BAYSIDE ORTHOPEDICS, LLC
Office of Erik S. Larsen, D.O.
780 Route 37 West Suite 330
Toms River, NJ 08755
Phone (732) 966 6317
Fax (732) 998-8086

Dear Patient:

We welcome you as a new patient to Bayside Orthopedics, and we would like to thank you for choosing Dr. Erik Larsen as your Orthopedic Specialist.

For your convenience, please see the list below of things to bring with you to your initial visit:

- ☐ Photo **identification**
- ☐ Your **health insurance card(s)** and copay
- ☐ Please check with your insurance company prior to your visit with us and see if **Referrals are required** to see a specialist. If they are, please make sure to obtain this from your primary care physician and bring it to the appointment
- ☐ A list of **current medications**
- ☐ Our list of participating insurances may change from time to time, so we will review your insurance card when you come for your first appointment. If you have a question about whether or not we participate with your insurance, contact your insurance prior to your appointment
- ☐ Please bring report(s) and CD's/images of recent **x-rays, MRIs or CTs** within the past year) that are relevant to your appointment
- ☐ A list of your **questions and concerns**
- ☐ Patients under the age of 18 must be accompanied by a **parent or legal guardian**
- ☐ Please **complete** and bring the following **New Patient Forms** to your scheduled appointment. Filling these out before arriving at the office will help ensure your appointment runs as smoothly as possible
- ☐ Please also arrive at least **15 minutes prior** to your appointment time so that we may process your paperwork and insurance information prior to you seeing the Doctor

If you have any questions or concerns regarding your upcoming appointment, please call 732-966-6317 and speak with our appointment specialists.

REGISTRATION FORM

Date_____ *Welcome to our office*

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married/Civil Union ☐ Widowed ☐ Divorced ☐ Separated

Name_____Date of Birth_____

Address_____Home Phone_____
Street Apt.

_____Work Phone_____
City State Zip

_____-_____-_____ Cell Phone_____
Social Security#

Occupation: _____ Employer:_____

☐ Employed Full-time ☐ Employed Part-time ☐ Retired ☐ Disabled ☐ Not Employed ☐ Self Employed

You were referred by: ☐ Dr. ☐ Friend/Relative First Name_____ Last Name_____

Primary physician for medical care: First Name _____ Last Name _____

What pharmacy do you use? Name _____ Phone#_____

Pharmacy Location: _____

Patient's email address: _____

You will be contacted via your cell phone number, if provided, as your contact of preference unless otherwise specified.

♦EMERGENCY CONTACT: ☐ Spouse ☐ Child ☐ Friend ☐ Other_____

➢Name_____Phone_____

Address_____

♦The U.S. Government requires the following to be completed: Height _____ Weight_____

Race _____ Ethnicity _____ Language _____

➢➢Please give the receptionist your insurance cards to be copied.➢➢

➢➢Also, please give the receptionist any x-rays, films or CD's and/or reports you might have.➢➢

The undersigned hereby authorizes Bayside Orthopedics, LLC to release or obtain information as may be necessary to determine benefits entitlement, process payment of claim and/or diagnostic and therapeutic information for health care services provided to the above named patient. I authorize payment of medical benefits to Bayside Orthopedics, LLC for medical services. Should my insurance(s) deny or if Bayside Orthopedics, LLC does not participate with my insurance, I am aware I am responsible for the payment. Also, all obligations of my insurance (such as referrals written to Bayside Orthopedics, LLC, referral dates and visits, properly determining primary vs secondary insurance, etc.) are my responsibility. Should Bayside Orthopedics, LLC submit to my nonparticipating insurance as a courtesy I realize I might be responsible for payment. If this is a Workers Comp claim and the Workers Comp insurance fails to make payment after one year I will be responsible for payment. Please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred: Green Acres Manor and Physicians SurgiCenter. I may, of course, seek treatment at a health care service provider of my own choice. A listing of alternative health care service provider can be found in the classified section of my telephone directory under the appropriate heading. I also authorize Bayside Orthopedics, LLC to contact my pharmacy, to release or obtain information as well as speak to my family members and/or emergency contacts, leave messages pertaining to my medical condition and/or appointment on an answering machine if applicable. I authorize Bayside Orthopedics, LLC to download insurance eligibility and medication history. I authorize a copy of this authorization to be used in the place of an original. I also understand I have the right to revoke this authorization except to the extent the action has already been taken in reliance of the authorization. This authorization will be in effect until seven years after the last date of treatment or until it is revoked by either party. Once the information is disclosed to a third party, they may in turn disclose it to someone else and they may not be a covered entity under the Health Insurance Portability and Accountability Act. I may be held responsible for collection costs, attorney fees, and court costs for delinquent accounts. I understand that the office is not responsible for loss of, damage to, or theft of my personal possessions while I am on the premises.

Regarding Medicare Patients:
I request that payment of authorized Medicare and/or Medigap benefits be made either to me or on my behalf to Bayside Orthopedics, LLC for any services furnished me by the physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents and/or the Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE_____DATE_____
(If signed by patient representative, state relationship)

RELATIONSHIP_____

INSURANCE INFORMATION FORM

Name_____ Date of Birth_____ Date_____

➢➢PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARDS TO BE COPIED≺≺

◆Primary Insurance Plan Name_____

Insured : ☐ Self ☐ Spouse ☐ Parent ☐ Other_____ If Other than Self please complete the following:

Subscriber's Name_____ Date of Birth_____

Subscriber's Address_____ Subscriber's Gender: ☐ Male ☐ Female
Street Apt.

_____ _____-_____-_____
City State Zip Subscriber's Social Security#

◆Secondary Insurance Plan Name_____

Insured ☐ Self ☐ Spouse ☐ Parent ☐ Other_____ If Other than Self please complete the following:

Subscriber's Name_____ Date of Birth_____

Subscriber's Address_____ Subscriber's Gender: ☐ Male ☐ Female
Street Apt.

_____ _____-_____-_____
City State Zip Subscriber's Social Security#

WORKERS COMP OR MVA RELATED? Please complete this section.

Is this a job related injury? ☐ No ☐ Yes If yes, please also advise the Front Desk staff.

Is this a car accident related injury? ☐ No ☐ Yes If yes, please also complete health insurance info.

Is car insurance primary to health insurance? ☐ No ☐ Yes If yes, please also complete health insurance info.

➢Insurance Company Name_____Adjustor _____

Claim # _____Date of Injury_____

Insur. *Billing* Address_____ Phone _____
Street or PO Box

_____Fax _____
City State Zip

➢Employer Name_____

Employer Address_____ Phone_____
Street or PO Box

_____ Contact Person_____
City State Zip

➢Attorney Name_____ Phone_____

Attorney Address_____ Fax Number _____
Street or PO Box

_____ Contact Person_____
City State Zip

I declare, under penalty of perjury, that the above is true and accurate. I authorize a copy of this form & my signature to be used in lieu of an original. Should I fail to provide my insurances in their proper order I will be responsible for payment due to penalties of timely filing.

_____ _____
Patient Signature (If signed by patient representative, state relationship) Date

BAYSIDE ORTHOPEDICS, LLC
HIPAA 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. ♦PLEASE SIGN THE NEXT PAGE OF THIS FORM♦

INTRODUCTION

Bayside Orthopedics, LLC and staff understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information." "Protected health information" is also referred to as PHI. PHI includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all PHI we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy Officer,

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of treatment, payment and health care operations. For each of these categories of uses and disclosures, we have provided a description and an example below. However, not every particular use or disclosure in every category will be listed.

♦ *Treatment* means the provision, coordination or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

♦ *Payment* means the activities we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with information regarding your care if necessary to obtain payment. Federal or State law may require us to obtain a written release from you prior to disclosing certain specially PHI for payment purposes, and we will ask you to sign a release when necessary under applicable law.

