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: _____

Name: _____ **Date of Birth:** ___/___/___
Last First Middle Initial

Social Security Number: _____-_____-_____ Email: _____

Home Phone: _____ Cell Phone: _____ Preferred contact _____Text _____Call

Home Address: _____
Street City State Zip Code

Married_____Single_____Divorced_____Separated_____Widow_____Widower_____

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	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Lung Disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Diabetes	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Ulcer or Stomach Disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Kidney Disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Liver Disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Anemia or other blood disease	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Cancer	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Depression	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Osteoarthritis, degenerative arthritis	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Back pain	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Rheumatoid arthritis	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Thyroid disorder: Hypo Hyper	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Other medical problems (please specify)	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

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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 and/or Surgical Appointments:

Appointments will be assessed a **$50** fee when cancelled with less than 24 hours' notice OR No show without prior notice. Two or more no show/cancel less than 24hrs visits may be cause for dismissal from the practice.

Please be advised that an inconvenience fee of **$100** will be charged for illegitimate cancellations for patients that cancel or no show to their scheduled surgical date.

ALL OUT OF NETWORK PATIENTS MUST READ AND SIGN **YES/NO (CIRCLE ONE)**

I understand that Performance Orthopaedic & Sports Medicine is out of network and I may receive payments for their services, I agree to forward all payments within 14 days upon receipt. I also understand I am responsible for my copay of $_____ and possible applied deductible balance of $_____. Performance Orthopaedics & Sports Medicine will accept what your insurance company pays for services rendered.

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