Mercer-Bucks Orthopaedics

Patient Information

SSN: _____ - ____ - _____ Name (first, mi, last):_____

Gender: ☐ M ☐ F Date Of Birth:___/___/_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Declined Ethnicity: ☐ Latino ☐ Not Latino ☐ Declined

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

Address (no PO Box please): _____

_____

Email: _____

Home #: _____ Cell #: _____ Work #: _____

Primary Physician:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

*By indicating my pharmacy above, 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 treatments 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 ☐ Parent/Guardian's is the guarantor ☐ Address is the same as the patient

(if the patient is under 18)

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: ___/___/_____

SSN#: _____ - ____ - _____ Relation to Insured: _____

Is your visit related to Worker's Comp or a Motor Vehicle Accident? ☐ Yes ☐ No

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 test) so that any necessary treatment of the physician or employee can begin without delay.

Name:_____ Last 4 digits of SS# or DOB (required as identifier)_____

Name:_____ Last 4 digits of SS# or DOB (required as identifier)_____

Name:_____ Last 4 digits of SS# or DOB (required as identifier)_____

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. MBO or its affiliates may contact you via phone unless express written consent advises otherwise. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

Patient/Responsible Party Signature:_____ Date: _____

Notice of Privacy Practices

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: _____

Were Xrays/MRI taken? Y N If yes, what facility? _____

Body part to be seen: Right or Left _____

	Circle		Date of Injury	Please Explain
Were you hurt at work?	No	Yes		
Is injury related to an Auto Accident?	No	Yes		
Is this due to an injury?	No	Yes		
Have you had a fall in the last year?	No	Yes	**Did the fall result in an injury?**	No Yes

Medical History: *(Circle all current and previous illnesses)*

Anemia	No Yes	COPD/Lung Disease	No Yes	Heart Disease	No Yes	Osteoporosis	No Yes
Anxiety	No Yes	Depression	No Yes	Hepatitis	No Yes	Paget's Disease	No Yes
Asthma	No Yes	**Diabetes**	No Yes	HIV/AIDS	No Yes	Seizures	No Yes
Bleeding disorder	No Yes	**Type I ___ Type II ___**	No Yes	High cholesterol	No Yes	Sleep Apnea	No Yes
Blood Clot	No Yes	Fibromyalgia	No Yes	**High blood pressure**	No Yes	C-Pap Use?	No Yes
Cancer	No Yes	GERD/Ulcers	No Yes	Kidney Disease	No Yes	Stroke	No Yes
Type _____	No Yes	Glaucoma	No Yes	Neuropathy	No Yes	Thyroid disorder	No Yes

Drug Allergy? No Yes Food Allergy? No Yes Latex Allergy? No Yes Allergy to Metal? No Yes

PLEASE LIST ANY FOOD OR MEDICATION ALLERGIES: _____

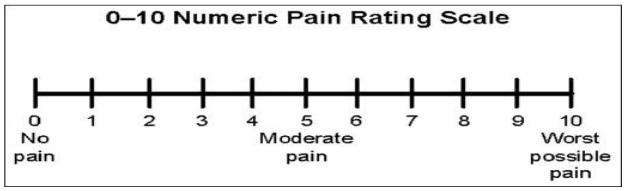
Allergic to iodine/shellfish/seafood? No Yes Reaction: _____

Have you ever been treated for Substance Abuse? No Yes

Have you had a bone density test (Dexa Scan)? No Yes

Possibility of Pregnancy? No Yes

Please circle pain level:



List all current Medications:

Name	Dose	Condition

List all Surgeries:	Date

MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM

Family History	Age	Major Illnesses	If deceased, cause of death
Mother			
Father			
Brother/Sister			
Brother/Sister			
Son(s)			
Daughter(s)			

Family History of Arthritis? No_____ Yes_____ Which family member?_____Type _____

Social History

Marital Status Single _____ Married _____ Widowed _____ Divorced_____

Use of Alcohol Never _____ Rarely _____ Moderate _____ Daily _____

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

Are you right or left handed?_____ Living Situation: Alone_____with Spouse/Family_____with Friends_____

Hobbies and sport activities you enjoy _____

Type of work _____

Are you a student? No Yes

Are there religious/cultural needs related to your care? (Please circle) No Yes

Please explain: _____

Systems Review

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

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Hematologic/Lymphatic

Anemia	No	Yes
Phlebitis	No	Yes
Past blood transfusion	No	Yes
Exposure to HIV	No	Yes
History of Blood Clots	No	Yes

Musculoskeletal

Osteoporosis	No	Yes
History of fractures	No	Yes
History of gout	No	Yes
Rheumatoid disease	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer	No	Yes
Hepatitis	No	Yes

Neurological

Lightheaded or dizzy	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Psychiatric

Depression	No	Yes
Memory loss or confusion	No	Yes
Insomnia	No	Yes
Nervousness	No	Yes

Reviewed by Dr. _____

Patient's Signature _____ *Date* _____