WORKERS'COMPENSATION

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES

John R. McCloskey, MD Stephen J. Zabinski, MD Gene J. DeMorat, MD
Richard B. Islinger, MD George C. Alber, MD Thomas A. Barrett, MD
Frederick G. Dalzell, MD Stanley C. Marczyk, MD Ira M. Fox, DPM

24 MacArthur Blvd
Somers Point, NJ 08244
609-927-1991

18 E Jimmie Leeds Rd
Galloway, NJ 08205
609-404-3353

9 Stites Avenue
Cape May Court House, NJ
08210 609-465-2774

Appointment Date: _____ Time: _____ Select Physician

PATIENT INFORMATION: **Today's Date: _____**

Name:_____ Male: ☐ Female: ☐

Address:_____

City: _____ State: _____ Zip: _____

Home phone: (____)_____ Cell phone: (____)_____

Work phone: (____)_____ Social Security #: _____

Date of Birth: _____ Age: _____ Email: _____

Your Employer: _____Occupation: _____

Pharmacy Name: _____

Pharmacy Address: _____

Mail-Order Pharmacy Name: _____

Mail-Order Address: _____

Referred to Shore Orthopaedic University Associates by:

Physician: (Name/Address) _____Other:_____
Insurance Co.☐ Internet☐ Newspaper☐ Emergency Room☐ Radio☐

Medical Physician Information:
Primary Care Physician:
Current: _____ Address: _____ Phone: _____
Previous: _____ Address: _____ Phone: _____
Cardiologist: (Name) _____
Pulmonologist: (Name) _____
Other Medical Specialists: (Name) _____

Circle all that apply:

Race:	☐ Asian	☐ Black	☐ Hispanic	☐ White	
Language:	☐ English	☐ Spanish	☐ Sign Language	Other: _____	
Ethnicity:	☐ Latino	☐ Not Latino			

WORKERS' COMP PATIENT INJURY/TREATMENT FORM:

Employer/Company where injury occurred: _____

Employer Address:_____

City: _____ State:_____ Zip:_____ Phone: _____

Risk Manager: _____ Phone:_____

Fax:_____

Workers' Comp Insurance Carrier: _____

Billing Address: _____

Claims Adjustor: _____Phone:_____Fax:_____

Claim # _____

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1. Date of Injury: _____ Time of Injury: _____

2. What part(s) of the body were hurt; and in what part(s) of the body do you feel pain? _____

_____

3. Briefly describe how you got hurt: _____

_____

_____

_____

_____

4. Related testing for above: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan Other:_____
   Facility/Date test performed: _____

5. Have you had treatment in the past for the same problem/medical condition? YES ☐ NO ☐
   If yes, provide the name and address of the treating physician(s) for this condition. List any medications you are or were taking for this condition/injury: _____
   _____

6. Have you filed any Workers' Compensation Claim(s) in the past for this medical condition? YES ☐ NO ☐
   yes, please provide details of the previous claim(s): _____
   _____
   _____

7. Have you ever been involved in any type of auto accident? YES ☐ NO ☐
   If yes, when? _____ Body part(s) injured: _____

8. Have you ever had an MRI or CAT Scan? YES ☐ NO ☐
   If yes, what body part: _____

9. Have you been treated by a Chiropractor? YES ☐ NO ☐
If yes, when and list the name and address of the Chiropractor: _____
_____

10. Have you ever received Pain Management Treatment? YES ☐ NO ☐
If yes, when and list the name and address where you received treatment: _____
_____

11. List any athletic, recreational or sporting activities you have participated in within the last 12 months:
_____
_____
_____

12. Do you have a second job or have you had a second job within the last 12 months? YES ☐ NO ☐
If yes, Where: _____ When: _____
What do you do? _____

THIS FORM MAY BE SENT TO YOUR INSURANCE COMPANY

I authorize Shore Orthopaedic University Associates to furnish information to insurance carriers concerning my illness, condition, accident, or injury and treatment. I hereby assign to Shore Orthopaedic University Associates all payments for medical services rendered to me or my dependent(s) which I have not already paid. I acknowledge that all of the above information is true and correct and that it has been furnished to Shore Orthopaedic University Associates with full knowledge that I, the patient, or my dependent, will be liable for all said services rendered and that I, the patient, or my dependent will be contracturally bound to pay for said services including all costs of collection and a reasonable attorney's fee should collection become necessary.