♦ *Health care operations* means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comments and complaints, physician reviews, compliance programs, audits, computer maintenance and support, backup maintenance and support, development, management and administrative activities. For example, we may use your PHI to evaluate the performance of our staff when caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information to study health care and health care delivery without learning who you are.

♦ *Business Associates:* We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us. Business associates are required by law to abide by the HIPAA regulations.

♦ *Friends and Family Involved in Your Care:* If you have not voiced an objection, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for your care, including following your death.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your PHI in the following ways:

- We may disclose to your family or friends or any other individual identified by you PHI directly relevant to such person's involvement with your care or payment for your care. We may use or disclose your PHI to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition or death. If you are present or otherwise available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not present or otherwise available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.
- We may disclose your PHI to a pharmacy on your behalf. As well as download /upload prescription information.
- We may contact you to provide appointment reminders for treatment or medical care or leave a message for you and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in. .
- When permitted by law, we may coordinate our uses and disclosures of PHI with public or private entities authorized by law or by charter to assist in disaster relief efforts.
- You are authorizing the doctor/the Practice to initiate a complaint to the Insurance Commissioner for any reason on your behalf
- We will allow your family and friends to act on your behalf to pick-up prescriptions, medical supplies, X-rays, and similar forms of PHI, when we determine, in our professional judgment that it is in your best interest to make such disclosures.
- Subject to applicable law, we may make incidental uses and disclosures of PHI. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
- Photographs, videotapes, digital, or other images may be recorded to document your care. The Practice will retain the ownership rights to these photographs, videotapes, digital, or other images, but you will be allowed access to view them or obtain copies. The images will be stored in a secure manner that will protect your privacy and that they will be kept for the time period required by law or outlined in the Practice's policy.
- We may use or disclose your PHI for research purposes, subject to the requirements of applicable law. For example, a research project may involve comparisons of the health and recovery of all patients who received a particular medication. All research projects are subject to a special approval process which balances research needs with a patient's need for privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
- We will use or disclose PHI about you when required to do so by applicable law.

[Note: In accordance with applicable law, we may disclose your PHI to your employer if we are retained to conduct an evaluation relating to medical surveillance of your workplace or to evaluate whether you have a work-related illness or injury. You will be notified of these disclosures by your employer or the Practice as required by applicable law.]

SPECIAL SITUATIONS OR PUBLIC NEED

Subject to the requirements of applicable law, we will make the following uses and disclosures of your PHI:

We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you. We may use or disclose your Protected Health Information in the following situations without your authorization: as required by law, public health issues, communicable diseases, abuse, neglect or domestic violence, health oversight, lawsuits and disputes, law enforcement, to avert a serious and

♦PLEASE SIGN ON THE OTHER SIDE♦ >

imminent threat to health or safety, national security and intelligence activities or protective services, military and veterans, inmates and correctional institutions, workers' compensation, coroners, medical examiners and funeral directors, organ and tissue donation, and other required uses and disclosures. We may release some health information about you to your employer if you employer hires us to provide you with a physical exam and we discover that you have a work related injury or disease that your employer must know about in order to comply with employment laws. Under the law, we must also disclose your Protected Health Information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your permission in a written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we already have taken action in reliance on your authorization.

YOUR RIGHTS

1. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket. However, we are not required to agree to your request. To request a restriction, you must make your request in writing to the Practice's Privacy Officer.

2. You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Your physician is not required to agree to your request except if you request that the physician not disclose Protected Health Information to your health plan when you have paid in full out of pocket. To make such a request, you must submit your request in writing to the Practice's Privacy Officer.

