SECKLER ORTHOPEDICS AND SPORTS MEDICINE
2444 HIGHWAY 34, SUITE B MANASQUAN NJ 08736
732-528-4407
WWW.SECKLERORTHO.COM

MOTOR VEHICLE ACCIDENT- INFORMATION FOR APPOINTMENT – must be COMPLETED prior to arrival
MVA Insurance Declaration page and PIP Application Required
Missing information/documents will result in your appointment being rescheduled to a later date.

Any person who knowingly or with intent to defraud any insurance company or other persons, provides false or misleading information concerning any fact(s), therefore commits an act of insurance fraud, which is a crime, subject to criminal prosecution and or civil penalties.

PATIENT NAME: ____ BIRTHDATE: _________________

Date of Accident: _____________ Location of Accident: ____

Driver's License # (required) ____ State ___________

Describe Your Injury and or Pain: ____

____

Did patient go to the Hospital? [ ]No [ ]Yes, Date:__________ Name of Hospital:___________________________
[ ] X-rays ______________ [ ]MRI__________________ Surgery or Other:_________________________________

The Patient was the [ ] Driver [ ] Passenger [ ] Pedestrian
Was seat belt worn? [ ] Yes [ ] No Police Notified? [ ] No [ ]Yes, copy of accident report required.

M.V. Insurance Company Name & Address: ____

M.V. Insurance Claim #________________________________ Policy #________________________

Is the patient the Policy Holder: [ ]Yes [ ]No Does the patient reside with Policy Holder [ ] Yes, [ ]No, then
M.V. Policy Holder Name:____
M.V. Policy Holder Address:____

[ ]Case Manager Name:________________________________ Phone #:______________________
Claims Billing Address:____

If you declared your Health Insurance carrier the primary payer of auto claims, you must provide us with a copy of the declaration page of your automobile policy. If you are unable to provide it, an appointment cannot be rendered.

I authorize SECKLER ORTHOPEDICS to furnish any and all information regarding my condition while under observation, care or treatment in accordance with the Personal Injury Protection Benefit Law. I authorize MARK M. SECKLER to file insurance claims on my behalf for services rendered. I also assign payment of authorized medical services be made to MARK M. SECKLER, M.D. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents, any information needed to determine benefits payable for medical related services. It is understood that if I falsify or omit any information, the balance will become my full responsibility payable upon demand. Further, I am responsible for all deductibles, coinsurance, and co-payments within 30 days of billing cycle.

Patient/Guardian Signature: ____ Date: _______________

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PATIENT FULL NAME ____ Date of Birth_______________ Sex: M F

HOME ADDRESS____CITY _________________STATE_____ ZIP _____

BILLING ADDRESS:____

TELEPHONE: Home__________________________ Cell_________________________ Other_______________________

SOC SEC # ______________________ PATIENT RESIDES WITH: □ SPOUSE □ PARENT/GUARDIAN □ OTHER________________

MARITAL STATUS ___SINGLE ___MARRIED ____WIDOWED ____DIVORCED

CHECK HERE IF PATIENT IS STUDENT _______Name of School ____ State_______

EMPLOYER NAME ____OCCUPATION_________________________

EMPLOYER ADDRESS____PHONE____________________________

EMERGENCY CONTACT NAME____ PHONE ____________________________

PLEASE TELL US WHO REFERRED YOU TO OUR OFFICE ____

*E-MAIL ADDRESS required for access to your medical records*____

HEALTH INSURANCE – CARD MUST BE PRESENTED AT VISIT - COPAYS MUST BE PAID AT THE TIME OF VISIT.

INSURANCE COMPANY________________________________ ADDRESS____
INSURANCE ID # ______________________________ GROUP # ____________________ EFFECTIVE DATE_________
IF THE FOLLOWING IS THE SAME AS PATIENT, INITIAL HERE _______AND SKIP TO NEXT SECTION
INSURED'S LAST NAME __________________________________ FIRST ______________________ MI_____
BIRTH DATE _____________RELATIONSHIP TO PATIENT □ Parent/Guardian □Spouse □ Other_________________
EMPLOYER ____ PHONE___________________

SECONDARY/SUPPLEMENTAL/SCHOOL INSURANCE CARD/FORM /COPAY REQUIRED. Initial here if no secondary ______

INSURANCE COMPANY _____________________ADDRESS ______________________________________
INSURANCE ID # ___________________________ GROUP # ________________________EFFECTIVE DATE
IF THE FOLLOWING IS THE SAME AS PATIENT, INITIAL HERE _____AND SKIP TO NEXT SECTION
INSUREDS LAST NAME___________________________ FIRST_________________________________MI______
BIRTH DATE _______________ RELATIONSHIP TO PATIENT □ Parent/Guardian □Spouse □ Other______________
EMPLOYER ____ OCCUPATION_________________________

