South Mountain Orthopaedics, 61 1st Street, South Orange, NJ 07079 973 762-8344

Kindly bring the following to your visit:

- **Completed Patient Information Forms**
- **Photo Identification (mandatory by law)**
- **Current Insurance Cards**
- **EXACT copayment (Credit cards, Cash ONLY – no checks)**
- **REFERRAL FORMS from your Primary doctor (if your plan requires this)**

Please **REFRAIN FROM SMOKING** prior to your visit & avoid wearing strong perfume/cologne.
If you need to BRING a companion, kindly ONLY bring one person – We have limited seating in our reception room
You may be asked to **change into a hospital coverup** during the examination

NO REFERRAL – WE CANNOT TREAT YOU. Call Member Service (on your insurance card) if unsure

MINORS: Must be accompanied by a parent or guardian who has valid photo identification.

NO TALKING ON CELL PHONES (texting allowed)

NO EATING , NO DRINKING except WATER in our office. .

AUTOMOBILE or WORK –related injuries Please call our office ASAP and advise us that your visit is for an accident. We will inform you of the information required for your appointment

X-RAYS, MRI, CTscan: Please bring the report & the ACTUAL films for MRI, CT scans, Diagnostic X-rays, Nerve Conduction Studies, EMG. We can take x-rays in our office when the tech is here.

DISABILITY/FLMA FORMS: Fee is $10 - $15 per form payable in advance

COPIES of records: $1.00 per page COPIES of X-rays: $30.00 per film, payable in advance

PARKING: We have a security guard monitor our complimentary parking lots(across the street

DIRECTIONS: Visit our website: www.NJortho.com for GPS please use either 61 1st Street or 20 Valley Street , South Orange, NJ Our building is on the corner of both streets. Large brown building.

We are required to obtain this information from every patient:

Patient's Name:_____ **Today's Date**:_____

1. What is your **PREFERRED/primary language** (eg. English, Spanish, Italian, etc)_____

2.

Your RACE (check or circle below)	**Your ETHNICITY (check or circle below)**
____American Indian/ Alaska Native	_____ Hispanic, Spanish, Latino
____Asian / from India	_____ Not Hispanic
____Black / African American	_____ Unknown
____White / Caucasian	_____ I decline to specify
____Other Race	
____ I decline to specify	

3. In the event surgery is recommended, will you accept blood products, transfusions IF medically necessary?
   Please *Answer: Yes or NO* _____ **Your SIGNATURE:**_____

PLEASE read and INITIAL the statements below. Any questions, please ask receptionist or our Manager.

_____**Copayments**. I understand they are payable at the time of the visit, otherwise, my appointment will be rescheduled. The office ONLY accepts Cash, Credit or Debit cards. If sent to collection, unpaid balances over 30 days may incur $5.00 fee per
Statement plus 18% per annum interest. Overdue accounts over 60 days may be sent to the collection agency

_____**A $25.00 fee** will be charged if I fail to show up for my appointment. I understand that I must call office personnel to cancel or reschedule PRIOR to the appointed time. The office may remind me of the appointment, however, it is MY responsibility to remember your appointment. Any No-Show fee(s) must be paid prior to scheduling additional appointments.

_____The **contact phone numbers** supplied on the Patient Information Forms may be used to contact me for appointment reminders, outstanding balances, authorization numbers for tests and for other reasons. I will ONLY supply South Mountain Orthopaedic Associates with phone numbers for which they are authorized to leave messages for me.

Attestation (meaning you sign that you understand our policy and procedures)
\:
I have read, understand and completely agree that the information contained on this form is true & accurate and can be changed at any time in writing. I also understand and agree to the office policies outlined. I authorize South Mountain Orthopaedic to appeal and obtain records on my behalf.

Patient or Guardian's Signature:_____ Dated:_____

Witnessed by staff member of South Mountain Orthopaedic Associates:_____

TYPE CLEARLY- answer everything PLEASE !!! (1)

PATIENT INFORMATION:

DO YOU HAVE MEDICARE coverage?_____ Do you have MediCAID HMO coverage_____?
Is the patient a MINOR (under the age of 18?)_____
Are you here due to an AUTO ACCIDENT ?_____ Due to a WORK INJURY?_____
How were you injured(briefly)_____
_____

LAST NAME_____**FIRST NAME & middle initial**_____

Home ADDRESS:_____
street apt # City State zip code

BEST phone/cell numbers to contact you & leave a message per HIPAA privacy:
1) (_____)_____ **2)** ( )_____ **3)** ( )_____

BIRTHDATE_____ AGE_____MARITAL STATUS_____ SPOUSE'S NAME _____

HMO REFERRING DOCTOR_____ Your Social Security #_____-_____-_____

Driver's Lic #_____**EMAILaddress**:_____@_____.____

CIRCLE which applies: AUTO accident WORK INJURY NOT APPLICABLE

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 (_____) _____Position/type of work:_____

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

ONE-TIME AUTHORIZATION to be kept on file: All payments & co-payments are DUE at the time of service. Billed balances must be paid within 30 days and subject to monthly statement fees & accrued interest. I understand the office may charge a $25.00 "No show Fee" for uncancelled no-show appointments. I was given the South Mountain Orthopaedic's HIPAA policy.

