



MERCER-BUCKS ORTHOPAEDICS PC

PATIENT REGISTRATION

PLEASE PRINT

Last Name _____
 First Name _____
 Middle Name _____
 Sex _____
 Previous Last Name _____
 Date of Birth _____
 Social Security No. _____
 Address _____
 Zip _____ Email _____
 City _____
 State _____
 Home Phone _____
 Work Phone _____
 Mobile Phone (_____) _____
 Marital Status _____
 How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

Name _____
 Relation _____
 Phone (_____) _____

EMPLOYER INFORMATION

Name _____
 Phone (_____) _____

GUARANTOR INFORMATION (to whom statements are sent)

Last Name _____
 First Name _____
 Middle Name _____
 Address _____
 Zip _____
 City _____
 State _____
 Social Security Number: _____ - _____ - _____
 Phone (_____) _____
 Employer Name _____

PRIMARY INSURANCE INFORMATION

POLICY INFORMATION

Patient's relationship to policy holder _____

 ID/Certification No. _____
 Policy/Group No. _____
 Issue Date _____
 Primary Care Physician _____

POLICY HOLDER

Type of Insurance _____
 Last Name _____
 First Name _____
 Middle Name _____
 Social Security Number _____ - _____ - _____
 Sex M____ F____ Date of Birth ____ / ____ / ____

SECONDARY INSURANCE INFORMATION

POLICY INFORMATION

Patient's relationship to policy holder _____

 ID/Certification No. _____
 Policy/Group No. _____
 Issue Date _____

POLICY HOLDER

Type of Insurance _____
 Last Name _____
 First Name _____
 Middle Name _____
 Social Security Number _____ - _____ - _____
 Sex M____ F____ Date of Birth ____ / ____ / ____



AUTHORIZATION FOR RELEASE OF CONFIDENTIALITY & MEDICAL INFORMATION

This authorization or photocopy thereof will authorize Mercer Bucks Orthopaedics to furnish all information they may have regarding my condition, while under their observation or treatment, to any party who may be responsible for payment to Mercer Bucks Orthopaedics, including the history obtained, X-ray and physical findings, diagnosis and prognosis.

In addition to release of information as authorized and in the interest of confidentiality with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information to on your behalf is required. This would pertain specifically to personal relations, i.e. family, friends, etc.

I authorize the release of medical information (health and demographics) as it pertains to my care only to the following. (You may contact our office at any time should you wish to make changes to this authorization)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

ASSIGNMENT OF INSURANCE BENEFITS

I assign the group physician benefits herein specified and otherwise payable to me to Mercer Bucks Orthopaedics, but not exceed Mercer Bucks Orthopaedics charge for this period of treatment. I authorize and request that payment be made directly to Mercer Bucks Orthopaedics. I understand and agree that regardless of my insurance coverage, I am financially responsible to Mercer Bucks Orthopaedics for charges not covered by my insurance company or this authorization. This assignment or photocopy is acceptable.

MEDICARE AND MEDIGAP ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to Mercer Bucks Orthopaedics for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I further authorize any holder of Medicare and/or Medigap information about me to release to Mercer Bucks Orthopaedics any information needed to determine benefits payable for related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, Mercer Bucks Orthopaedics agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

Date _____ Signature _____

Witness _____ Signature _____

Form reviewed by: _____ Date _____

Copy of Insurance Card ___Y ___N

Verified Auto Accident ___Y ___N

Entered demographics into system:

Name _____ Date _____

NOTES: _____



Mercer-Bucks Orthopaedics, P.C.

Diplomates American Board of Orthopaedic Surgery

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

<p>PATIENT HEALTH INFORMATION Under Federal Law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment billing, and insurance information.</p> <p>How We Use Your Patient Health Information: We use health information about you for treatment to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.</p> <p>Examples of Treatment, Payment and Health Care Operations: Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment to pharmacists who are filling your prescriptions, and to family members who are helping with your care. Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it. Special Uses: We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Other Uses and Disclosures: We may use or disclose identifiable health information without your permission for the following purposes: Required by Law: We may be required by law to report gunshot wounds, suspect abuse or neglect,</p>	<p>or similar injuries or events.</p> <p>Research: We may use or disclose information for approved medical research.</p> <p>Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recall of dangerous products, and similar information to public health authorities.</p> <p>Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.</p> <p>Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.</p> <p>Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.</p> <p>Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies.</p> <p>Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or health and safety of the public or another person.</p> <p>Military and Special Government Functions: If you are a member of the armed forces, we may release information to correctional institution to correctional institutions or for national security purposes.</p> <p>Worker's Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illnesses. If any other situation, we will ask for your written authorization before using or disclosing any identifiable health information, you can later revoke that authorization to stop any further uses and disclosures.</p> <p>INDIVIDUAL RIGHTS You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights. Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restriction, but if you do agree, we must abide by those restrictions.</p>	<p>Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.</p> <p>Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.</p> <p>Amend Information: If you believe that information in your records is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add missing information.</p> <p>Accounting of Disclosure: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment or health care operations.</p> <p>Our Legal Duty: We are required by Law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.</p> <p>Changes of Privacy Practices: We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below:</p> <p>Complaints: If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the US Department of Health and Human Services. This person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.</p> <p>Contact Person: If you have any questions, requests or complaints, please contact: Constantine A. Solomos, MBA, CMPE C.E.O. 3130 Princeton Pike Lawrenceville, NJ 08648 609-896-0444</p> <p>I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.</p> <p>Signed _____</p> <p>Date _____</p> <p>If not signed, reason why acknowledgement was not obtained: _____ _____</p> <p>Staff Witness seeking acknowledgement _____ _____</p> <p>Date _____</p>
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Mercer-Bucks Orthopaedics, P.C.

