Comprehensive Orthopaedics, P.A.
Sports Medicine & Orthopaedic Surgery

☐ 235 Millburn Ave. Suite 102, Millburn, NJ 07041
☐ 100 Commerce Place, Clark, NJ 07066
☐ 221 Chestnut Street, Newark, NJ 07105

☐ Dr. Schob ☐ Dr. Richmond

Appointment Date: ______________________ Appointment Time: ______________________

Thank you for choosing Comprehensive Orthopaedics.

Please complete this form and bring it with you along with any x-rays, test results, referrals or MRI's needed for the visit.

Last Name: ______________________ First Name: ______________________

Home Address: ______________________ Apt. # __________ City: __________

State: ________ Zip: __________ Date of Birth: __________ SS # __________

Home Phone: ______________ Cell: ______________ Email: ______________

Race (*please choose one of the following*): ☐ American Indian ☐ Asian ☐ African American ☐ White ☐ Hispanic ☐ Native Hawaiian/Pacific ☐ Other ☐ Unknown ☐ Patient Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Other ☐ Patient Refused

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Sex: ☐ Male ☐ Female

Referred by: ☐ Attorney ☐ Adjuster ☐ Friend ☐ School ☐ Other ______________________

Employer: ______________________ Work Phone: ______________________

Pharmacy Name and Address: ______________________________________

Primary Care Doctor: ______________________ Phone: ______________________

Emergency Contact Name: ______________ Relationship: __________ Phone: ______________

Part of Body Injured: ______________________ Date of Onset: ______________

Is Injury Related to: ☐ Work ☐ School ☐ Auto Accident ☐ Other ______________________

Do you have an attorney for this injury? ☐ No ☐ Yes, *if Yes*: Name: ______________ Phone: __________

Primary Medical Insurance Co: ______________ ID# ______________ Group # __________

Insurance Co. Address: ______________________ Policy Holder Name: ______________________

Policy Holder SS# ______________________ Policy Holder Date of Birth: ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ☐ Do you need a Referral? ☐ Yes ☐ No

Secondary Medical Insurance Co. : ______________ ID# ______________ Group # __________

Insurance Co. Address: ______________________ Policy Holder Name: ______________________

Policy Holder SS# ______________________ Policy Holder Date of Birth: ______________________

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other ☐ Do you need a Referral? ☐ Yes ☐ No

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Name: ______________________________

Chief Complaint: Why are you seeing the doctor today? ______________________________

Allergies: ______________________________

Medications:	Dosage:	Medications:	Dosage:

Review of Systems: Are you currently having or have you had problems with: (*circle answers*)

Eyes	No	Yes	Bleeding Problems	No	Yes	Epilepsy	No	Yes
Ear, Nose, Throat	No	Yes	Balance Problems	No	Yes	Ulcers	No	Yes
Thyroid	No	Yes	Numbness/Tingling	No	Yes	TB	No	Yes
Heart	No	Yes	Swelling of Ankles	No	Yes	Digestion	No	Yes
Lungs, Breathing	No	Yes	Blackouts/Fainting	No	Yes	Cancer	No	Yes
Psychological Problems	No	Yes	Arthritis	No	Yes	Diabetes	No	Yes
Bowel Movement	No	Yes	AIDS/HIV	No	Yes	Polio	No	Yes
Bladder Problems	No	Yes	High Cholesterol	No	Yes	Last EKG ________		
High Blood Pressure	No	Yes	Last Chest X-ray ________			Last Blood Work ________		

Describe ALL YES Responses: ______________________________

Surgeries/Hospitalizations: Name of Hospital ______________________Lab ______________

Doctor's Office ______________________________

Date	Reason for Hospitalization	Complications

Have you ever had general anesthesia? ☐ No ☐ Yes Problems? - Describe ______________

Family history of cancer, heart disease, diabetes, etc. ______________________________

____

Are you on a special diet? ☐ No ☐ Yes If yes, explain: ______________________________

Exercise: ☐ Never ☐ Rarely ☐ Monthly ☐ Daily What type: ______________________________

HIstory of Substance Abuse ☐ No ☐ Yes Smoke ☐ No ☐ Yes Previously smoked ☐ No ☐ Yes

Drink Alcohol ☐ No ☐ Yes ☐ Daily ☐ 1-2 x/week ☐ 1-2 x/month Do you live alone ☐ No ☐ Yes

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Personal Information ☐ may be ☐ may not be Left On My ☐ home phone ☐ cell phone ☐ email

I authorize the release of my personal information to the following individual(s):

____________________ ____________________

____________________ ____________________

____________________ ____________________

I hereby authorize ***Comprehensive Orthopaedics*** to furnish any designated insurance company all information necessary to file an insurance claim. Worker's Compensation sign here.

Name (Please Print) Patient Signature

Date

Assignment of Benefits/Authorization Notice of Collection Action

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I further understand that all co-payments are due at the time of service and I am responsible to pay other amounts due; these amounts may include annual deductibles, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E. G. late fees, collection agency, court or attorney costs). I agree this authorization shall remain valid unless/until I rescind in writing.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's record and may be used by the patient's health care provider solely for the purposes of patient identification.

Signature Required

The undersigned acknowledges that I have read and understand the above terms and conditions.

Patient Name (Please Print) Patient Signature

Guarantor/Parent/Guardian completing this form (Please Print) Date

I authorize ***Comprehensive Orthopaedics*** to arbitrate any ***Personal Injury Protection*** (PIP) insurance based denials of coverage/claims on my behalf and to release all pertinent medical records required to pursue such arbitration.

Patient Name (Please Print) Patient Signature

Guarantor/Parent/Guardian completing this form (Please Print) Date

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CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize COMPREHENSIVE ORTHOPAEDICS to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, view and transmit for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

____

PHARMACY NAME

____

PHARMACY ADDRESS

____

PATIENT SIGNATURE

____

DATE

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ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the provider(s) listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information alcohol and substance abuse treatment information, mental health information, and genetic information from my provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me and for the business operations of the practice, its staff, and its business associates.

____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

____

DATE

____

DESCRIPTION OF PERSONAL REPRESENTATIVE’S AUTHORITY