

Name \_\_\_\_\_  
SS# \_\_\_\_\_

Today's Date \_\_\_\_\_  
Date of Birth \_\_\_\_\_

### CHIEF COMPLAINT

Why are you seeing the Doctor today? \_\_\_\_\_  
Current problem is a result of (check all that applies) \_\_\_\_\_ Car Accident \_\_\_\_\_ Work Accident  
\_\_\_\_\_ Accident \_\_\_\_\_ Other (explain) \_\_\_\_\_

<u>Medication</u>	<u>Dose(es)</u>	<u>Reason for Meds</u>	<u>Side Effects</u>

Allergies:  
Medication Allergy: \_\_\_\_\_ Side Effects \_\_\_\_\_  
Medication Allergy: \_\_\_\_\_ Side Effects \_\_\_\_\_

Are you age appropriate Immunized? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If NO, which immunizations are due? \_\_\_\_\_

**Are you currently pregnant?** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No**

### Review of Symptoms and PMH

Are you currently having or have you had problems with your:

**Circle**

Describe all **YES** responses

	Yes	/	No	
Eyes		/		_____
Ears, Nose Throat		/		_____
Lungs, Breathing		/		_____
Digestion		/		_____
GI: Ulcer/Reflux		/		_____
Bowel Movement		/		_____
Bladder Problem		/		_____
Diabetes		/		_____
High Blood Pressure		/		_____
Bleeding Problems		/		_____
Balance Problems		/		_____
Numbness/tingling		/		_____
Blackout/fainting		/		_____
Psychological Problems		/		_____
Cardiac System		/		_____
Stroke		/		_____
AIDS		/		_____
Cancer		/		_____
Arthritis		/		_____
Polio		/		_____
TB		/		_____
Epilepsy		/		_____
Hepatitis		/		_____
Asthma		/		_____
Fever/Chills/Night Sweats		/		_____
Weight Loss/Weigh Gain		/		_____
Appetite Increase/Decrease		/		_____

Patient Signature \_\_\_\_\_  
Reviewed by \_\_\_\_\_, MD

Date \_\_\_\_\_  
Date \_\_\_\_\_



**UNION COUNTY ORTHOPAEDIC GROUP**

**PATIENT INFORMATION (PLEASE PRINT)**

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Birth date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_  
Home phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work phone ( \_\_\_\_\_ ) \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Nearest Relative: \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
If patient is a child; name of Father: \_\_\_\_\_ SS# \_\_\_\_\_  
If patient is a child; name of Mother: \_\_\_\_\_ SS# \_\_\_\_\_  
Father's date of birth \_\_\_\_\_ Mother's date of birth \_\_\_\_\_  
Name of Guardian, if other than parent: \_\_\_\_\_

**BILLING INFORMATION**

Responsible Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home phone# \_\_\_\_\_  
Employer \_\_\_\_\_ Work phone number: \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance ID# \_\_\_\_\_ Name of Insured \_\_\_\_\_  
Insurance Co. Name and Address \_\_\_\_\_  
Medicare # \_\_\_\_\_ Medicaid # (must be 12 digits) \_\_\_\_\_  
Secondary Insurance Co. Name \_\_\_\_\_ Name of Insured \_\_\_\_\_  
ID# \_\_\_\_\_ Address \_\_\_\_\_

If **AUTO ACCIDENT**, check here \_\_\_\_\_ and complete **ACCIDENT DETAIL FORM**

If **WORKMAN'S COMP ACCIDENT**, check here \_\_\_\_\_ and complete **ACCIDENT DETAIL FORM**

If **OTHER ACCIDENT**, check here \_\_\_\_\_ and complete **ACCIDENT DETAIL FORM**

Name of Referring Physician \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_

**Assignments of Benefits:** I irrevocably assign to Union County Orthopaedic Group all my rights and benefits under any insurance contract payments for services rendered by UCOG. I irrevocably authorize all information regarding my benefits under all insurance policies regarding to any claims by UCOG to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to UCOG. I irrevocably authorize to act on my behalf and report any suspected violations of proper practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and understand its nature and effect. I understand that I am financially responsible for all charges. I understand I charged the rate of service charge of .5% per month on all accounts over 90 days or more. In addition I will be responsible for collection fees/court costs and attorney fees.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Print Patient's Representative's Name

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\* IF NO ACCIDENT; CHECK HERE \_\_\_\_\_ AND SIGN BELOW \*\*\*\*\*

## ACCIDENT DETAIL FORM

1. Describe how the injury occurred: \_\_\_\_\_  
\_\_\_\_\_

Date of Accident: \_\_\_\_\_

Accident location: \_\_\_\_\_

**2. COMPLETE THIS SECTION IF WORKMAN'S COMP INJURY**

Were you on the job or was the injury related to your job? \_\_\_\_ Yes \_\_\_\_ No

If yes, Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Phone # \_\_\_\_\_

Did you report your injury to your employer? \_\_\_\_ Yes \_\_\_\_ No

Name of Workman's Comp Insurance Carrier \_\_\_\_\_

Address for claims \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone# \_\_\_\_\_ Ext# \_\_\_\_\_

Claim Number \_\_\_\_\_ Fax # \_\_\_\_\_

**3. COMPLETE THIS SECTION IF IT WAS AN AUTO ACCIDENT**

I was the: \_\_\_\_ DRIVER \_\_\_\_ PASSENGER \_\_\_\_ PEDESTRIAN

My auto insurance carrier is \_\_\_\_\_

Claims address \_\_\_\_\_

Policy Number \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone # \_\_\_\_\_ Ext. \_\_\_\_\_

Fax # \_\_\_\_\_

**4. If you were NOT in a work or auto related accident, please complete this section:**

Did the Accident occur on someone else's property? \_\_\_\_ Yes \_\_\_\_ No

Name and Address of property owner? \_\_\_\_\_  
\_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Phone# \_\_\_\_\_ Ext. \_\_\_\_\_

Claim # \_\_\_\_\_ Fax# \_\_\_\_\_

**5. Have you received any settlement money or insurance money because of this injury?**

\_\_\_\_ Yes \_\_\_\_ No - If yes, who paid? \_\_\_\_\_

6. Do you intend to make any claims other than your health insurance: \_\_\_\_ Yes \_\_\_\_ No

Have you hired an attorney because of this accident: \_\_\_\_ Yes \_\_\_\_ No

Attorney's Name \_\_\_\_\_ Phone \_\_\_\_\_

Attorney's Address \_\_\_\_\_

7. If none of the above applies, please explain: \_\_\_\_\_  
\_\_\_\_\_

The foregoing is true and correct to the best of my knowledge.

Patient's Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_

Guardian's Name (please print) \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_

# UNION COUNTY ORTHOPAEDIC GROUP

## ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

### I. Acknowledgment of Privacy Practice Notice

I have received a copy of the Union County Orthopaedic Group's Notice of Privacy Practices.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Birth date

\_\_\_\_\_  
Signature of Patient, Parent or  
Guardian

\_\_\_\_\_  
Date

### II. Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Union County Orthopaedic Group may disclose certain of my health information to the family member, close personal friend or other caregivers because such person is involved with my health care. In that case, Union County Orthopaedic Group will **disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.**

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of Union County Orthopaedic Group's making the lined disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

Print Name \_\_\_\_\_

Date of Birth (required) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient / Parent / Guardian

\_\_\_\_\_  
Date