Name:
DOB:
Chart:
Age:
Date:

ORTHOPEDIC ASSOCIATES OF CENTRAL JERSEY, PA

* JEFFREY H. CHAREN, M.D. * JOSHUA M. ZIMMERMAN, M.D. * ALEXANDER M. MARCUS, M.D. * DAVID LESSING, M.D. *
* MITCHELL STROH, D.O. *

PATIENT INFORMATION:

PATIENT LAST NAME FIRST MIDDLE	DATE OF BIRTH	AGE	SEX	Marital Status S M W D Sep	SSN
STREET ADDRESS APT #					Home Phone

RACE ☐ American Indian/ Alaskan Native ☐ Asian ☐ Black/ African American ☐ White
☐ Native Hawaiian/ Other Pacific Islander ☐ Unknown ☐ Declined to answer

ETHINICITY ☐ Hispanic Origin ☐ Non Hispanic Origin ☐ Unknown ☐ Declined to answer

PREFERRED LANGUAGE: _____ EMAIL: _____

PATIENT'S EMPLOYER (If student, school)	Occupation or Grade	Cell Phone
EMPLOYER'S OR SCHOOL ADDRESS	CITY, STATE, ZIP	Business Phone / Ext.
SPOUSE OR NEXT OF KIN	Relationship / SPOUSE'S OR NEXT OF KIN'S ADDRESS	Phone
SPOUSE'S OR NEXT OF KIN'S EMPLOYER	OCCUPATION	Cell Phone
SPOUSE'S OR NEXT OF KIN'S EMPLOYER'S ADDRESS	CITY, STATE, ZIP	Business Phone / Ext.

IF PATIENT IS A MINOR OR STUDENT:

PARENT'S POLICY HOLDER	STREET CITY, STATE, ZIP	Home Phone
PARENT'S EMPLOYER	OCCUPATION	How Long Employed (or Grade)
EMPLOYER'S ADDRESS	CITY, STATE, ZIP	Business Phone

ALL PATIENTS PLEASE COMPLETE THE FOLLOWING:

Seen in Emergency Room?	Auto Accident?	Injured at work?	Date of any accident	Tested Here Before? If so, when?

REFERRING PHYSICIAN'S NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ STATE _____

DOCTORS ALREADY SEEN FOR CURRENT PROBLEM

INSURANCE INFO				
	☐ PRIMARY CO-PAY	GROUP NO.	NAME OF POLICYHOLDER	DATE OF BIRTH
	☐ SECONDARY	GROUP NO.	NAME OF POLICYHOLDER	DATE OF BIRTH
	☐ MEDICARE NO.		☐ NO INSURANCE/SLF PAY	

I hereby authorize any physician, hospital or other medical facility to release to Orthopedic Associates of Central Jersey, P.A. all medical records and x-rays or copies thereof in their possession concerning my illness and treatment. A photocopy of this authorization shall be as valid as the original. I authorize payment of medical benefits to Orthopedic Asociates of Central Jersey, P.A.

Date Account # Patient, parent or legal guardian

Name:
DOB:
Chart:
Age:
Date:

ORTHOPEDIC ASSOCIATES OF CENTRAL JERSEY, P.A. Date: _____

In order to better address your current orthopedic problem, please fill out the following medical information sheet.

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

HEIGHT _____ WEIGHT _____ RIGHT HANDED ☐ LEFT HANDED ☐

CURRENT PHYSICIAN: _____

CURRENT COMPLAINT/DATE OF INJURY:

What treatment & physicians if any have you had for your current orthopedic problem?

CURRENT MEDICATIONS: **DOSAGE:**

PAST MEDICAL HISTORY: e.g. High Blood Pressure, Diabetes, Asthma, etc.

PAST SURGICAL HISTORY: **DATE**

SOCIAL HISTORY:

SMOKING STATUS

☐ Current every day smoker ☐ Current some days ☐ Smoker, current status unknown
☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked.
☐ Heavy Tobacco smoker ☐ Light Tobacco smoker
Start Date if Current Smoker ____ Start Date if Former Smoker _____

ALCOHOL ☐ YES ☐ NO How many drinks per day?? _____

PREFERRED PHARMACY: Address: _____
Phone/Fax: _____

ALLERGIES TO MEDICATIONS: e.g. Rash, Hives, Difficulty Breathing, etc.

OCCUPATION:

Is this primarily sitting, standing, climbing, or lifting? Other - explain:

FAMILY HISTORY (Cancer, Arthritis, etc.)

Name:
DOB:
Chart:
Age:
Date:

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* *Board Certified in Orthopedic Surgery*
† *Board Certified in Sports Medicine*
\# *Fellowship Shoulder & Elbow Surgery*
\+ *Fellowship Hand & Wrist Surgery*
^ *Fellowship Sports Medicine*

205 May Street
Suite 202
Edison, New Jersey 08837
(908) 757-1520 • (908) 769-1388 Fax

3 Hospital Plaza, Suite 411
Old Bridge, NJ 08857
(732) 360-2400 • (732) 360-0775 Fax

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

I agree that Orthopedic Associates of Central Jersey, PA may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

Print Name: _____ Signature: _____ Date _____

Name:
DOB:

Age:
Date:

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THE FINANCIAL POLICY OF ORTHOPEDIC ASSOCIATES OF CENTRAL JERSEY. P.A.

Commercial/Indemnity Subscribers:

For Office Services: Payment is expected as services are rendered unless prior financial arrangements have been made. A charge slip and receipt will be provided for submission to your health insurance carrier. We will need

For Surgical Services: Our billing department will submit surgical fees to your health insurance carrier. It will be necessary to assign payment to our office.

No Fault Patients: In order to submit charges for services rendered you will need to provide the name and address of your no fault carrier as well as the assigned claim number and adjuster's name.

There are deductibles and co-insurance balances which can be covered by your health insurance carrier, therefore we will need copies of your health insurance identification cards. Also, if your health insurance carrier requires a referral from your primary care physician, you must provide them as services are rendered.

Workers' Comp: Services for injuries that occurred while working for your employer are usually paid by your employer's work comp insurance carrier. It is necessary to report this injury to your employer who will advise you where you can seek medical treatment.

In order to submit charges for services rendered, you will need to provide the name and address of your employer as well as the name and address of the work comp carrier with the assigned claim number.

If the injury is not recognized as work related, we will submit the charges to your health

HMO & PPO Patients: It is impossible for the staff to know everything about your health insurance coverage, they are often tailored to suit the needs of the employer. Please read the information booklet provided by your health insurance carrier.

If the injury is not recognized as work related, we will submit the charges to your health insurance carrier, therefore we will need copies of your health insurance cards.

You will be responsible for any deductibles, co-insurance, and any charges for non-covered services.

Medicare & Medicare HMO Patients: We are participating providers for Medicare, therefore you are responsible only for deductibles and the 20% co-insurance. If your primary or secondary health insurance carrier is an HMO, you will need to provide referrals from your primary physician, We will need copies of your health insurance identification cards.

* CASH * VISA * MASTERCARD * DISCOVER * AMERICAN EXPRESS * CHECKS *
Returned check fee is $50.00

By reading and signing this document, I fully understand my responsibilities described in the policy above. I also realized that non covered services will be billed directly to me as well as deductibles, co-insurance amounts, and that copays are payable at time of service.

Print Patient Name _____ Signature of Patient or Parent _____ Date _____

FOR BILLING INQUIRES, PLEASE CALL OUR BUSINESS OFFICE AT 908-757-8378