➡PATIENT/GUARANTOR SIGNATURE:____ DATE:__________

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PATIENT NAME:____ **BIRTHDATE**_________________

NAME, ADDRESS PHONE OF YOUR FAMILY DOCTOR____

PHARMACY NAME, STREET/TOWN, PHONE ____

Describe the part of your body affected: □**KNEE** □**SHOULDER** □**OTHER** ___________________□**RIGHT** □**LEFT** □**BILATERAL**

Date you first noticed any symptom(s) ______________________ **List all symptoms** __________________________________

List any other Physician(s)/Hospital you saw for this problem ____

List any other treatment past or present you have had on this same body part __________________________________
When ____

List All medications you are currently taking for this condition:

Name of Medication	Dosage	Frequency	Last Dose Date

On a scale between 0 (least) and 10 (worst), how severe is your pain ____
0 1 2 3 4 5 6 7 8 9 10

What relieves your pain/discomfort ____

What aggravates your pain/discomfort ____

Have you contacted any attorney □**NO** □**YES, Name and Address**
____

Please note: the Doctor will not complete disability forms during your visit. All Forms will be completed and mailed 7-10 working days from the date of your surgery, or from the date which the Doctor renders you disabled. There may be a fee for completing forms. Medication requests and or prescription refills will be taken Monday through Friday *during office hours only*.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mark M. Seckler, M.D. or any insurance company to release any information required to process my claim.

➡ **Signature**____ **Date**______________________

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PATIENT NAME ____ **BIRTHDATE**____________________________

Patient Medical History

Please check if you have had any of the following:

□ Alcoholism
□ Anemia
□ Anxiety
□ Arrhythmia
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bronchitis
□ CAD
□Cancer Type:______________
□ Cardiovascular Disease
□ CHF
□ Crohn's Disease
□ Cirrhosis
□ Colitis
□ Constipation
□ COPD
□ CRF
□ CVA
□ Dementia / Alzheimer's
□ Disc Disease
□ DJD
□ Depression
□ DM Type I
□ DM Type II
□ Emphysema
□ Epilepsy
□ Fracture
□ GERD
□ Glaucoma
□ Hepatitis
□ High Cholesterol
□ Hyperlipidemia
□ Hypertension
□ Implanted Medical Devices
□ Kidney Disease
□ Liver Disease
□ Migraine
□ Multiple Sclerosis
□ Nephrolithiasis
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Prior MI
□ Pulmonary Disease
□ Rheumatoid Arthritis
□ Seizures
□ Sickle Cell Disease
□ STD
□ Thyroid Disease
□ TIA
□ Tuberculosis
□ Ulcers
□ Valve Problems

□Other____

FEMALES: Is there any chance you may be pregnant? □ Yes □ No Last date of menses:_________

Past Surgical History: □ No prior surgical history Sign here: __________________

□ Shoulder Surgery Date__________
□ Spinal Surgery Date__________
□ Knee Surgery Date__________
□ Total Knee Replacement Date__________
□ Total Hip Replacement Date__________
□ Other _____________ Date__________
□ Appendectomy Date__________
□ D & C Date__________
□ Hysterectomy Date _________
□Tonsillectomy Date__________
□ Tubal Ligation Date__________
□ Mastectomy Date__________

□ ANY/ALL Surgical Complications: □ NO □ YES, describe____________________ Date_________

□ ANY/ALL Infections: □ NO □ YES, describe:_______________________ Date_________

□ DVT (BLOOD CLOT) □ NO □YES Date __________

Any problems with anesthesia? □ NO □ YES, describe:______________________________________

PLEASE DESCRIBE ALL INFECTIONS AND OR COMPLICATIONS/PROBLEMS ON THE BACK OF THIS PAGE

➡ **Signature**____ **Date**____________________________

FOR OFFICE USE ONLY:

HT ____________ ***WT***____________ ***PULSE***____________ ***BP***____________ ***Note:***__________

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PATIENT NAME ________________________ **BIRTHDATE**________________

R.O.S. -Please check if you have the following:

□ Joint Pain	□ Radiculopathy	□ Fractures
□ Back Pain	□ Joint Stiffness	□ Sudden unexplained fractures
□ Loss of appetite	□ Recent change in weight	□ Fatigue (Tired)
□ Fever	□ Chills	□ Night Sweats
□ Headache	□ Vision Problems	□ Ear pain
□ Hearing difficulty	□ Sinus Problems	□ Neck Stiffness
□ Chest Pain	□ Ankle swelling	□ Cold hands or feet
□ Palpitations	□ Heart murmur	□ Persistent cough
□ Shortness of breath	□ Difficulty Breathing	□ Chest congestion
□ Nausea	□ Vomiting	□ Diarrhea
□ Constipation	□ Abdominal Pain	□ Polyuria (Frequent Urination)
□ Excessive Thirst	□ Heat intolerance	□ Cold intolerance
□ Seizures	□ Dizziness	□ Numbness
□ Tingling	□ Confusion	□ Sensory Disturbances
□ Anxiety	□ Depression	□ Panic Attacks
□ Suicidal Thoughts/Attempts	□ Sleep Disturbances	□ Mood Disorders
□ Emotional Problems	□ Depression Screening Completed	□ Easy Bleeding tendency
□ Easy Bruising tendency	□ Frequent Infections	
□ Food Allergy	□ Environmental Allergies	

Preventive Care: ***Have you had any of the following? If so, please provide the date.***

□ Last Complete Physical Exam	___/___/___	□ Bone Density	___/___/___
□ Colonoscopy	___/___/___	□ Mammography	___/___/___
□ Flexible Sigmoidoscopy	___/___/___	□ Chlamydia Screening	___/___/___
□ PSA	___/___/___	□ HIV Testing	___/___/___
□ Stool Occult Blood	___/___/___	□ Flu Vaccine	___/___/___
□ Stress Test	___/___/___	□ Pneumovax	___/___/___
□ Routine Eye Exam	___/___/___	□ Zoster Vaccine	___/___/___
□ Dilated Eye Exam	___/___/___	□ Tdap Vaccine	___/___/___
□ Foot Exam	___/___/___	□ TD	___/___/___
□ HPV	___/___/___	□ Tuberculin PPD	___/___/___

General Family History (Please Circle: Mother, Father, Sibling)

Mother □ Living □ Deceased Age_____ Cause____________ **Father** □ Living □ Deceased Age_____ Cause____________

□ Ankylosing Spondylitis	M F S	□ Colitis	M F S	□ Kidney Disease	M F S
□ Arthritis	M F S	□ COPD	M F S	□ Liver Disease	M F S
□ Alcoholism	M F S	□ Crohn's Disease	M F S	□ Osteoarthritis	M F S
□ Anemia	M F S	□ CVA / TIA	M F S	□ Osteoporosis	M F S
□ Anxiety	M F S	□ Depression	M F S	□ Psoriasis	M F S
□ Asthma	M F S	□ Diabetes	M F S	□ Pulmonary Disease	M F S
□ Bleeding Disorder	M F S	□ Epilepsy	M F S	□ Renal Disease	M F S
□ CAD	M F S	□ GERD	M F S	□ Rheumatoid Arthritis	M F S
□ MI's	M F S	□ Gout	M F S	□ SLE	M F S
□ CHF	M F S	□ Hypertension	M F S	□ Thyroid Disease	M F S

➡ **Signature**________________________________ **Date**________________

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PATIENT NAME ____ BIRTHDATE________________

LIST ALL CURRENT MEDICATIONS & DOSAGE

□Initial here if taking NO MEDICATIONS__________

MEDICATION	DOSE	FREQUENCY

LIST ALL ALLERGIES & REACTION

□Initial here if NO KNOWN ALLERGIES _______

ALLERGY	Reaction

Health Habits

Caffeine: _____cups/day

Alcohol: □ Never □ Social: ____ drinks per week: □ Beer □ Wine □Other:________________

Tobacco □ Never □Currently □Previously pack(s)/day for __years □Cigarette/Cigar □ Pipe □ Chew/ Smokeless □ Quit: When_______________

Drug Use: Prescription □ Never □ Recovering □ Current Specify:_____________________________________
Recreational □ Never □ Recovering □ Current Specify:_____________________________________

Signature____ **Date**____________________

MARK M. SECKLER, M.D.
SECKLER ORTHOPEDICS AND SPORTS MEDICINE
2444 HIGHWAY 34, SUITE B MANASQUAN, NJ 08736

PATIENTNAME:____BIRTHDATE:___________________

CONDITIONAL ASSIGNMENT OF PERSONAL INJURY PROTECTION BENEFITS

PLEASE READ CAREFULLY AS THIS ASSIGNMENT IMPOSES DUTIES AND OBLIGATIONS UPON THE PERSON(S) AND/OR THE ENTITIES WHO SIGN IT

BY PATIENT/CLAIMANT: By signing this Conditional Assignment below, I ___________________________ (Claimant/Patient) hereby assign my right to pursue a claim for reimbursement of PIP benefits directly and irrevocably to the doctor or other health care provider (his employees, designees, and/or assignees) that has executed this Assignment.. Furthermore, I authorize the release of medical records from the provider to the insurance carrier. A photocopy of this document shall be considered as effective and valid as the original.

