

# 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: \_\_\_\_\_  
(Signature of insured or authorized person, patient or parent if minor)

Date: \_\_\_\_\_ / \_\_\_\_\_ / 2015

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: \_\_\_\_\_