Print Name	***Signature**	**Date**
Parent or Guardian's Name	***Signature**	**Date**

PATIENT MEDICAL HISTORY FORM:

Name:_____ Age:_____ Height:_____ Weight:_____

Are you: ☐ right-handed ☐ left-handed

What makes your symptoms worse? _____

_____

What makes your symptoms better ?_____

_____

For each, circle what BEST applies:

The pain is: ☐ RARE ☐ INTERMITTENT ☐ CONSTANT ☐ DULL

The pain is: ☐ SHARP ☐ ACHY ☐ THROBBING ☐ BURNING OTHER_____

0-10 severity scale (worst = 10) the pain is a: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Associated symptoms: Check ALL that apply:

☐ POPPING ☐ LOCKING ☐ GRINDING ☐ SWELLING ☐ STIFFNESS ☐ WEAKNESS

☐ TINGLING ☐ NIGHT PAIN OTHER_____

Have you ever had a previous injury or symptoms involving this body part in the past? ☐ Yes ☐ No

Have you had any previous treatment for this problem? ☐ NONE ☐ medication ☐ injection

☐ physical therapy ☐ surgery ☐ chiropractic care Explain: _____

_____

MEDICAL HISTORY: Do you currently or have you ever had any of the following: Check all that apply:

☐ Anemia	☐ Arthritis	☐ Asthma	☐ Rheumatoid Arthritis
☐ Emphysema	☐ Blood clots	☐ Lyme Disease	☐ Non-insulin diabetes
☐ Depression	☐ High blood pressure	☐ Irregular heartbeat	☐ Insulin - diabetes
☐ Heart disease	☐ Hepatitis A / B / C	☐ Gout	☐ Circulatory disease
☐ HIV/AIDS	☐ Kidney disease	☐ Osteoporosis	☐ Anxiety Disorder
☐ COPD	☐ Reflux/heartburn	☐ Seizures	☐ Urinary Infections
☐ Stomach ulcers	☐ Parkinson's disease	☐ Hyperthyroidism	☐ Hypothyroidism
☐ Sleep Apnea	☐ Glaucoma	☐ Stroke	☐ Fibromyalgia
☐ Other Psych Illness		☐ Bleeding disorder	☐ Increased Cholesterol

☐ Cancer:(type)_____

☐ Other/Details:_____

_____

☐ NONE

Have you ever had a DEXASCAN? ☐ YES ☐ NO If yes, Date: _____/_____/_____

SURGICAL HISTORY: Check all that apply: ☐ None

Eyes/ENT: ☐ cataracts ☐ sleep apnea ☐ tonsils ☐ sinus surgery ☐ thyroid

Heart: ☐ bypass ☐ valve replacement ☐ stent placement ☐ angioplasty ☐ pacemaker

GI: ☐ appendix ☐ gallbladder ☐ hernia ☐ gastric bypass

Gynecologic: ☐ C-section ☐ hysterectomy ☐ tubal ligation

Urologic: ☐ prostate ☐ bladder ☐ vasectomy

Orthopaedic: ☐ right hip replacement ☐ left hip replacement ☐ right knee replacement
☐ left knee replacement ☐ right knee arthroscopy ☐ left knee arthroscopy
☐ right shoulder arthroscopy ☐ left shoulder arthroscopy ☐ fracture surgery

Spine: ☐ cervical fusion ☐ lumbar fusion ☐ cervical disk removal
☐ lumbar disk removal fracture surgery

Vascular: ☐ carotid aneurysm leg bypass

Cancer: ☐ skin ☐ breast ☐ lung ☐ prostate other: _____

Other/details from above: _____

_____

History of surgical infection? ☐ Yes ☐ No If yes, explain _____

History of failed surgery? ☐ Yes ☐ No If yes, explain _____

History of anesthesia complication? ☐ Yes ☐ No If yes, explain _____

FAMILY HISTORY:

Mother: ☐ Living ☐ Deceased Cause of death: _____ Age: _____

☐ anesthesia complications ☐ bleeding disorder ☐ arthritis ☐ heart disease ☐ diabetes

☐ cancer:_____ ☐ malignant hyperthermia: _____

☐ other: _____

Father: ☐ Living ☐ Deceased Cause of death: _____ Age: _____

☐ anesthesia complications ☐ bleeding disorder ☐ arthritis ☐ heart disease ☐ diabetes

☐ cancer: _____ ☐ malignant hyperthermia: _____

☐ other: _____

SOCIAL HISTORY:

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed

Alcohol use: ☐ none ☐ occasionally ☐ daily _____ times per week

Tobacco use: Have you smoked at least 100 cigarettes in your entire life? ☐ Yes ☐ No

☐ Previous smoker When quit? _____ Years smoked? _____

☐ Current smoker Cigarettes/day? _____ Years smoked? _____

OTHER CURRENT SYMPTOMS: Check all that apply: ☐ None

General Health:	☐ weight loss	☐ weight gain	☐ fever	☐ night sweats	☐ fatigue
ENT:	☐ headaches	☐ difficulty swallowing		☐ nose bleeds	
Cardiovascular:	☐ chest pain	☐ palpitations		☐ fainting	
Respiratory:	☐ shortness of breath	☐ wheezing		☐ coughing	☐ snoring
Gastrointestinal:	☐ heartburn	☐ nausea		☐ constipation	☐ diarrhea
Urinary:	☐ urinary frequency	☐ urgency		☐ pain	☐ incontinence
Musculoskeletal:	☐ joint pains	☐ swelling		☐ stiffness	☐ muscle pain
Skin:	☐ skin changes	☐ poor healing		☐ rash	☐ itching
Neurological:	☐ numbness/tingling	☐ unsteady gait		☐ dizziness	☐ tremors
Hematologic:	☐ easy bleeding	☐ bruising			

Other: _____

MEDICATION ALLERGIES: (rash, swelling, shortness of breath, etc.) ☐ NONE

☐ Penicillin ☐ Sulfa ☐ Latex ☐ Iodine (IV contrast) ☐ Shellfish ☐ Poultry products

☐ other:_____

MEDICATION SIDE EFFECTS: (heartburn, nausea, vomiting) ☐ NONE

☐ NSAIDS ☐ Codeine ☐ Percocet ☐ Vicodin/Lortab ☐ other:_____

MEDICATIONS: ☐ NONE ☐ additional medications attached on a seperate sheet

Medication	Dosage	Times per day

***Patient or Responsible Party Signature** _____ Date_____

Physician Review_____ Date_____

SHORE ORTHOPAEDIC UNIVERSITY ASSOCIATES
PF-2000 Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your protected health information will be used by Shore Orthopaedic University Associates or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Shore Orthopaedic University Associates may or may not agree to restrict the use or disclosure of your protected health information.

If *Shore Orthopaedic University Associates* agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation or consent is received will not be affected.

Reservation of Right of Change Privacy Practices
Shore Orthopaedic University Associates reserved the right to modify the privacy practices outlined in this notice.

"Public law of the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his patients of any significant financial interest he may have in a health care services. Accordingly, I wish to inform you that I do have a financial interest in the following health care service(s) to which I refer my patients:

Shore Ambulatory Surgical Center, LLC d/b/a Jersey Shore Ambulatory Surgery Center

You may, of course, seek treatment at a health care service provider of your own choice. A listing of alternative health care service providers can be found in the classified section of your telephone directory under the appropriate heading. NJSA 45:9-22.6"

Signature
I have reviewed this consent form and give my permission to *Shore Orthopaedic University Associates* to use and disclose my health information in accordance with it.

_____ _____

Name of Patient *Signature of Patient

_____ _____

*Signature of Patient Representative Relationship to Patient

_____
Date

PRINT

1. Save this docoument for your records

2. Print the entire form and bring it with you for your appointment. (*sign all signature sections and add your ss# after printing)