BY PROVIDER: By signing this Conditional Assignment below, I , MARK M. SECKLER, M.D. assert that I am the health care provider noted above, and on behalf of all medical staff associated with the provider, we collectively understand and agree to obtain a fully executed Conditional Assignment in order to be paid directly by the carrier for covered services. A fully executed copy of this Conditional Assignment will be furnished to the carrier upon request.

The Conditional Assignment must be signed by the patient/claimant and the treating health care provider or an agent authorized to act on behalf of the provider.

Decision Point Review/Precertification is only a determination of medical necessity and is not a guaranty of payment. Decision Point Review/Precertification does not confirm or verify eligibility for coverage, statutory benefits or payment.

“Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.” N.J.S.A. 17:33A-6

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS AND CONDITIONS SET FORTH IN THIS ASSIGNMENT.

➡ Patient/Claimant Signature: __________________________________ Date:_________________________

PIP APPLICATION- SEPERATELY

GENERAL APPLICATION OF BENEFITS – PERSONAL INJURY PROTECTION

1) To enable us to determine if you are entitled to benefits under the Personal Injury Protection law, you MUST complete and sign this form.
2) You must also sign the attached authorization(s). 3) Return these forms promptly with any medical bills you have received.

DATE	POLICYHOLDER	DATE OF ACCIDENT

INSURANCE CARRIER ______________________________ POLICY #______________________
INSURANCE CARRIER ADDRESS , CITY, STATE ZIP______________________________
CLAIM REPRESENTATIVE______________________________ CLAIM REP PHONE #______________________
INSURANCE AGENT______________________________ AGENT PHONE #______________________

YOUR NAME______________________ HOME PH #__________ WK #__________ CELL #__________
ADDRESS ______________________ CITY ______________ STATE ________ ZIP__________
BIRTH DATE______________________ SOCIAL SECURITY #______________________

DATE & TIME OF ACCIDENT______________________ ______________________A.M./P.M.
PLACE OF ACCIDENT (STREET, CITY, STATE)______________________________

Do you or any member of your household own an automobile? ☐ Yes ☐ No
Were you the owner? ☐ Yes ☐ No Were you a passenger in the automobile? ☐ Yes ☐ No
Were you a member of the automobile owner's household? ☐ Yes ☐ No
Name of insurance company______________________________

AS A RESULT OF THIS ACCIDENT WERE YOU INJURED? ☐ YES ☐ NO
If your answer is yes, complete the remainder of this form. If no, sign here and return the form to us.

SIGNATURE:______________________________ DATE:______________________

DESCRIBE YOUR INJURY:______________________________

Were you treated by a doctor? ☐ Yes ☐ No
If yes, name & address of doctor:______________________________
Were you treated at a hospital? ☐ Yes ☐ No If yes, ☐ in-patient or ☐ out-patient?
If yes, name & address of hospital:______________________________
Amount of medical bills to date: $______________________ Will you have more medical expenses? ☐ Yes ☐ No

At the time of your accident, were you in the course of your employment? ☐ Yes ☐ No
Did you lose wages or salary as a result of your injury? ☐ Yes ☐ No
If yes, amount lost to date: $______________ What is your average weekly wage or salary? $______________
If you lost wages, give the date disability from work began ______________ Date returned to work ______________

Have you received or are you eligible for benefits under ☐ Worker's Compensation; or ☐ Temporary Disability; or ☐ Medicare?
If yes, amount of benefit $______________ per ☐ week or ☐ month
List names & addresses of your employers for one year prior to the accident date as well as your occupation and dates of employment:

As a result of this injury, have you any other expenses? ☐ Yes ☐ No If yes, please explain on reverse side.

SIGNATURE: ______________________________ DATE: ______________________

AUTHORIZATION FOR MEDICAL INFORMATION AND ASSIGNMENT

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, e-rays and physical findings, diagnosis & prognosis. You are authorized to provide this information in accordance with the personal injury protection benefits law. I hereby assign my insurance benefits to Mark M. Seckler, M.D. herein specified, otherwise payable to me, not to exceed medical fees. I understand I am financially responsible for services not covered by this assignment and I agree to pay them, if any.

SIGNATURE: ______________________________ DATE: ______________________

AUTHORIZATION FOR WAGE AND SALARY INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding wages or salary while employed by you. You are authorized to provide this information in accordance with the personal injury protection benefits law.

SIGNATURE: ______________________________ DATE: ______________________