**PATIENT INFORMATION SHEET**

**Rahway-Edison Orthopaedic Group**

**(Please *PRINT* clearly)**

LAST NAME FIRST NAME MI

BIRTH DATE / / SOCIAL SECURITY NO / /

If minor, parent’s Social Security Number / /

ADDRESS

CITY STATE ZIP CODE

Home Phone ( ) Cell ( ) Work( )

Email Address:

Sex: Male/Female

Referring Doctor Medical Doctor

Pharmacy Name and Phone No

**Type of Visit**

MEDICAL AUTO ACCIDENT WORKMAN’S COMP LEGAL

If auto or legal: Date of Accident Claim Number

**PRIMARY NSURANCE**

NAME OF INSURANCE COMPNY:

MEDICARE ID or INSURANCE ID:

**CARDHOLDER NAME** **CARDHOLDER’S Date of Birth**:

**SECONDARY INSURANCE**

**CARDHOLDER NAME** **ID#**

**CARDHOLDER’S Date of Birth:**

**ASIGNMENT OF BENEFITS/RELEASE OF INFORMATION**

I hereby authorize any MEDICARE and/or INSURANCE benefits for services furnished be paid directly to Rahway-Edison Orthopaedic Group, PA. I also agree to fully accept financial responsibility for all non-covered services and pay outstanding balances upon receipt of the monthly statement.

I authorize the physician to release to the Health Care Financing Administration/Insurance Carrier and/or its agents any information required in the processing of all submitted claims.

A copy of this signature is valid as the original.

Signature Date

RAHWAY-EDISON ORTHOPAEDIC GROUP/HOWARD M. PECKER, M.D.

**Visit Intake Form and Initial Medical History**

**Please print and fill out this form COMPLETELY - every question is important to your care and treatment**

**Date**  / / **NAME:** **AGE:** Sex

**Chief complaint/reason for this visit:**

**Date Problem started:**  / /

**Treatment so far (list tests already performed):**

**List all other medical conditions, past and present**, **such as Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Heart attack, etc.**

**List all past surgeries** - date/year:

**Medications:** dosage, reason for taking & date you started the medication

Place an X or Check mark next to any condition that you currently have. Leave the enty blank if it does not apply to you:

shortness of breath hepatitis chills or fever HIV emphys ema frequency/retention urinating (circle one) stroke thyroid condition cancer

change in bowel or bladder habits Date of Last Menstrual Period

**MEDICATION ALLERGY/ Reaction:**  / / /

**OCCUPATION:**  **BRIEF JOB DESCRIPTION**

**Social History/Living arrangements:**

Lives Alone with partner, husband or wife with extended family with children

**FAMILY MEDICAL HISTORY:**

in Mother Diabetes Heart Disease Hypertension Cancer

in Father Diabetes Heart Disease Hypertension Cancer

**Smoking:**  packs a day for years - stopped in

**Alcohol:** beers per day glasses of wine per day oz. Distlled per day

**HEIGHT:** Feet Inches **WEIGHT:** lbs.

**RAHWAY-EDISON ORTHOPEDIC GROUP**

**HOWARD M. PECKER, MD**

Due to the new patient privacy laws regarding patient records, we can no longer submit

claims, receive authorization/ precertification or release medical records unless we have authorization from the patient.

If you would like this office to continue submitting medical claims for payment and receiving authorization/ precertification for procedures, we cannot disclose information from your medical records, on the telephone, without written authorization. You must sign below authorizing the above.

We will supply your insurance company with the minimum, but necessary information required for payment and/ or authorization/ precertification for payment.

**If you do not authorize us to release medical information, you will be responsible for your office visit and cost at the time of your visit.**

I HERBY AUTHORIZE THE ABOVE MEDICAL OFFICE TO RELEASE MEDICAL INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT. THIS WILL ALSO SERVE AUTHORIZATION TO RELEASE INFORMATION FOR DISABILITY BENEFITS.

**×**

PATIENT SIGNATURE

DATE

**Notice of Privacy Practices Acknowledgement**

**Howard M. Pecker, MD**

I understand that, under the Health Insurance Portability & Accountability Act of 1995 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**PATIENT NAME**

**I authorize RAHWAY-EDISON ORTHOPAEDIC GROUP TO RELEASE MEDICAL INFORMATION AND/OR PICK-UP NOTES, FORMS, ETC TO:**

NAME RELATIONSHIP PHONE #

NAME RELATIONSHIP PHONE #

**I AUTHORIZE RAHWAY-EDISON ORTHOPAEDIC GROUP TO LEAVE A DETAILED MESSAGE ON THE FOLLOWING PHONE ANSWERING MACHINE**

PHONE PATIENT **SIGNATURE**

DATE