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

This form to be completed IF you have been a patient of Dr. Seckler's within the past 11 months, AND you have had a change of information, and or are here for a new or different problem.

PATIENT NAME: _____ □Changed since last visit

ADDRESS: _____ □Changed since last visit

MARITAL STATUS: □Single □ Married □ Divorced □Widowed EMERGENCY NAME,PHONE_____

PREFERRED PHONE: _____ □ Cell □ Home □ Work E-Mail:_____

FAMILY PHYSICIAN: _____PHONE_____

PHARMACY NAME, STREET/TOWN: _____

**If you would like to give permission for us to discuss or release your treatment records, please complete a HIPAA release form.*

INSURANCE CARDS REQUIRED: □ CHANGE □ ADD Initial here_____ if NO change

Primary Insurance _____ Policy Holder _____ Date of Birth_____

Effective: _____Relationship To Patient: □ SELF □ SPOUSE □ PARENT/GUARIDAN □ OTHER_____

Secondary Insurance_____ Policy Holder _____ Date of Birth_____

Effective: _____Relationship To Patient: □ SELF □ SPOUSE □ PARENT/GUARIDAN □ OTHER_____

EMPLOYER NAME, ADDRESS, PHONE _____

OCCUPATION DETAILS _____

REASON FOR APPOINTMENT TODAY: □KNEE □SHOULDER □OTHER _____□RIGHT □LEFT □BILATERAL

□ Sudden Pain □ Gradual onset □ INJURY or □ ACCIDENT **Details: _____**

To what do you attribute the cause? _____

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

How long have you had any symptom(s) _____ List all symptoms _____

Where did the problem occur? □ HOME □ SCHOOL □ OTHER_____ ***This form is NOT for Work or MVA***

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

Did you have x-rays or MRI? □NO □YES, Name & Location of Facility _____

RECENT ILLNESS: _____ SURGERY OR HOSPITALIZATIONS:_____

CURRENT MEDICATIONS _____ ALLERGIES_____

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PATIENT NAME:_____ BIRTHDATE:_____

List any medications you are or have taken for this problem :

Name of Medication Dosage Frequency Last dose Date

Relief from medication: □None □Some/Temporary □Significant how long_____

Other Non-Pharmacologic Remedies you have tried: □Ice □Heat □Rest □Exercise □Other_____

What was the result? □No Improvement □Slight/Temporary Improvement □Significant Improvement

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

Does your pain interfere with: (check all that apply) □Normal Daily Activity □Work □Other_____

What do you think is the cause? _____

What relieves your pain/discomfort _____

What aggravates your pain/discomfort _____

Have you contacted an attorney □NO □YES, Name and Address _____

Caffeine: _____cups/day

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

Tobacco □ Never □ Currently_____pack(s)/day for _____years □ Cigarette/Cigar □ Pipe □ Chew/ Smokeless □ Quit: When_____

Drug Use: □ Never □ Recovering □ Current Specify: _____

The information contained herein, is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to MARK M. SECKLER, M.D. and understand that I am financially responsible for any services not covered by my plan.

➡ **GUARANTOR SIGNATURE:_____ DATE:_____**

FOR OFFICE USE ONLY:

HT_____ WT_____ PULSE_____ BP_____ Note:_____