

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.

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:

Last, First: _____ Phone: _____

Address: _____

Cardiologist: Last, First: _____ Phone: _____

Pulmonologist: Last, First: _____ Phone: _____

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: _____

Name _____ Date of birth _____

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

Are you Covid-19 vaccinated? Yes _____ No _____

Name _____ Date of birth _____

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

Name _____ Date of birth _____

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 _____

Name _____ Date of Birth _____

Assignment 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 _____ **Date:** _____

Name _____ Date of birth _____

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: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ---45 CFR Parts 160 and 164)

Patient Name: _____ Date of Birth: ____/____/____

Email Address _____

I _____, hereby authorize and request _____ to release my health information (PHI) to:

Performance Orthopaedics & Sports Medicine

780 Route 37 West

Toms River, NJ 08755

In addition to the authorization for release of my Protected Health Information (PHI), I furthermore acknowledge that I have the right to authorize access and disclosure of my PHI to anyone of my choosing for billing, condition, treatment and prognosis to the following individuals:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I request the following restriction to releasing my PHI (if any):

I understand that I am entitled to a copy of Performance Orthopaedics & Sports Medicine Privacy Practices. I can access a copy of the Notice of Privacy Practices from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

Signature of Patient

Date: