

Somerset Orthopedics & Sports Medicine

Patient Health History

Date: _____

Name _____

Date of Birth: _____

Today's Chief Complaint: _____

Doctor to Notify: _____ Referred By: _____

How did you learn about our practice? Online Mail Friend Other: _____

Past Medical History: (please circle all that apply)

High Blood Pressure Strokes Diabetes Blood Clots

Angina Vascular Disease Seizures Asthma

Palpitations Gout Bleeding Problems Emphysema

Other: _____

Past Surgical History: (please circle all that apply - indicate the year the procedure was performed)

Stents/Pacemaker: _____

Total Joint Replacements: _____

Knee Surgery: _____

Shoulder Surgery: _____

Spine Surgery: _____

Other: _____

Social History:

Tobacco Use - Yes/No/Former: _____ packs/day Quit _____ years ago and smoked _____ packs/day

Alcohol Use - Daily/Occasional/None Drug Use - Never/Current/Past: type _____

Occupation: _____

Review of Systems: (please circle all that apply)

Eyes: Double Vision Blurring Glasses Others:

ENT (ears/nose/throat): Loss of Hearing Hearing Aid Sinsusitis Hoarseness Vertigo

Heart: Chest Pains Palpitations High Blood Pressure Others:

Lungs: Asthma Shortness of Breath Cough Emphysema COPD

GI: Stomach Bowels Diarrhea Constipation Weight Loss Appetite

GU: Kidneys Bladder Incontinence Painful Urination

MSK: Muscles Joints

Skin: Rashes Ulcers Masses Scars

Neurological: Coordination Weakness Visual Changes Changes in Sensation Balance

Psychiatric: Depression Sleep Disturbances Mood Swings Hallucinations

Endocrine: Growth Changes Hair Changes Hyperactivity Hypoactivity

Hem/Lymph: Bleeding Anemia Lymph Node Swelling

For Office Use Only:

Reviewed By: _____ Signature _____

Somerset Orthopedics & Sports Medicine

Patient Name _____ Age _____ Date _____

Please select from the following:

- Work Injury Auto Accident No Apparent Reason Other

Dominant Hand: Left Right

History:

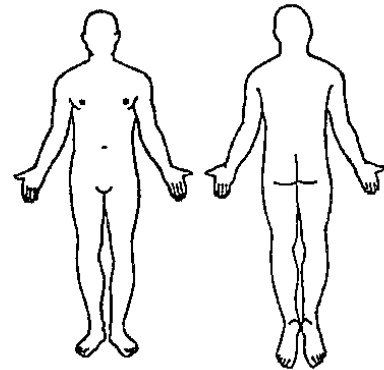
Location of Pain:

- Left Right Both
 Back Buttock Groin
 Calf Foot Neck
 Shoulder Arm Hand
 Anterior Thigh Posterior Thigh
 Knee Other _____

Is Condition: Improving Unchanged
 Worsened

Percentage of Pain: (if applicable)

Back _____ Leg _____
Neck _____ Arm _____ Total = 100%



Mark all areas with an:
X - where you experience pain
O - where you experience numbness

Rate pain on a scale of 0 -10:

(0 = no pain, 10 = most severe pain imaginable)

Back ____ Buttock ____ Groin ____ Thigh ____
Neck ____ Shoulder ____ Calf ____ Foot ____
Arm ____ Hand ____ Knee ____ Elbow ____

What makes symptoms worse?

- | | | | |
|---|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Sitting | <input type="checkbox"/> Rising | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lying | <input type="checkbox"/> Stationary | <input type="checkbox"/> On the Move |
| <input type="checkbox"/> A.M. | <input type="checkbox"/> As the day progresses | <input type="checkbox"/> P.M. | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Up/Down the Stairs | | | |
| <input type="checkbox"/> Other _____ | | | |

What makes symptoms better?