3. You have the right to inspect and copy the protected health information contained in your medical and billing records and in any other Practice records used by us to make decisions about you, except:

(i) for psychotherapy notes, which are notes that have been recorded by a mental health professional documenting or analyzing the contents of conversations during a private counseling session or a group, joint or family counseling session and that have been separated from the rest of your medical record;

(ii) for information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;

(iii) for protected health information involving laboratory tests when your access is restricted by law;

(iv) if you are a prison inmate, obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody, or rehabilitation or that of other inmates, or the safety of any officer, employee, or other person at the correctional institution or person responsible for transporting you;

(v) if we obtained or created protected health information as part of a research study, your access to the health information may be restricted for as long as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate in the research;

(vi) for protected health information contained in records kept by a Federal agency or contractor when your access is restricted by law; and

(vii) for protected health information obtained from someone other than us under a promise of confidentiality when the access requested would be reasonably likely to reveal the source of the information.

In order to inspect and copy your health information, you must submit your request in writing to the Practice's Privacy Officer. If you request a copy of your health information, we may charge you a fee for the costs of copying and mailing your records, as well as other costs associated with your request. If you would like an electronic copy of your health information, we will provide one to you as long as we can readily produce such information in the form requested

We may also deny a request for access to protected health information if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

4. You have the right to be notified within sixty (60) days of the discovery of a breach of your unsecured protected health information if there is more than a low probability the information has been compromised.

5. You have a right to request an "accounting of disclosures" every 12 months, except for disclosures made with the patient's or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the request. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer.

6. You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home. We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.

7. You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

8. If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

9, If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at 732 966 6317, or with the Secretary of the Department of Health and Human Services. We will not withhold treatment or take action against you for filing a complaint.

10. Some kinds of information, such as alcohol and substance abuse treatment, HIV-related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

11. If you believe that the health information we have about you is incorrect or incomplete, you may request an amendment in writing. If we deny your request, we will provide a written notice that explains our reasons. You will have the right to have certain information related to your request included in your records.

If we deny a request for access for any of the reasons described, then you have the right to have our denial reviewed in accordance with the requirements of applicable law. I authorize a copy of this form & my signature to be used in lieu of an original. Your signature also represents your acknowledging that you received or have been given the opportunity to receive a copy of our Notice of Privacy Practices. This notice is effective 07/02/12.

Signature_____

If signed by patient representative, state relationship

Date_____/_____/_____ Relationship_____

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Patient Financial Agreement

PATIENT NAME:_____ DATE OF BIRTH:_____

If the information you have given us about your insurance company is not correct for each date of service, of if your coverage has lapsed, or if your plan requires you to obtain a referral to see a specialist and you failed to obtain a referral, you will be responsible for paying for services in full. You will be responsible for a returned check fee. This information is posted within the office. If your insurance has denied due to a timely filing issue because of any of the above reasons the balance will be your responsibility. You are also responsible for all credit card fees, collection costs, attorney fees and court costs as well as delinquent account fees incurred.

You agree to appropriately endorse and promptly forward to Bayside Orthopedics any payments sent to you by your insurance company(s). "With respect to a carrier which offers a managed care plan that provides for both in-network and out-of-network benefits, in the event that the covered person assigns, through an assignment of benefits, his right to receive reimbursement for medically necessary health care services to an out-of-network health care provider, the carrier shall remit payment for the reimbursement directly to the health care provider in the form of a check payable to the health care provider, or in the alternative, to the health care provider and the covered person as joint payees, with a signature line for each of the payees."N.J.S.A. 26:2S-6.1c.

Please take notice that practitioners in this office do have a financial interest in the following health care service(s) to which patients are referred: Physicians SurgiCenter. You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service provider can be found in the classified section of your telephone directory under the appropriate heading or online.

Bayside Orthopedics does not accept letters of protection. This office does not participate in any settlements or bill any third party businesses or homeowners insurances. Bayside Orthopedics requires written authorization from your employer or its workers compensation insurance carrier prior to your Workers Comp first visit. Denied charges due to lack of proper authorization will be your responsibility. Your private insurance cannot be used to cover treatment for work injuries unless your workers compensation coverage has denied, does not exist or your case has been settled. It is your responsibility to clearly identify those medical injuries and/or conditions that have been reported as due to motor vehicle or work related injury prior to your initial visit.

