Orthopaedic Associates of Marlborough P.C.

PATIENT REGISTRATION FORM

- ☐ Israel S. Hurwitz, M.D.
- ☐ Steven H. Sewall, M.D.
- ☐ Harvey A. Taylor, M.D.
- ☐ Markian D. Stecyk, M.D.
- ☐ Donald H. Hangen, M.D.
- ☐ Paul J.P. Pongor, M.D.

PATIENT NAME: | DATE OF BIRTH:

SOCIAL SECURITY NUMBER: | MARITAL STATUS: | MALE: | FEMALE:

HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

HOME PHONE #: | CELL PHONE #:

EMPLOYER NAME: | WORK PHONE #:

EMPLOYER ADDRESS: | PRIMARY CARE PHYSICIAN:

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME: | PHONE #:

IF UNDER 18, PERSON(S) LEGALLY RESPONSIBLE FOR PATIENT

NAME: | PHONE #:

ADDRESS:

INJURY INFORMATION

IS THIS INJURY DUE TO: AUTO ACCIDENT: | WORK INJURY:

DATE OF INJURY: | OTHER ACCIDENT/INJURY:

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: | SUBSCRIBER'S DOB:

ID OR MEMBER #: | GROUP OR POLICY #:

SUBSCRIBER NAME: | RELATION TO PATIENT:

SUBSCRIBERS EMPLOYER NAME:

SECONDARY INSURANCE:

SECONDARY INSURANCE NAME: | PCP NAME:

ID OR MEMBER #: | GROUP OR POLICY #:

SUBSCRIBER NAME: | RELATION TO PATIENT:

SUBSCRIBERS EMPLOYER NAME: | SUBSCRIBER'S DOB:

ASSIGNMENT OF BENEFITS:

I hereby authorize assignment of payments directly to Orthopaedic Associates of Marlboro, P.C. for any surgical and/or medical benefits, which are payable to me for this service described above. I understand that I am financially responsible for the charges not covered by this assignment of benefits or my insurance. I hereby authorize Orthopaedic Associates of Marlboro, P.C. to release any information related to medical care received by me for purposes of treatment and/or payment. Furthermore, by signing below, I declare that I have received a copy of Orthopaedic Associates of Marlboro, P.C. privacy precautions.

SIGNATURE (MUST BE 18 OR OLDER) | DATE

Health Assessment Questionnaire – Orthopaedic Associates

Patient Name: ______________________________ **Date**: __________

Age: ________ Occupation / Work: ______________________________

Primary Care Physician: ______________________________

Referred By (E.R., Primary Care, Clinic, Employee Health, Med Works, Patient Etc): ______________________________

Current Orthopedic Problem (Why are you here today?) Date of Injury: ____________

#1 ______________________________

#2 ______________________________

History of Current Problem (Location, Severity, Timing, Duration): ______________________________

____

____

____

How Long Have Your Symptoms Been Present? ______________________________

Work Related: Y N

Height ____________ Weight ____________

General Medical Condition

Heart Trouble	Y	N				____________
Cancer	Y	N				____________
Stomach Ulcers	Y	N				____________
Diabetes	Y	N	High Blood Pressure	Y	N	____________
Stroke	Y	N	Blood Clots	Y	N	____________
Bleeding Tendency	Y	N	Asthma	Y	N	____________
Osteoporosis	Y	N	Fibromyalgia	Y	N	____________

Other Medical Conditions / Illnesses / **Arthritis**: ______________________________

____

Current Medications: ______________________________

____

____

Previous Surgery: ______________________________

List Allergies: ______________________________

Recreational and Social History

Status	Child	Single	Married	Widowed
Alcohol Use	N	Rarely	Socially	Daily
Tobacco Use	N	Y	Packs / Day ____________	
Nonprescription Drug Use	N	Y	Describe ____________	
Current Sports/Activities	____________			

Family History (Ages, Major Medical Problems, if Deceased, Cause of Death)

Mother ______________________________

Father ______________________________

Siblings ______________________________

Children ______________________________

Spouse ______________________________

Previous Questionnaire Reviewed Y N

No Change in Health Status Y N

Signature of Patient / Guardian if under 18

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ORTHOPAEDIC ASSOCIATES

RECEIPT OF PRIVACY PRACTICES AND DISCLOSURE AUTHORIZATION

DATE: ______________

PATIENT NAME ______________________________

PATIENT PHONE # ______________________________

DO WE HAVE PERMISSION TO :

Leave a message on your answering machine at home?	YES ☐	NO ☐
Leave a message at your place of employment or voice mail?	YES ☐	NO ☐
Discuss your condition with spouse, partner or children?	YES ☐	NO ☐
Can your interpreter or friend receive verbal communication from physician?	YES ☐	NO ☐

If yes, whom?

NAME ______________________________

RELATIONSHIP ______________________________

NAME ______________________________

RELATIONSHIP ______________________________

MY SIGNATURE BELOW CERTIFIES THAT I HAVE BEEN PROVIDED WITH A WRITTEN COPY OF THE ABOVE NAMED PRACTICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT OR GUARDIAN IF UNDER 18

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For office use only ______________________________

❑ Lic/Photo ID: ______________ ❑ Lic/Photo ID: ______________