

**Performance Orthopaedics & Sports Medicine
New Patient Packet**

Thank you for completing this questionnaire. In order to provide the highest quality of healthcare, please fill out this questionnaire as completely and accurately as possible. All answers are strictly confidential.

Date: _____ **Account #** _____
Name: _____ **Date of Birth:** ___/___/___
 Last First Middle Initial
Social Security Number: _____ - _____ - _____ Email: _____
Home Phone: _____ Cell Phone: _____
Home Address: _____
 Street City State Zip Code

Primary Care Physician:

Name (Last, First): _____ Phone: _____
Address: _____

Referring Physician:

Were you referred to us by any doctor?: Y N

If yes: Name (Last, First): _____ Phone: _____
Address: _____

HISTORY:

Age: _____ Height: _____ Weight: _____ Dominant Hand: L R Gender: M F
Race: _____ Ethnicity: _____
Occupation: _____ Hobbies/Sports: _____
Location of symptoms: L R Circle one: Shoulder Elbow Hip Knee Ankle Other
Please describe: _____
Circle one: Pain Swelling Stiffness Instability Locking Numbness Weakness
Duration of symptoms: _____
How did the injury occur (circle one): Sports injury Job-related Auto accident Other _____
If job-related: -was the injury reported to the employer: Y N
 -are you currently working for this employer: Y N
Symptoms made worse by : _____
Symptoms made better by : _____
Treatment: _____

Has another physician previously treated/seen you for this problem?: Y N

If yes: Name (Last, First): _____ Phone: _____

Address: _____

MEDICAL HISTORY: _____

Women only: Are you or do you have any reason to believe that you may be pregnant? Y N

Are you taking oral contraceptive medication? Y N

PRIOR SURGERIES: _____

MEDICATIONS: _____

ALLERGIES: _____

ALLERGIES TO (circle all that apply): Tape Iodine Latex None

SMOKING HISTORY (circle one): None Quit smoking Currently smoke # packs per day: _____

ALCOHOL USE (circle one): None Rare Social Frequent

MAJOR FAMILY MEDICAL CONDITIONS: _____

REVIEW OF SYSTEMS:

	Do you have the problem?	Do you receive treatment for it?	Does it limit your activities?
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcer or Stomach Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia or other blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoarthritis, degenerative arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disorder: Hypo Hyper	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other medical problems (please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Emergency Contact Information

Last Name First Name Relationship to Patient

Home Phone: _____ Cell Phone: _____

Employer Information

Company Name

Work Address: _____
Street City State Zip Code

_____-_____-_____
Work Phone Number Occupation

Referral Information

How were you referred to us? (circle one)

MD Family Friend Directory Attorney Hospital Patient

Staff Member Yellow Pages Website Radio Other _____

Person Responsible for Payment (if other than patient)

Last Name First Name Relationship to Patient

Address: _____
Street City State Zip Code

_____-_____-_____
Home Phone Work Phone Date of Birth

Primary Insurance Information

Primary Insurance Carrier

Policy Holder Last Name Policy Holder First Name Relationship to Patient

_____/_____/_____
Date of Birth _____-_____-_____
Social Security Number

Secondary Insurance Information

Secondary Insurance Carrier _____

Policy Holder Last Name _____

Policy Holder First Name _____

Relationship to Patient _____

_____/_____/_____
Date of Birth

____-____-_____
Social Security Number

If applicable:

Workers' Compensation Injury

Auto Injury Information

Insurance Carrier: _____

Address: _____

Street

City

State

Zip Code

Carrier/Claim Case # _____ Policy # _____

Case Manager:

Name (Last, First): _____

Address: _____

Street

City

State

Zip Code

Phone: _____

Fax: _____

Attorney:

Name (Last, First): _____

Address: _____

Street

City

State

Zip Code

Phone: _____

Fax: _____

Date of Injury: _____

Time of Injury: _____ AM PM

Pharmacy Information (Important)

Name: _____

Address: _____

Street

City

State

Zip Code

I authorize Dr. Dickerson to download my medication history:

Signature: _____

Assignments of Benefits

Your signature is required for us to protect any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims of that is pertinent to my medical and/or surgical benefits, including downloading major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature

Date

If Patient is a minor, Signature of Parent

Date

Billing Waiver for Insurance Patients:

I understand that my insurance carrier may deny payment for certain screenings, labs, tests, DMEs, supplies, or injections in the doctor's office. It is my right to refuse these, and my responsibility to pay for them if I accept to receive them.

I also understand that Dr. David B. Dickerson may be out of network with my insurance and I will be responsible for all deductibles and office fees at the time of my visit.

I also understand that any DME and/or supplies that are purchased are non-refundable.

I further understand that all balances not paid within 90 days will be subject to a 30% collection fee and or interest charges.

Insurance Release & Authorization:

I, _____, clearly understand the above information, and accept responsibility for my bill.

Patient Signature _____

Dated _____

Missed/Cancelled Appointments:

Missed appointments will be assessed a "no-show" fee depending on the type of visit. Appointments cancelled with less than 24 hours notice are considered a missed appointment and will be charged a \$25.00 fee.

Signature: _____

ALL HORIZON PATIENTS MUST READ AND SIGN

I understand that Dr. Dickerson is out of network and I may receive the payment for his services, I agree to forward all payments received onto him within 30 days of receiving payment.

Signature: _____

Written Acknowledgement of Receipt of Notice of Privacy Practices

_____ Last Name _____ First Name _____ Date of Birth

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have any further questions or complaints I may contact:

Performance Orthopaedics & Sports Medicine
780 Route 37 West, Suite 330, Toms River, New Jersey 08753
(732) 691-4898

I also understand that I am entitled to receive updates upon my request if the Performance Orthopaedics & Sports Medicine Notice of Privacy Practices is amended or changed in a material way.

_____ **Signature** _____ Relationship to Patient

_____ Date