Patient Information

Please answer all questions fully

Date:

Account Number:

Premier Orthopaedic Of SJ

1007 Mantua Pike
Woodbury, NJ 08096-3963

Phone: (856) 853-8004 **Fax: (856) 853-8022**

Patient					
Name (Last, First, MI)	Social Security	Age	Birthdate	Sex	Home Phone Cell Phone
Mailing Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone	

Responsible Party					
Name (Last, First ,MI)	Social Security		Birthdate	Sex	Home Phone
Address	City	State	Zipcode	Marital Status	
Employer	City	State	Zipcode	Work Phone	

Primary Provider	**Referring Provider**	**Referring Address**	**Phone**	**Fax**

Insurance Information				
Primary Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Second Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay
Third Insurance Company	Subscriber's Name, Birthdate, SSN	Relationship	Policy Number/Group#	Copay

Emergency Contact Information				
Contact Name	Relationship	Home Phone Number	Work Phone Number	Cell Phone Number

Please List Additional Medical Information

Patient Release:
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDER'S CURRENT RATE, MAY BE CHARGED on all balances owing to the provider that are past due.

I permit a copy of this release to be used in place of the original.

Signature: _____ Date: / / 2015

(Signature of insured or authorized person, patient or parent if minor)

PLEASE COMPLETE ENTIRE FORM

PREMIER ORTHOPAEDICS OF SOUTH JERSEY
Meaningful Use Intake Form

Date: _____

Patient: _____ **DOB:** _____

Email Address: _____

Pharmacy: _____ **Pharmacy Address:** _____

Pharmacy Phone Number: _____

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Decline to specify
- ☐ Hispanic
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Language

- ☐ Decline to Specify
- ☐ English
- ☐ Other
- ☐ Sign Language
- ☐ Spanish

Ethnicity

- ☐ Decline to Specify
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino

Medications: _____ _____

_____ _____

_____ _____

_____ _____

Allergies: ☐ No Known Allergies ☐ Allergies (please list)

☐ No Known Drug Allergies _____

_____

Smoking History:

Have you smoked 100 cigarettes in a lifetime? ☐ Yes ☐ No

Current Status: ☐ Everyday ☐ Some days ☐ Former Smoker ☐ Never Smoker

Current Smoker: ☐ Advised to Quit ☐ Gave Cessation Materials/ Counseling

Vitals:

Blood Pressure: _____

Height: _____ Weight: _____ lbs.

Todd M. Lipschultz, M.D.
Premier Orthopaedic of South Jersey

Medical History

Date: _____

Name_____ Age_____ Occupation_____

Chief Complaint (reason for your visit): **Date of Accident/injury**: _____

_____

_____

_____

_____

Injury to: _____

Prior injury/surgery to affected area: _____

Hand Dominance: left / right

Have you had any treatment or tests performed? Yes / No

If yes, with whom: _____

Tests performed: _____

_____

Have you had follow up care before today? Yes / No

Are you currently working? Yes / No if no, last day worked:_____

Past Medical History: High BP Heart Disease Asthma Emphysema Diabetes TB GERD Phlebitis Cancer Gout Rheumatoid Arthritis Thyroid

Current Medications: _____

_____

Medication Allergies: _____

_____

Past Surgical History: _____

_____

_____

Height _____ **Weight** _____ **B.P.** _____

Patient Signature: _____ **Date**: _____

Doctors Signature: _____ **Date:** _____