DATE:_____SIGNATURE_____(patient or guardian)

COMPLETE THIS PAGE & the following pages:

(If female, are you pregnant?_____notify medical personnel IMMEDIATELY) **(2)**

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: _____ ___hone ( )_____
Address (necessary for electronic prescribing)_____

CHIEF COMPLAINT & Present History

- Reason for visit today, what are your ORTHOPAEIDIC complaints/concerns:

_____
_____

***IS INJURY due to 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_____

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: ***COMPLETE each section below :***

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 Throat: Loss of hearing Ear Ache or Infection Ringing in Ear Sinus Problems
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 Brusing Easy Bleeding Anemia NONE
Other _____

PAST MEDICAL HISTORY:

Surgeries/Hospitalization YEAR Doctor Complications? **(4)**

_____

_____

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:

_____**AIDS/HIV**
_____**BLEEDING DISORDERS**
_____**BROKEN BONES/FRACTURES**
_____**HEPATITIS**
_____**LIVER PROBLEMS**
_____**HIGH BLOOD PRESSURE**
_____**HEMMOROIDS**
_____**STROKE** when_____
_____**TUBERCULOSIS(TB)** .
_____**ULCERS**
_____**HEART PROBLEM**
Specify _____
_____ **LUNG PROBLEMS**
Specify:_____

_____**ANEMIA**
_____**COLITIS**
_____**DIABETES**
_____**KIDNEY PROBLEMS**
_____**GLANDULAR PROBLEMS**
_____**HISTORY OF CANCER**
_____**SEIZURES**
_____**THYROID PROBLEMS**
_____**TUMORS**
_____**PHLEBITIS/varicose veins**
_____ **PULMONARY/EMBOLISM/blood clots**
_____ **CANCER** explain_____
_____ **PSYCOLOGICAL PROBLEMS, Anxiety**

Please list any other **MEDICAL PROBLEMS:**

_____

FAMILY HISTORY

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

REVIEWED BY: DR'S SIGNATURE_____

South Mountain Orthopaedic Associates Phone 973 762-8344 FAX 973 762-1626

Attestation of Patient receipt of HIPAA Privacy Notice
& Authorization for Use or Disclosure of Protected Health Information

I, the patient or guardian, was given the complete HIPAA Privacy Notice to read and maintain for my own records. I may request another copy of the HIPAA Private Notice at any time upon request .

I authorize the staff of South Mountain Orthopaedic to render medical care for my condition & 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 may restrict how the information is used or disclosed by indicating any restriction IN WRITING & South Mountain Orthopaedic will make every effort to comply with my request, however, they are not required to agree to the restriction.

***** IMPORTANT, please read:** I hereby authorize the office to contact me and/or leave messages on any personal telephone, cell, office telephone number and/or email which has been provided to the office either by way of the patient-information forms or provided verbally. IF there is a change to this method of communication, I will contact the Manager immediately or the Assistant Manager by calling 973 762-8344.

My protected health information may be used or disclosed to the following:

- Another healthcare provider, facility or medical supply company, diagnostic testing, CT scan, MRI or other related person(s) or entity involved in the treatment plan.
- Full disclosure of medical records to 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 *(only applicable to patients of Dr. Buechel who undergo total joint replacement surgery by Dr. Buechel)*

Complete BELOW: Please list names of any person(s) we are authorized to speak with concerning your care: (eg. spouse, significant partner, friend or any family member). Without authorization we cannot discuss anything. Include Name of person, relationship to you and phone number (if known)

_____

_____

_____ _

Disclosure: Dr. Helbig has financial interest in Florham Park Surgery Center. We are mandated to disclose this information to you according to "Public Law of the State of NJ. The doctors also operate at St. Barnabas (hospital)

ATTESTATION: I have been given a copy of the HIPAA Privacy Act and 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. **I authorized the practice to contact me & leave messages on the phone numbers listed on the Patient Information Form – Page 1 and on any other phone number I verbally provide in the future**.

Patient's signature: _____ PRINT name_____Dated:_____

FOR OFFICE USE ONLY: *I attest that the Patient was given the HIPAA Privacy Notice to read, review and maintain for their records:* ***Signed by office Staff member:*** _____

Updated 2.2016