If you require surgery, an estimate of your financial responsibility may be provided to you and your estimated financial responsibility will be expected prior to surgery. A $200.00 cancellation fee for surgery may be applied if surgery is cancelled by the patient. There may be a need for a Surgical Assistant for surgery. The Surgical Assistant may not participate with your insurance. The Surgical Assistant is independent of our office and you may be billed separately from the Surgical Assistant.

The following paragraph will allow our office to send your claim to appeal on your behalf, if necessary:
I authorize an appeal of adverse Utilization Management determination(s) or any other adverse determination for all stage appeals as allowed by N.J.S.A. 26:2S-11, and release of personal health information to DOBI (Department of Banking and Insurance), its contractors and/or my insurance company(s) for the Independent Health Care Appeals Program, and independent contractors and reviewing the appeal. My consent to representation and authorization of release of information expires in seven years. I understand I may revoke it sooner by sending the revocation in writing.

SIGNATURE_____DATE_____
(If signed by patient representative, state relationship below)

RELATIONSHIP_____

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Pain Treatment with Opioid Medications: Patient Agreement

This Agreement is essential to the trust and confidence necessary in a prescriber/patient relationship. My prescriber has discussed my treatment plan with me. I understand that there is a risk of psychological and/or physical dependence and addiction associated with the chronic use of controlled substances for pain. I understand I will be told about the side effects that I may experience. My prescriber is undertaking to treat me with controlled substances for pain.

I (Patient Name), _____, Date of Birth _____
understand and voluntarily agree to the following:

I have told my prescriber about other medications I am taking and my medical history, including my prior experience with pain medications or other drugs. Throughout my treatment, I will communicate fully with my prescriber about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is helping to relieve pain. I will take my medication, as instructed and not change the way I take it without first talking to my prescriber or other members of the treatment team. I understand that my prescriber may change this medication during my course of treatment. I will not attempt to obtain pain medications from any other prescribers and understand that my prescriptions will be issued only during scheduled office visits with the treatment team or during regular office hours. If I require surgery or emergency treatment, and I am able to communicate, I will tell the health care professional taking care of me about all the medications I am taking and, at or before my next refill, I will tell my prescriber about my use of medications in these circumstances. I agree not to use illegal drugs or alcohol while on these medications. I understand that I should not drive a motor vehicle or operate machinery if the medication causes dizziness, drowsiness, or sedation. I will use one pharmacy to get all my medications. I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team or during regular office hours.

I understand that I may be referred to other health care professionals for other modes of treatment, such as physical therapy, exercise, relaxation techniques or psychological counseling, or for certain diagnostic tests and that my prescriber may speak with other health care professionals about my treatment plan. I will keep the medicine safe, secure, and out of reach of others, and will dispose of unused medications via a legal and safe disposal method. I will not sell this medicine or share it with others. If my medicine or prescription is lost or stolen, I understand that it may not be replaced. I understand that I may need to submit to random urine drug testing and pill counts if requested by my prescriber and that my prescriber will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site. I understand that if I do not follow all of the terms of this Agreement, my prescriber may stop prescribing pain medications, and/or that I could be required to find another prescriber or health care professional for my future medical treatment. I will keep all of my scheduled appointments including appointments for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

Patient/Patient Representative Signature	Patient/Representative Name Printed (State Relationship if Representative)	Date
Erik S. Larsen	ERIK S. LARSEN, DO	
Prescriber Signature	Prescriber Name Printed	

ORTHOPEDIC HISTORY

Name_____ Date of Birth_____ Date_____

Reason for today's visit: _____

Please specify_____ ☐ RIGHT ☐ LEFT

➢ **Are you right or left handed? ☐ RIGHT ☐ LEFT**

Is this problem a result of an:

☐ auto/motorcycle accident? Date of Injury _____

☐ injury? Date of Injury _____ Where? _____

☐ injury at work? Date of Injury _____ Date you last worked_____

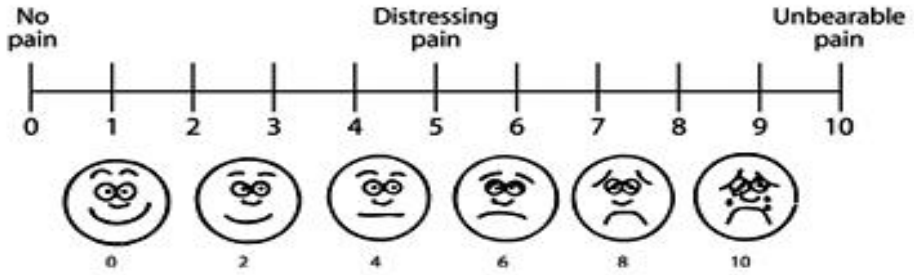
☐ other Date of Injury _____ How long? _____

Briefly describe how this problem occurred and when it first appeared _____

_____

How often do you get pain/symptoms? ☐ sometimes ☐ daily ☐ constant ☐ other _____

Please use the following pain chart to describe the intensity of your pain. Circle the number that applies:



Describe the pain/symptoms ☐ stabbing ☐ burning ☐ aching ☐ sharp ☐ dull ☐ other _____

Does the pain travel/move? ☐ No ☐ Yes If yes, where _____

Do you get other symptoms with the pain, such as ☐ numbness/tingling ☐ swelling ☐ other _____

What makes pain better or worse? _____

Have you tried treating yourself? ☐ ice or heat ☐ salves or creams ☐ bandages or braces ☐ crutches or cane

☐ Tylenol ☐ Advil ☐ Aleve ☐ aspirin ☐ other _____

Have you been to ☐ your family doctor ☐ emergency room? If yes, did you have ☐ X-rays or ☐ MRI?

If X-rays or MRI was performed, where? _____ Date _____

What medicine(s) were you given? _____

Have you had this problem before? ☐ No ☐ Yes If yes, when _____

Describe any previous orthopedic problems or surgery and give dates _____

I authorize a copy of this form & my signature to be used in lieu of an original.

_____ _____

Patient Signature (If signed by patient representative, state relationship) Date

MEDICAL HISTORY

Name_____ Date of Birth_____ Date_____

Have you had any previous operations? ☐No ☐Yes If so, please complete below:

(Type of Operation) (Approximate Date)

1. _____ _____
2. _____ _____
3. _____ _____

Please list any other medical problems past or present that you may have which are not listed below.

_____

_____

_____

♦IMPORTANT♦ MEDICATIONS: List ALL medications and dosages you are now taking

_____

_____

_____

➢➢➢Allergies: ☐None If so, please list_____

_____

Do you use tobacco? ☐No ☐Yes If so, how much? _____

Do you use alcohol? ☐No ☐Yes If so, how much? _____

➢ **PATIENT: Height _____ Weight _____ Blood Pressure Reading _____/_____**

➢ **Female patients: Are you pregnant?** ☐No ☐Yes **Are you still menstruating?** ☐No ☐Yes

FAMILY HISTORY:	L=Living D=Deceased	Age Now or At Time of Death	Medical Condition Including Cause of Death, if Deceased
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please check any of the following conditions that you have had in the past or presently have:

☐No major medical problems
☐Coronary Artery Disease (CAD)
☐High Blood Pressure-Hypertension (HTN)
☐Chronic Obstructive Pulmonary Disease (COPD)
☐Congestive Heart Failure
☐Diabetes
☐Hypothyroid Disorder
☐Hyperthyroid Disorder

☐Cancer (body part)_____

☐Other_____

I authorize a copy of this form & my signature to be used in lieu of an original.

_____ _____

Patient Signature (If signed by patient representative, state relationship) Date