____ Date _____</p>
<p>I authorize employees of Edison-Metuchen Orthopaedic Group to disclose my (health / financial account) information to the following</p> <p>_____</p> <p>Name _____ Relationship to patient _____</p> <p>_____</p> <p>Name _____ Relationship to patient _____</p>	<p align="right">Signature _____ Date _____</p>

PATIENT HISTORY

This form must be filled out before seeing the Doctor

What is the main reason for your visit today? Please be specific. (i.e. location of bodily complaint, right or left) _____

History of Present Illness

Please answer the following questions (circle your answer when applicable)

- 1) How long have you had this problem? _____
- 2) How did this problem begin? Car Accident Work Injury Fall Lifting Sports
Other _____
- 3) Describe your pain. Sharp Aching Dull Stabbing Burning Numb
Other _____
- 4) Does anything make this problem worse? Walking Standing Bending Sitting Lying
Lifting Other _____
- 5) What treatment have you had for your current problem? Physical Therapy X-Rays
MRI Chiropractic Care Medications
Other _____
- 6) Have you had this problem before or any prior injury to the same area? No Yes
(Explain _____)
- 7) On a scale of 1-10, with 10 being the most severe, circle the number best describing your pain. 1 2 3 4 5 6 7 8 9 10

Past Medical History

Please circle Y or N if applies to you

- Y N Diabetes
- Y N High blood pressure
- Y N Cancer (_____)
- Y N Lung disease (asthma COPD)
- Y N Stomach problems (ulcers reflux)
- Y N Thyroid problems (over or under active)
- Y N Heart disease (MI MVP arrhythmia)
- Y N Bleeding disorder
- Y N Sleep apnea
- Y N Latex Allergy
- Y N Substance Abuse
- Y N HIV
- Y N Hepatitis

List ALL drug allergies? _____

Family and Social History

List any surgeries and approximate dates of procedures _____

Do you smoke? No Yes ___ Pack/Day Do you drink? No Occasionally Daily

Do any medical problems run in your family? _____

What is your height? _____ Weight? _____ Are you RIGHT or LEFT handed?
Are you currently pregnant? YES NO

REVIEW OF SYSTEMS

Do you currently have or recently had any problems related to the following? Circle Yes or No

Constitutional Symptoms:

Fever	Y	N
Chills	Y	N
Headache	Y	N

Eyes:

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Glaucoma	Y	N

Allergic/Immunologic:

Hay Fever	Y	N
Novacaine/Lidocaine Allergy	Y	N
Aspirin Allergy	Y	N

Neurological:

Tremors	Y	N
Dizzy Spells	Y	N
Seizures or Convulsions	Y	N
Stroke	Y	N

Endocrine:

Excessive Thirst	Y	N
Too Hot/Cold	Y	N
Tired/Sluggish	Y	N
Hormonal Problem	Y	N

Gastrointestinal:

Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Indigestion/Heartburn	Y	N
Rectal Bleeding	Y	N
Blood in Stool	Y	N

Cardiovascular:

Chest Pain	Y	N
Varicose Veins	Y	N
Swelling: Feet/Ankle/Hand	Y	N
Shortness of Breath While Lying Flat	Y	N

Integumentary:

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Breast Pain/Lump	Y	N

Musculoskeletal:

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

Ear/Throat/Mouth/Nose:

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Swollen Glands in Neck	Y	N

Genitourinary:

Urine Retention	Y	N
Painful Urinary	Y	N
Urinary Frequency	Y	N
Sexual Difficulty	Y	N

Respiratory:

Wheezing/Asthma Attack	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Spitting up Blood	Y	N

Hematologic/Lymphatic:

Swollen Glands	Y	N
Blood Clotting Problem	Y	N
Anemia	Y	N
Slow to Heal After Cast	Y	N

Psychologic:

Memory Loss/Contusion	Y	N
Depression	Y	N
Insomnia	Y	N

PATIENT'S NAME _____

DATE _____

PLEASE BE SURE TO FILL THIS OUT ACCURATELY. MARK THE AREA ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATION. USE THE APPROPRIATE SYMBOL. MARK AREAS OF RADIATION AND INCLUDE ALL AFFECTED AREAS.
THANK YOU.

PINS & NEEDLES **NUMENESS** **BURNING PAIN** **STABBING PAIN** **ACHING PAIN**
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