

DO YOU HAVE MEDICARE coverage?_____ Do you have Medicaid coverage_____?
Is patient a MINOR (under the age of 18 ?) _____?
Is your injury the result of an Auto Accident or Work Injury?_____

- Have you EVER been a victim of IDENTITY THEFT ? _____

LAST NAME _____ FIRST NAME & middle initial _____

Home ADDRESS: _____
street apt # City State zip code

HOME PHONE (_____) _____ BIRTHDATE _____ AGE _____

MARITAL STATUS _____ SPOUSE'S NAME _____ HMO REFERRING DOCTOR _____

Patient's Social Security # _____ - _____ - _____ CELL phone (_____) _____

Your EMAIL address: _____ @ _____ .com

PLEASE SUPPLY US WITH YOUR INSURANCE CARDS AND PHOTO ID OR DRIVER'S LICENSE.

If Auto or Work related injury, Date of Injury _____ Claim # _____
Responsible Insurance _____ Adjuster's name _____
Adjuster's phone (_____) _____ Adjuster's fax (_____) _____

PRIVATE HEALTH INSURANCE INFORMATION:

• **PRIMARY Health INSURANCE** _____ POLICY/ID# _____
Policyholder's name _____ Policyholder's Soc. Security # _____ - _____ - _____
Patient's relationship to policyholder: _____ Policyholder's birthdate: _____ / _____ / _____

• **SECOND INSURANCE** _____ POLICY/ID# _____
THIRD INSURANCE _____ POLICY/ID# _____
Policyholder's name _____ Policyholder's Soc. Security # _____ - _____ - _____
Patient's relationship to policyholder: _____ Policyholder's birthdate: _____ / _____ / _____

MISCELLANEOUS INFORMATION:

EMPLOYER'S NAME/ADDRESS/PHONE: _____
Phone (_____) _____ Extension _____ Position _____

Name/Address/Phone of a **FRIEND/RELATIVE** not living with you (in event of emergency: _____)

ONE-TIME AUTHORIZATION to be kept on file: I understand that all payments/co-payments, unmet deductibles & uncovered services are DUE at the time of service. Unpaid balances are subject to a \$5.00 monthly billing fee and interest may be accrued at 18% annually. I authorize S. Mountain to release to my insurance, intermediaries or carriers any information to process a claim or obtain authorization for treatment. If I am a Medicare beneficiary, I authorize release of records to Medicare (CMS) and a copy of this authorization will be kept on file. I have received or read South Mountain Orthopaedic's HIPAA policy and understand that I may have a copy upon request.

DATE: _____ SIGNATURE _____ (patient or guardian)

(If female, are you pregnant? _____ notify medical personnel IMMEDIATELY)

CURRENT MEDICAL INFORMATION:

Patient's name _____ Age _____ Weight _____ Height _____

Circle your gender: Male or Female Circle: are you RIGHT HANDED or LEFT HANDED ?

Referring Doctor Address Phone

Other Treating Doctors:
Physician's name City/State Specialty

PHARMACY Name, City & phone _____ () _____

CHIEF COMPLAINT & Present History

• Reason for the office consultation:
What orthopaedic problems & complaints do you have? _____

Is your condition due an Auto accident _____ OR Work-related injury _____
If YES - date of injury _____

- How long have you had this problem? _____
- Does the pain/problem occur at a **specific time**? _____
- **Employment:** What Is your Job title & what does your **job involve**? (i.e. sitting, standing, lifting, climbing, etc) _____
- ❖ List the dates you missed from work due to this condition: _____

List any **RECENT TESTS** that you have had for your orthopaedic problem & where were these tests done? (MRI, CT SCAN, BONE SCAN, EMG, RAYS) _____

List ALLERGIES or reactions that you have to Medication _____

Indicate the medication you are current taking (attach a separate paper if necessary)

| MEDICATION | DOSE | REASON FOR MEDICATION | HOW LONG ON THIS? |
|------------|------|-----------------------|-------------------|
| | | | |
| | | | |

Please list all Vitamins or Supplements that you routinely take: (attach a separate paper if necessary):

REVIEW OF SYSTEMS:

CIRCLE ANYTHING THAT APPLIES TO EACH SECTION:

1) General Recent weight gain/ loss Chills Fever Weakness/Fatigue NONE
Other: _____

2) Eyes: Vision Change Glasses/Contacts Cataracts Glaucoma NONE
Other: _____

3) Ears,Nose Loss of hearing Ear Ache or Infection Ringing in Ear Sinus Problems
Throat: Horseness NONE Other: _____

4) CardioVascular: Chest Pain Swelling in Legs Shortness of Breath Palpitations NONE
Other: _____

5) Respiratory: Shortness of Breath Wheezing/Asthma Frequent Cough NONE Other?
Other: _____

6) Gastrointestinal: Heartburn Acid Reflux Nausea/vomiting Abdominal Pain NONE
Other: _____

7) Skin : Rash Skin Ulcers Abnormal scars Open Sores NONE
Other: _____

8) Neurological Headaches Faintness/Dizziness Numbness, tingling, loss of sensation in body NONE
Other: _____

9) Psychiatric Depression Nervousness Anxiety Mood Swings Bipolar NONE
Other: _____

10) Endocrine Excessive thirst or hunger Hot/Cold intolerance Hot Flashes NONE
Other: _____

11) Hematological: Easy Bruising Easy Bleeding Anemia NONE
Other: _____

PAST MEDICAL HISTORY:

Surgeries/Hospitalization YEAR Doctor Complications?

if more space is needed, indicate so & continue on back of this paper)

SOCIAL HISTORY

Use of Alcohol: Never____ Rarely____ Moderate____ Daily____
 Use of Tobacco: Never____ Rarely____ Moderate____ Daily____
 Use of Drugs: Never____ Type/Frequency:_____

PRESENT MEDICAL HISTORY:

Please CHECK if you have had any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> COLITIS |
| <input type="checkbox"/> BROKEN BONES/FRACTURES | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> KIDNEY PROBLEMS |
| <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> GLANDULAR PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> HISTORY OF CANCER |
| <input type="checkbox"/> HEMMORROIDS | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> STROKE when _____ | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> TUBERCULOSIS (TB) . | <input type="checkbox"/> TUMORS |
| <input type="checkbox"/> ULCERS | <input type="checkbox"/> PHLEBITIS/varicose veins |
| <input type="checkbox"/> HEART PROBLEM | <input type="checkbox"/> PULMONARY/EMBOLISM/blood clots |
| Specify _____ | <input type="checkbox"/> CANCER explain _____ |
| <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> PSYCHOLOGICAL PROBLEMS, Anxiety |
| Specify: _____ | |

Please list any other MEDICAL PROBLEMS:

FAMILY HISTORY

| | Living? | Age | List health status or the cause of death |
|----------------|---------|-----|--|
| Mother | | | |
| Father | | | 0 |
| Sister/Brother | | | |
| Sister/Brother | | | |
| Sister/Brother | | | |
| Sister/Brother | | | |

REVIEWED BY: DR'S SIGNATURE_____

Authorization for Use or Disclosure of Protected Health Information Updated June 30, 2009

I, the patient or guardian, authorize the staff of South Mountain Orthopaedic to render medical care for my condition and to release my Protected Health Information (PHI) to carry out treatment, for reimbursement and/or health care operations. This includes and is not limited to any information including diagnostic testing results, medical notes, drug/alcohol abuse, psychiatric treatment or any contagious disease information which is considered my Protected Health Information. I understand that I may restrict how the information is used or disclosed by indicating any restriction IN WRITING. I understand that South Mountain Orthopaedic will make every effort to comply with my request, however, they are not required to agree to the restriction.

I understand that the complete Privacy Notice is posted in the waiting room and is available to me at any time upon request. My protected health information may be used or disclosed for the following purposes:

- Another healthcare provider, facility or medical supply company (EBI) involved in my treatment
- Diagnostic testing, such as but not limited to, CT scan, bone scan, MRI, x-rays
- Outpatient and/or In-patient admissions, pre-certification
- My insurance carrier(s) and/or any third-parties that are designated by my insurance carrier to process claims or appeals. Demographic and billing information will be disclosed to SaVit Collection or any collection attorney or small claims court if my account becomes delinquent.
- Buechel Patient Care, Education & Research Fund which applies ONLY to patients of Dr. Buechel who undergo total joint replacement surgery by Dr. Buechel. The non-profit organization is the doctor's research and development department.

Complete BELOW: We cannot speak with your spouse, significant partner, friend or any family member without authorization from YOU !

| <u>List Names</u> | <u>relationship to you</u> | <u>phone #</u> |
|-------------------|----------------------------|----------------|
| | | |
| | | |
| | | |

Our doctors are affiliated with the following hospitals/surgical facilities and your personal health information will be disclosed at the facility if you are having a surgical procedure.

- Dr. Buechel: St. Barnabas Medical Center (Livingston, NJ)
- Dr. Helbig: St. Barnabas Medical Center (Livingston, NJ), Florham Park Surgery Center (Florham Park, NJ)
- Dr. Cuomo: St. Barnabas Medical Center (Livingston, NJ) and Clara Maass Medical Center (Belleville, NJ)
Short Hills Surgical Center (Millburn, NJ), Florham Park Surgery Center (Florham Park, NJ)

Please be aware that both Dr. Helbig and Dr. Cuomo have financial interest in Florham Park Surgery Center and we are mandated to disclose this information to you according to "Public Law of the State of NJ"

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. This authorization shall be in force and effect until I revoke it IN WRITING, at which time this authorization to use or disclose this protected health information expires. The written notification should be sent to the Privacy Officer: DR. THOMAS HELBIG, 61 First Street, South Orange, NJ 07079 (973) 762-8344.

Patient's signature: _____ dated _____

PRINT PATIENT'S NAME: _____

Please read & keep this page

Please COMPLETE the forms on ALL pages – BRING completed FORMS to your visit .

Welcome to our office ! Kindly read our policies, thank you.

TURN OFF YOUR CELL PHONE please when you enter our office. You may use them in the atrium ONLY.

Kindly do NOT wear PERFUME or COLOGNE Due to various allergies among staff and other patients

CALL us and advise us NOW if you forgot to tell us your visit is related to a work injury or auto accident.
The reason is that some insurance plans require you to see their own network of doctors.

CURRENT INSURANCE CARDS and PHOTO IDENTIFICATION to be presented to the Receptionist arrival along with paperwork that was sent to you.

Co-PAYMENTS: are required at the time of the visit !!! We accept cash, major credit and debit cards. BRING the EXACT cash amount, we do not have cash on hand to give out change. CHECKS are NOT accepted. There is a ATM machine around the corner.

X-RAYS and other tests: Please bring the report & the ACTUAL films for MRI, CT scans, Diagnostic X-rays, Nerve Conduction Studies, EMG.

CHANGE OF ADDRESS/PHONE NUMBER: Inform receptionist upon arrival

NO REFERRAL - Sorry, NO VISIT ! It is NOT our responsibility to contact your doctor for a referral. Kindly obtain the referral before your visit(s). We cannot see you if you need a referral and don't have it with you.

WORK OR AUTO INJURY: If you are here for a NEW PROBLEM OR ANY PROBLEM related to an injury on the job or due to a motor vehicle accident, **CALL US NOW !!!!** Injuries that occur at work must be reported to your employer. Some workman compensation carriers mandate that you be seen by their panel of physicians. If you were injured in an automobile accident, we must contact the automobile carrier for authorization. This must be done prior to your visit !!!

PRESCRIPTIONS: Medication and refills for medication will be handled Monday through Thursday ONLY between the hours of 9-4pm. No refills on weekends / holidays !

Disability FORMS: Please allow 5-7 business days for completion of forms. Copies/Fax services to authorized 3rd parties or to the patient are available. Our fee is \$10.00 for completion of forms, payable in advance.

MRI/CT scans and other testing: Some insurance plans require pre-authorization. please allow 7 business days for us to contact you with the authorization number.

COPIES OF RECORDS Minimal fee is \$10.00 (1-10 copies), additional \$1.00 for each page

COPIES OF X-RAYS \$20.00 per film (most xrays are 1 or more films)