Peter Blank, D.O. Julie Lin, M.D. Dana Cortese, PA-C
150 North Finely Avenue, Basking Ridge, New Jersey

New Patient Registration

Name: ___________________________________ **Date of Birth**: ________________ **SS#:** _______________________
Address: ________________________________ **City:** ______________________ **State**: ______ **Zip**:________________
Home Phone #: _________________________ **Cell Phone #:** _________________________ **Fax #:** ________________
Employer: ____**Work Phone #** :_________________________________
E-Mail: ____ **Language:** □ English □Other: ____________________________
Race: □American Indian/Alaskan Native □African American □Asian □Hispanic □Native Hawaiian/Other Pacific Islander
□White □Other □DECLINE TO ANSWER **Ethnicity:** □Hispanic/Latino □NOT Hispanic/Latino □DECLINE TO ANSWER

Name of Pharmacy/Location: _________________________________ **Phone #:** _______________________________
Referring Physician: _______________________________________ **Phone #:** _______________________________
Primary Care Physician: ______________________________________ **Phone#:** _______________________________

Emergency Contacts
Name:____ Phone #: __________________Relation: ____________________
Name:____ Phone #: _________________ Relation: ___________________

Insurance Information
□ Medicare □Private/Other
□Workman's Compensation: **Date of Accident**: _______________ **Claim #:** ____________________________________
□Motor Vehicle Accident : **Date of Accident**: _______________**Claim #:** ____________________________________

Primary Insurance
Address (on back INS card):
____
ID#: ____ **Group #:** ____
Name of Subscriber: ____ **Relation:** ______________________________
SS# (Subscriber): _________________________________ **DOB of Subscriber**: __________________________________
Is the Subscriber the responsible party for payment: □ **Yes** □**No If "No" please list who is:** _________________

Secondary Insurance (if applicable)
Address (on back INS card):
____
ID#: _______________________________________ **Group #:** ____
Name of Subscriber: ____ **Relation:** ____________________________
SS# (Subscriber): _________________________________ **DOB of Subscriber**: ________________________________
Is the Subscriber the responsible party for payment: □ **Yes** □**No If "No" please list who is:** __________________

Assignment Of Release of Information Statement- I certify that the information given by me is correct. I hereby authorize the release of ANY information related to my medical care, as requested by Government agencies and/or insurance carriers. I hereby assign benefits to my Physician and understand that in the absence of accepted insurance coverage, I/legal guardian are responsible for FULL PAYMENT of services rendered including deductibles and co-insurance.

NEW JERSEY CENTER FOR
ORTHOPAEDICS & SPORTS MEDICINE

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Medicare Patients- I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services, and 20 % co-insurance on ancillary services. When Medicare is deemed the secondary insurance I will follow payment terms under my Physician's policies.

____

Patient or Guardian Signature Date

<u>Injury Information</u>

Chief Complaint:

____

____

Duration of Symptom's: _______Days ________Weeks __________Months __________Years

____

Medical History

List medical problems':

____

____

List surgeries & dates:

____

____

List current medications:

____

____

List medical allergies:

____

____

Family Medical History

Does anyone in your family have any of the following problems?

□ Heart Disease □Diabetes □High Blood Pressure □Cancer □Nerve Problems Other:

____

Do you have any of the following symptoms?

□Weight Loss □Fever/Chills □Night Pain □Weakness □Other Joint Pain □Numbness □Bowel/Bladder Changes
□Heart Problems □Breathing Problems □Morning Stiffness □Stomach Problems
Other:

____

____

Social History

□Single □Married □Divorced □Widow/Widower
□Non-Smoker □Smoker packs per day: _______
Alcohol Consumption: □Never □Occasionally □Frequent How often? ___________
□Working Working as: ____ □Unemployed □Retired

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Authorization for Release of Protected Health Information

I _________________________________, authorize the release of my protected health information to the following Physician(s) and/or facility(s) upon request of the Physician(s) or facility(s) for the purpose of my treatment:

Physician(s) Facility(s) Name:
____

Physician(s) Facility(s) Name:
____

I am **over the age of 18 OR a parent and/or guardian of a child under the age of 18** and authorize the staff and/or Physician(s) at this office to discuss my healthcare, diagnosis, test results, procedures, prognosis, and any additional aspects of my healthcare, as well as insurance and billing information with the following person(s):

Name of individual: ____Relation: ________________________
Name of individual: ____Relation: __________________________

I **authorize** the staff and/or Physician(s) to leave a message with test results, and other limited information on my private voicemail.

Phone #: ______________________________________   □ I **deny** voicemails to be left.

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Welcome to the office of New Jersey Center for Orhopaedics & Sports Medicine. We thank you for allowing us to participate in your care.

Please bring this form along with your registration form, any medical reports, x-rays, MRI's or other information pertaining to your visit. Make sure to bring your insurance cards with you so that we may photocopy them for our file to maximize your benefits.

Please arrive for your appointment 15 minutes prior to your scheduled appointment time to cpmplete the necessary paperwork.

We encourage you to become familiar with your insurance policy. You may ask your emloyee benefits representative any questions as to what is covered and what is not. You may also contact your member services area at your insurance company.
Payment for services is required at the time of service unless prior arrangements have been made with our billing office. If we are a participating provider with your insurance carrier we will abide by the terms of the contract and collect a co-payment at the time of service. As a courtesy to you, our office will submit claims to your insurance carrier. Please remember, you are liable for payment of all deductibles and co-insurance.

If your insurance company requires referrals, it is your responsibility to bring in your referral to your appointment. Failure to do so will result in either rescheduling your appointment or you being responsible for payment at the time of service.

Worker's Compensation and motor vehicle patients must call prior to their appointment with the name of their insurance carrier, claim number, billing address, name and phone number of their adjuster. Failure to do so will result in either rescheduling your appointment or you being responsible for payment at the time of service.

Prescription refills will be written during office hours, Monday-Thursday 8-5 and until 11:30 a.m. on Friday. Unless an emergency, medications are not refilled over the weekend. Please make every effort to check the status of your medications and notify our office in a timely manner.

If you have any questions, please feel free to call the office at 908-340-4266.

Assignment and Release of Information Statement- I certify that the information given by me is correct. I hereby authorize the release of any information related to my medical care, as requested by government agencies, and/or insurance carriers. I hereby assign benefits to my physician and understand that in the absence of accepted insurance coverage or my insurance company fails to pay, I/legal guardian am responsible for full payment of services rendered.

Medicare Patients – I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services and 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow the terms of my primary insurance carrier.

____

Patient or Guardian's Signature **Date**