Mercer-Bucks Orthopaedics

Patient Information

SSN: _____ Name: _____

Gender: _____ Date Of Birth: _____ Marital Status: _____

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Declined ☐ American Indian or Alaskan Native ☐ Native American ☐ Pacific Islander Ethnicity: ☐ Latino ☐ Not Latino ☐ Declined

Primary Language: ☐ English ☐ Spanish ☐ Indian ☐ Russian ☐ Other ☐ Declined

Address (no PO Box please): _____

_____

Email: _____

Primary#: _____ Cell #: _____ Work #: _____ Extension #: _____

Do you have a Primary Care Physician? ☐ Yes ☐ No

Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Do you have a preferred pharmacy? ☐ Yes ☐ No

Preferred Pharmacy: _____ Pharmacy Phone: _____

* By indicating my pharmacy above, I agree that Mercer Bucks Orthopaedics may request and use my prescription medication history from other health care providers or third party pharmacy benefit payors for treatment purposes.

Employer: _____ Occupation: _____

Employer Address: _____

Parent/Guardian's information - if the patient is under 18 ☐ Address is the same as the patient

Name: _____ DOB: _____

Address: _____

Financial Guarantor's information (if the patient is under 18) ☐ Parent/Guardian's is the guarantor ☐ Address is the same as the patient

Name: _____ DOB: _____

Address: _____

Insurance Information

Body part(s) injured? _____

Primary Insurance: _____

Member ID #: _____ Group #: _____

Secondary Insurance: _____

Member ID #: _____ Group #: _____

(Policyholder's information - if it is different than the patient)

Name: _____ DOB: _____

Type of insurance: _____

Authorization/Release of Medical Information

This authorization or photocopy thereof will authorize Mercer Bucks Orthopaedics to furnish all information they may have regarding my condition, while under their observation or treatment, to any party who may be responsible for payment to Mercer Bucks Orthopaedics, including history obtained, X-ray and physical findings, diagnosis, and prognosis. I designate the following persons listed below as persons acceptable to receive information. **Please include yourself.** I also understand that I may change this at any time in writing. I understand that Mercer Bucks Orthopaedics will not disclose health information to any person not designated except in case of an emergency. In the event a physician or an employee is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I hereby consent to having my blood tested for the AIDS virus (HIV), Hepatitis B, and Hepatitis C, so that any necessary treatment of the physician or employee can begin without delay.

Name: _____ DOB (required as identifier) _____

Name: _____ DOB (required as identifier) _____

Name: _____ DOB (required as identifier) _____

☑ I, patient _____ or guarantor _____ agree to sign forms electronically.

Patient/Responsible Party Signature: _____ **Date:** _____

Financial Responsibility Agreement

- I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any Medical service visit, Radiology, EMG, OMT, DME, Therapy or any other services ordered by my physician or my physician's staff.
- I understand and agree it is my sole responsibility and not the responsibility of the provider of services, hospital, surgery center, therapists or supplier to know if my insurance will pay for my Medical service or visit, Radiology, EMG, OMT, DME, Therapy or any other services ordered by my physician or my physician's staff.
- I understand and agree it is my sole responsibility to know if my insurance has any Deductible, Referral Requirement, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.
- I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.
- I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly. If I am being seen under a motor vehicle claim, I must provide active health insurance as a supplement to the motor vehicle claim and will be held responsible for any balance not paid through my motor vehicle claim and health insurance.
- I request that payment of authorized insurance benefits be made either to me or on my behalf to Mercer Bucks Orthopaedics for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize Mercer Bucks Orthopaedics to release to any information needed to determine benefits payable for related services.
- In Medicare assigned cases only, Mercer Bucks Orthopaedics agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.
- I agree that if my check is returned from the bank for "Insufficient Funds" or any other reason I will be responsible for an additional returned check fee imposed on Mercer-Bucks Orthopaedics by the bank of thirty dollars ($30.00).
- I agree that if my account is referred to an outside agency or attorney for collection; I will be responsible for an additional collection fee of fifty dollars ($50.00) or 35% of the balance owed, whichever amount is greater.
- By signing below, I agree to accept full financial responsibility as a patient or as the responsible party for a minor patient who is receiving Medical services, Radiology, EMG, OMT, DME, Therapy or any other services. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Credit Card on File Agreement

At Mercer Bucks Orthopaedics, we require the ability to keep your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, the insurance portion of the claim has been paid and posted to the account and you are mailed a statement showing the remaining balance owed. By my signature below, I authorize Mercer Bucks Orthopaedics to charge the portion of my bill that is my financial responsibility to the credit or debit card I provide to Mercer Bucks Orthopaedics for balances due for services rendered that my insurance company identifies as my financial responsibility. I understand that my card will be charged at any time after thirty (30) days since the date my last bill was mailed to me by Mercer Bucks Orthopaedics reflecting such balances. This authorization relates to all payments not covered by my insurance company for services provided to me by Mercer Bucks Orthopaedics. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a notification to Mercer Bucks Orthopaedics in writing and the account must be in good standing.

I have read and agree to the above authorization/release of medical information, financial responsibility agreement, credit card on file agreement, and I acknowledge that a copy of the Privacy Practices has been made available to me via a hard copy in the office as well as an electronic copy at www.mbortho.com. This policy explains your rights including your right to see and copy your records, to limit the disclosure of your protected health information and to request an amendment to you record.