- | | | | |
|--------------------------------------|----------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Sitting | <input type="checkbox"/> Rising | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lying | <input type="checkbox"/> Stationary | <input type="checkbox"/> On the Move |
| <input type="checkbox"/> Other _____ | | | |

Do you experience pain at night? Yes No

Does coughing, sneezing, or straining increase pain? Yes No

Do you experience loss of bowel/bladder control? Yes No

Do you experience: dizziness Nausea Headache Ringing in ears

How long can you: walk _____ stand _____ sit _____ drive _____

Any previous back/neck history? _____

Any recent surgery? _____

If yes, please indicate the type and surgery date: _____

Have you experienced a recent weight loss? How much? _____

Somerset Orthopedics & Sports Medicine

Patient Registration

Name _____ Social Security # _____ DOB _____

Address _____ Home Phone _____ Cell Phone _____

_____ Work Phone _____ Email _____

_____ Referring Dr _____ Employer _____

Ethnicity: Hispanic or Latino YES NO Employer Address _____

Race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian, White, Other _____

Primary Language Spoken _____ How did you hear about our Practice? _____

Do you have any allergies? If so please list all _____

Is your visit due to an injury at work? Yes No

Do you have an active Worker's Compensation Claim? Yes No

Is your visit due to a motor vehicle accident? Yes No

Are you a resident in a skilled nursing facility? Yes No

Was this a sports/school/league injury? Yes No

RESPONSIBLE PARTY

Name _____ Relationship to patient _____

Social Security # _____ DOB _____ Employer _____

Address _____ Work Phone _____

_____ Home Phone _____ Cell _____

Name _____ Relationship to Patient _____

Home Phone _____ Cell _____ Work Phone _____

Primary Insurance _____ Effective Date _____

ID _____ Policy Owner/Subscriber _____

Group # _____ Social Security # _____

Group Name _____ Subscriber DOB _____

Co -Payment _____ Relationship to Patient _____

Secondary Insurance _____ Effective Date _____

ID _____ Policy Owner/Subscriber _____

Group # _____ Social Security # _____

Group Name _____ Subscriber DOB _____

Co -Payment _____ Relationship to Patient _____

ASSIGNMENT OF MEDICAL BENEFITS and AUTHORIZATION TO RELEASE INFORMATION

I authorize Somerset Orthopedics & Sports Medicine to release any medical information necessary to process insurance claims relating to the medical care provided by its doctors and/or associates. I also authorize release of medical information to my primary referring physician. I authorize payment of medical benefits to Somerset Orthopedics & Sports Medicine for any medical care provided to me or to my dependent(s). I understand that I will be responsible for any charges not covered by my insurance carrier(s). Should enforcement be necessary for the collection of the bill, a \$50 fee for account balances up to \$99.99 and \$100 will be added to the bill.

By my signature, I verify that the information on this form is true and correct as of the date indicated below.

Signature, Patient or Patient's Representative _____ Date _____

Somerset Orthopedics & Sports Medicine

OUT OF NETWORK FORM

I, _____, am aware that the physician I will be treating with at Somerset Orthopedics & Sports Medicine is not a participating physician with my insurance plan.

I authorize Somerset Orthopedics & Sports Medicine to submit an unassigned claim to my insurance carrier on my behalf when I have made payment at the time of service, or an assigned claim if I have not made a payment at time of service.

I understand that I am responsible for any charges my insurance company does not pay.

Signature of Patient or Guardian if patient is a minor

Date

Signature of Authorized Representative if other than patient

Date

Somerset Orthopedics & Sports Medicine

1 Robertson Drive – Suite 24
Bedminster, NJ, 07921

I, _____ (Patient Name) acknowledge receipt of the above organization's
Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

-OFFICE USE ONLY-

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be completed only if no signature is obtained. If it is not possible to obtain the individual's
acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and
the reason why the acknowledgement was not obtained.

Reason: _____

Signature of Covered Entity Representative: _____

Printed Names: _____ Date: _____