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 ______________________________________

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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

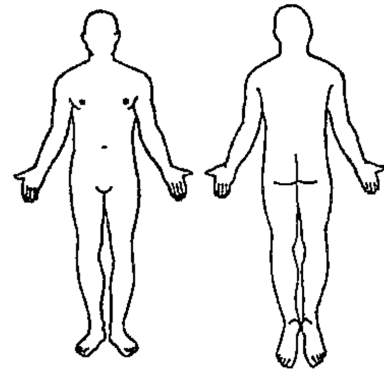
Percentage of Pain: (if applicable)

Back _________ Leg ___________
Neck _________ Arm ___________ Total = 100%

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 _______



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

What makes symptoms worse?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( )Walking ( ) Lying ( ) Stationary ( ) On the Move
( ) A.M. ( ) As the day progresses ( ) P.M. ( ) Driving
( ) Up/Down the Stairs
( ) Other ____

____

What makes symptoms better?

( ) Bending ( ) Sitting ( ) Rising ( ) Standing
( )Walking ( ) Lying ( ) Stationary ( ) On the Move
( ) 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

Name: ____ **Date:** ___________________

Height: __________ **Weight:** ____________

Please list all allergies:

Are you currently on any blood thinning medications? Yes No

**Please indicate the medication and dosage: ____

Pharmacy Name and Phone Number: ____

____

Please list all current medications:

Medication	Dosage	Frequency

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

- ☐ Ambulatory Surgical Center of Somerset
- ☐ Somerset Surgical Center
- ☐ Somerset Orthopedics & Sports Medicine
- ☐ NJ Spine Institute, P.A.

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and or employee health benefits coverage with the above captioned, and hereby assign, designate, and dually authorize the provider designated above as my representative all patient rights afforded to me under ERISA and Department of Labor guidelines regarding all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that:

I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney too release to such doctor and clinic any and all planned documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on my insurance and/or employee health benefits claim and appeal submissions.

I hereby convey to the above named provider, to the full extent permissible under the law and under any applicable insurance policies and or employee health care plan any claim, chosen action, or other rights I may have to such insurance and or employee health benefits coverage under any applicable insurance policies and or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and to the extent permissible under the law to claim such medical benefits insurance reimbursement and applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider in any attempts by such provider to pursue such claim, choice in action or right against my insurers and or employee health care plan, including, if necessary, to bring suit with such provider against such insurers and or employee health care plan in my name but at providers expense.

This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_______________________________ _______________________

Signature Date

____

Please Print Name

Somerset Orthopedics & Sports Medicine

Worker's Compensation Information:

Patient Information

Name ______________________ DOB ____________ SS #______________

Address: ______________________

____

Telephone: ______________ Occupation: ______________

Employer Information

Employer Name: ______________________

Employer Address: ______________________

____

Employer Telephone #: ______________ Injury Verified By (Office Use):______________

Contact Person: ______________________

Workers Compensation Carrier (For Office Use)

Worker Compensation Carrier: ______________________

Carrier Address: ______________________

____

Carrier Phone #: ______________ Coverage Verified By: ______________

Adjuster's Name: ______________ Claim #: ______________

Adjuster's Phone #: ______________ Adjuster's Fax #: ______________

Injury Information

Date of Injury: ____________ Time: ______________ ____A.M. ____P.M.

Place of Injury: ______________________

Accident reported to employer? _____Yes _____No Name of person you reported accident to: ______________

Give full description of how accident happened: ______________________

____

____

____

____

Have you lost time from work? ___Yes ____No How much?______________

Other doctors seen for this condition:

Doctor's Name: ______________ Diagnosis: ______________

Were x-rays taken? ___Yes ___No Other tests? ____Yes ____No

If yes, by whom? Please list test(s) and result(s): ______________________

____

____

____

Any previous Worker Compensation injuries? ___Yes ____ No Date(s) of previous injuries:______________

____

Describe previous Worker Compensation Injuries: ______________________

____

____

Authorization

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Workers Compensation benefits is denied.

Patient Signature: ______________________ Date: ______________

Print Name: ______________________

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: ______________