Patient/Responsible Party Signature: _____ **Date:** _____

MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM

Name : _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weight:** _____

Primary Care Physician: _____ Cardiologist/Specialist: _____

How did you hear about us? ☐ Word of Mouth ☐ Primary Care Doctor ☐ Urgent Care Facility ☐ Emergency Room ☐ MBO Website ☐ Google ☐ Social Media ☐ Current Patient ☐ Rider University

X-ray/MRI taken? ☐ Yes ☐ No If yes, what facility? _____

Body part to be seen (For example: Left Knee): _____

			Date	*How Injury Occurred?*
Is this problem due to an injury?	☐ No	☐ Yes		
Onset:				
Is this injury work related?	☐ No	☐ Yes		
Is injury related to an Auto Accident?	☐ No	☐ Yes		
Have you had a fall in the last year?	☐ No	☐ Yes	**Did the fall result in an injury?** ☐ No ☐ Yes	

PAST MEDICAL HISTORY: *(Select all current and previous illnesses)*

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Colitis
- ☐ COPD/Lung Disease
- ☐ Depression
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver-Disorder
- ☐ Lyme's Disease
- ☐ Neuropathy
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Paget's Disease
- ☐ Seizures
- ☐ Shingles
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcers
- ☐ Vascular Disease
- ☐ None

CANCER ☐ **Yes** ☐ **No**

Select Type of Cancer:

- ☐ **Bladder**
- ☐ **Blood**
- ☐ **Bone**
- ☐ **Brain**
- ☐ **Breast**
- ☐ **Cervical**
- ☐ **Colon**
- ☐ **Kidney**
- ☐ **Liver**
- ☐ **Lung**
- ☐ **Melanoma**
- ☐ **Pancreas**
- ☐ **Prostate**
- ☐ **Stomach**
- ☐ **Testicular**
- ☐ **Throat**
- ☐ **Thyroid**
- ☐ **Uterine**
- ☐ **Other**

If Other, Please mention here : _____

Heart Disease: ☐ **Yes** ☐ **No** **Pacemaker:** ☐ **Yes** ☐ **No**

Arthritis: ☐ **Yes** ☐ **No** **Type:** _____

MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM

Hepatitis ☐ Yes ☐ No If Yes, Select the Type? ☐ Type A ☐ Type B ☐ Type C

Diabetic ☐ Yes ☐ No If Yes, Select the Type? ☐ Type I ☐ Type II

Sleep Apnea? ☐ Yes ☐ No **C-Pap Use?** ☐ **Yes** ☐ **No**

Had Bone Density test (Dexa-Scan)? ☐ **Yes** ☐ **No** If Yes, mention the Year :_____

Any Other Medical Conditions :_____

Pain Level: (0-10) 0 = No pain, 10 = Worst possible pain:_____

ALLERGIES

Do you have any Allergies? (Please be sure to include any allergies to Medications, Antibiotics, Latex, Iodine, Shellfish, Seafood or Metal) ☐ **Yes** ☐ **No**

List of Allergies: _____

MEDICATIONS:

Do you take any medications or vitamins regularly? ☐ **Yes** ☐ **No**

PAST SURGICAL HISTORY

Do you have any past surgeries? ☐ Yes ☐ No

If yes, Please select all that are applicable from the list below:

- ☐ **Appendectomy**
- ☐ **Back Surgery**
- ☐ **Carpal Tunnel**
- ☐ **Cataract Surgery**
- ☐ **Cesarean Section**
- ☐ **Gallbladder Surgery**
- ☐ **Hip Replacement**
- ☐ **Hemorrhoidectomy**
- ☐ **Heart Surgery**
- ☐ **Hysterectomy**
- ☐ **Hernia Repair**
- ☐ **Knee Replacement**
- ☐ **Knee Scope (meniscus)**
- ☐ **Prostate Surgery**
- ☐ **Rotator Cuff Repair**
- ☐ **Thyroid Surgery**
- ☐ **Tonsillectomy/Adenoidectomy**
- ☐ **Surgery related to Cancer**
- ☐ **Other**

Type of Other Surgery:_____

MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM

FAMILY HISTORY

	Father	Mother	Brother	Sister	Son	Daughter	None
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Heart Diseases	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐
Arthritis (Osteo/bone)	☐	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐

Do you have any other family member with a major illness to report? ☐ Yes ☐ No If Yes, Explain: _____

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

Use of Alcohol ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco ☐ Never ☐ Previously but quit ☐ Current packs/day: _____

Have you smoked in the last two months? ☐ Yes ☐ No

Are you right or left handed? ☐ Left ☐ Right ☐ Ambidextrous

Living Situation: ☐ Alone ☐ with Friends ☐ with Spouse ☐ with Family ☐ Other

What is your employment status? ☐ Working full time ☐ Working part time ☐ Unemployed ☐ Retired from work

What is the type of work you do? _____

Are there religious/cultural needs related to your care? ☐ Yes ☐ No

Please explain: _____

Do you use any recreational drugs? ☐ Yes ☐ No Treated for Substance Abuse? ☐ Yes ☐ No

Possibility of Pregnancy? ☐ Yes ☐ No

SYSTEMS REVIEW *(Did you have any of the following symptoms within the past 6 months?)*

Good general health lately? ☐ Yes ☐ No

Constitutional Symptoms
- ☐ Fatigue
- ☐ Fever
- ☐ Recent weight change
- ☐ None

Hematologic/Lymphatic
- ☐ Past blood transfusion
- ☐ None

Gastrointestinal
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ None

Neurological
- ☐ Dizziness
- ☐ Light-headedness
- ☐ Paralysis
- ☐ Tremors
- ☐ None

Psychiatric
- ☐ Confusion
- ☐ Insomnia
- ☐ Memory loss
- ☐ Nervousness
- ☐ None

Musculoskeletal
- ☐ History of fractures
- ☐ None

Signature: _____