Diplomates American Board of Orthopaedic Surgery

Daren J. Aita, M.D.
Thomas K. Bills, M.D., Ph.D.
Paul W. Codjoe, M.D.
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David S. Eingorn, M.D.

Edward J. Ford, M.D.
Sandro LaRocca, M.D.
John P. Nolan, Jr. M.D.
Rikin J. Patel, DO

I _____ have informed Mercer-Bucks Orthopaedics that the treatment/services I am receiving starting _____ are not the result of an a automobile accident. The injuries for which I am seeking treatment/services do not arise out of the ownership, operation, maintenance, use of an automobile or as a pedestrian.

I _____ understand that by my notifying Mercer-Bucks Orthopaedics that the injuries are not automobile related, no notification or claim will be sent to my automobile insurance company. Therefore, any bills incurred but not covered by my personal health insurance will be my personal responsibility and obligation to pay. Payment is expected upon receipt of services.

We at Mercer-Bucks Orthopaedics ask that you sign this document only after any questions you may have concerning its content have been answered to your satisfaction and you understand your obligation to pay for any unpaid services by your insurance carriers.

Patient Signature

Date

Office Manager



Mercer-Bucks Orthopaedics, P.C.
 3120 Princeton Pike
 Lawrenceville, NJ 08648
 609-896-0444 fax: 609-896-1055

SPINE WELLNESS INTAKE FORM

Please fill this form out in its entirety. Thank you for your cooperation.

NAME: new, patient DATE OF BIRTH: _____
 AGE: _____ WEIGHT: _____ HEIGHT: _____
 PRIMARY CARE PHYSICIAN _____
 Are (Right) or (Left) handed (circle)

Clinical Information

Chief complaint: _____

1) How did your injury occur?

- Spontaneous onset Fall or Injury describe: _____
- Job Related describe: _____
- Motor Vehicle Accident **DATE of accident/injury:** _____
- Sports/Recreational Injury
- OTHER: please describe _____

2) What are your symptoms? _____

3) When did your symptoms begin? _____

4) Do you have any numbness? If yes, where? _____

5) Do you have any tingling? If yes where? _____

6) Do you have any weakness? If yes, where? _____

7) Any chance in your bowel or bladder habits as a direct result of your injury?
 Yes No If yes describe: _____

8) Since the pain began, has it: Improved Not changed Worsened Comes and goes

9) Does the pain you experience awaken you from sleep? Yes No

10) Do any of the activities listed below alter your level of pain?

Activity	Aggravates the Pain	Relieves the Pain	Neither
Sitting			
Standing			
Walking			
Lying down			
Leaning over a shopping cart			
Bending forward			
Bending backwards			
Twisting			
Lifting			
Driving			
Coughing or Sneezing			
Bowel Movement			



11) If you have tried any of the items listed below, please check and then circle if any were helpful in relieving your pain:

- Physical therapy Traction Active exercise Brace / Collar
 Heat/Cold Medication(s) Holistic or Alternative therapies
 Manipulation Pain psychology Chiropractor TENS unit
 Spinal Injection Date of last injection: _____ Did it help? YES__ NO__

RADIOGRAPHIC STUDIES COMPLETED

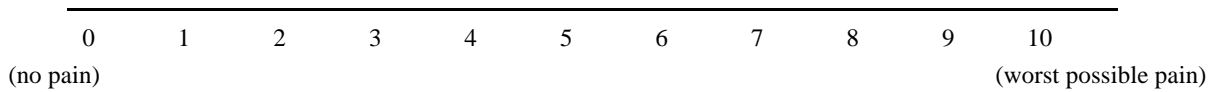
Please check all studies that have been completed.

- XRAY CT scan MRI Myelogram Bone Scan Other: _____
 EMG DEXA scan (bone density)

PAIN DIAGRAM

PAIN SCALE

On a scale of 1 to 10 circle the one that best describes your pain:



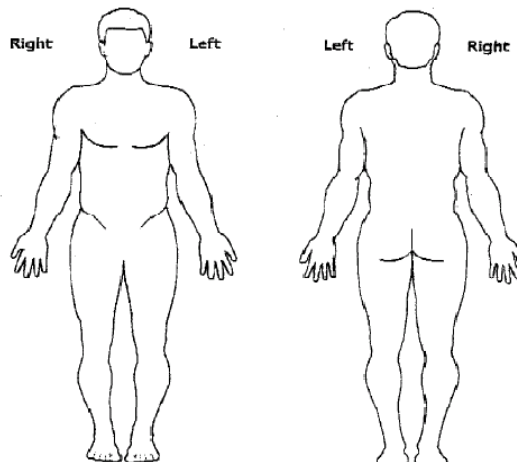
Faces Pain Rating Scale



0 No Hurt 1 Hurts Little Bit 2 Hurts Little More 3 Hurts Even More 4 Hurts Whole Lot 5 Hurts Worst

Using the symbols given below mark the areas on your body where you feel the described sensations. Include all affected areas. To complete the picture, draw your face.

- Aching Numbness Tingling Burning Stabbing Other
 ^^^^^^ ===== oooooooooooooo xxxxxx /////////////// -----



Pain in arm(s) compared with neck _____ worse _____ same _____ less
 Pain in leg(s) compared with back _____ worse _____ same _____ less



PAST MEDICAL HISTORY

Medical problems / Illnesses (please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Cardiac/Heart Problems | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis/HIV/AIDS |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> GERD or GI Ulcers | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Myocardial Infarction | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Pagets Disease |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prostate | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Peripheral Vascular Dz |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Asthma | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Restless Leg Syndrome |
- Recent Infection where? _____ on antibiotics Yes No
- DVT (clot in legs) Completed treatment Yes No
- Cancer Type: _____
- Other medical problems: _____

PRIOR SURGERY Previous spine surgery yes no List all other surgeries below:

Allergies to medications: Yes No **If yes List:**

Allergic to iodine/shellfish/seafood Yes No **Reaction:** _____

Are you allergic to latex: Yes No

LIST ALL MEDICATIONS and usage (including over-the-counter and herbal):

Do you take? Plavix ASA Coumadin Lovenox NSAIDs (circle)

List current pain medications (if any)

Any history of substance abuse or illicit drug use Yes No



Family History	Age	Major Illnesses	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Brother/Sister	_____	_____	_____
Brother/Sister	_____	_____	_____
Son(s)	_____	_____	_____
Daughter(s)	_____	_____	_____
Family History of Arthritis?	No _____ Yes _____	Which family member? _____	Type _____

Social History

Marital Status Single _____ Married _____ Widowed _____ Divorce _____

Use of Alcohol Never _____ Rarely _____ Moderate _____ Daily _____

Use of Tobacco Never _____ Previously but quit _____ Current packs/day _____

Are you right or left handed? _____ Living Situation: Alone _____ with Spouse/Family _____ with Friends _____

Hobbies and sport activities you enjoy _____

Type of work _____

Have you ever been on Disability ? _____ When ? _____

Was the disability work related ? Y N Do you have any Lawsuits Pending? Y N (If Yes Please Explain)

Are there religious/cultural needs related to your care? (Please circle) No Yes (If Yes Please Explain)

Systems Review

(Did you have any of the following symptoms within the past 6 months?)

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Hematologic/Lymphatic

Anemia	No	Yes
Phlebitis	No	Yes
Past blood transfusion	No	Yes
Exposure to HIV	No	Yes
History of Blood Clots	No	Yes

Musculoskeletal

Osteoporosis	No	Yes
History of fractures	No	Yes
History of gout	No	Yes
Rheumatoid disease	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer	No	Yes
Hepatitis	No	Yes

Neurological

Lightheaded or dizzy	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Psychiatric

Depression	No	Yes
Memory loss or confusion	No	Yes
Insomnia	No	Yes
Nervousness	No	Yes

Reviewed by Dr. _____ Date _____

Patient's Signature _____



MERCER-BUCKS ORTHOPAEDICS

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any Medical service visit, X-ray, EMG, OMT, DME or Therapy services ordered by my physician or my physician's staff.

I understand and agree it is my sole responsibility and not the responsibility of the provider of services, hospital, surgery center, therapists or supplier to know if my insurance will pay for my Medical service or visit, X-ray, EMG, OMT, DME or Therapy services ordered by my physician or my physician's staff.

I understand and agree it is my sole responsibility to know if my insurance has any Deductible, Referral Requirement, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied, or higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly.

By signing below, I agree to accept full financial responsibility as a patient who is receiving Medical services, X-rays, EMG, OMT, DME or Therapy services or as the responsible party for minor patients. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Patient Signature _____ Date _____

Responsible Party Name (please print) _____

Responsible Party Signature _____ Date _____