ORTHOPAEDIC & SPORTS MEDICINE SPECIALISTS INC.

David V. Lopez, M.D.

Office: 732-888-2100 Fax: 732-888-2188
www.lopezortho.com

Patient Registration

Date: / / **Email**:			☐ Female ☐ Male	
First Name:	Middle:	Last:		Age:
DOB: / /	Soc. Security No.: - -	Marital Status: ☐Married ☐Single ☐Divorced ☐ Widowed		
Home Address:	Apt. #:	City:	State:	Zip:
Home #: ( ) -	Cell #: ( ) -	Language:		
Race: ☐ Black or African American ☐ Caucasian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian		Ethnicity:		

Employer Information

Company:	Work Phone: ( ) -	Occupation:	
Address:	City:	State:	Zip:
Occupation: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Work at Home ☐ Retired ☐ Student			

Emergency Contact Information

Last Name:	First:	Relationship:
Home Phone: ( ) -	Cell: ( ) -	Work: ( ) -

Primary Care Physician

Name:	Office: ( ) -	Fax: ( ) -	
Address	City	State	Zip:

Referring Physician

Name:	Office: ( ) -	Fax: ( ) -	
Address	City	State	Zip:

Primary Insurance

Subscriber Name:	DOB: / /	Social Security No.: - -	
Relationship to Patient:	Carrier:	ID #:	Group #:

Secondary Insurance

Subscriber Name:	DOB: / /	Social Security No.: - -	
Relationship to Patient:	Carrier:	ID #:	Group #:

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Assignment of Benefits/Release of Information/Financial Responsibility by Patient

I, _____ (Patient Name) hereby irrevocably authorize **Orthopaedic & Sports Medicine Specialists, Inc**. and/or its designees to provide treatment and/or examination, and release any patient information to my physician, insurance company, adjustor or attorney if applicable, and to apply for Medicare/Medicaid, and other health insurance benefits if applicable (No Fault, Personal Injury Protection and Worker's Compensation), on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes. I hereby authorize payment of any/all medical benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my physician, health insurance carrier and Center for Medicare & Medicaid Services (CMS) agents, and any and all information needed to determine the benefits payable for related service(s).

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your medical insurance and are indicated on your insurance's Explanation of Benefits to be the patient's responsibility are due and payable upon receipt of a billing statement. Also, please be aware that this center will not forgive patient deductibles, patient co-payments and patient co-insurance payments. It is against the law to do so.

If you do not have medical insurance, financial arrangements will be made prior to services rendered. Otherwise full payment will be expected at the time of services. I agree if my account balance is over 90 days old, I will be responsible for a late fee of fifty dollars ($50.00). **A CHARGE OF $50.00 WILL BE MADE FOR BROKEN AND/OR NO SHOW APPOINTMENTS UNLESS 24 HOUR NOTICE GIVEN.**

_____ _____/_____/_____

(Signature of Patient/Parent/Guardian) Date (MM/DD/YY):

Assignment of Benefits/Authorization to release Information

I, _____ hereby authorize _____

(Subscriber name) (Insurance Company)

TO pay and assign directly to **David V. Lopez, M.D**. or his representatives, all benefits, if any, otherwise payable to me for his services as described in the attached forms. I understand that I am financially responsible for all charges incurred for services rendered by Dr. Lopez, whether or not paid by my Primary or Secondary insurers.

I authorize release of any medical information necessary to process this claim with my Primary and/or Secondary insurers. I further acknowledge that any insurance benefits, when received by and paid to David V. Lopez, M.D. or his representatives will be credited to my account, in accordance with the above assignment.

_____ _____/_____/_____

(Authorized Signature of Subscriber) Date (MM/DD/YY):

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Patient Contact Preferences

I may be contacted in the following manner (please check all that apply):

Telephone Messages	Home	Work	Written Communication	Home	Work
Leave message with information	☐	☐	Mail sent to	☐	☐
Leave message with call-back number	☐	☐	Fax message to this number: ( ) -		

Disclosure of Patient Information to Individuals other than the Patient

I agree that Dr. Lopez's practice may disclose information on my health and medical insurance billing to a family member, close personal friend, or other caregiver involved in my healthcare or payments relating to my healthcare. Dr. Lopez's practice will disclose only that information which is directly relevant to the person(s) involvement with my healthcare or payment relating to my healthcare.

I designate the following person(s) listed below as persons directly involved with my healthcare relationship and with whom Dr. Lopez's practice may disclose information.

Print Name	Relationship	Involvement with Patient: Healthcare	Payments	Both
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐
_____	_____	☐	☐	☐

Acknowledgement of HIPAA Privacy Notice & Designation of Disclosure

_____ _____/_____/_____

(Patient Name) Date of Birth (MM/DD/YY)

I have had the chance to read and think about the contents of this form, and I agree with all the statements made in this Authorization. I understand that by signing this form, I am confirming my authorization for disclosure of information by Orthopaedic & Sports Medicine Specialists, Inc. as indicated above.

_____ ____/_____/_____

(Signature of Patient/Parent/Guardian) Date (MM/DD/YY):

If this authorization form is to be signed by a personal representative of the patient named herein, provide the following information:

_____ _____ ____/____/____

(Print Name) (Signature of representative) Date (MM/DD/YY)

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Patient Examination

Today's Date:	Patient Name:	DOB: / /

Accident Date:	Location:	State:	Claim Number:
Motor Vehicle Accident: ☐ Yes ☐ No ☐ Driver ☐ Passenger ☐ Wearing Seatbelt?			
Lawyer's Name:		Phone: ( ) -	Fax: ( ) -
Address:		City:	State: Zip:
Workers Compensation Claim: ☐ Yes ☐ No		Claim Number:	

Chief Complaint

Describe complaint:

Which side is involved? ☐ Right ☐ Left ☐ Front ☐ Back ☐ Bilateral

What makes it better?	What makes it worse?

HEIGHT:	WEIGHT:	BP: /	Taken by:

The complaint is a result of (check all that apply)

☐ Lifting ☐ Pulling ☐ Pushing ☐ Twisting ☐ Falling ☐ Bending ☐ Reaching
☐ Squatting ☐ Hit by an object ☐ Other (explain) _____

Allergies

☐ None
☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Keflex ☐ Latex ☐ Sulfa ☐ Steroid Injection
☐ Tylenol ☐ Other (explain) _____ Serious effects:_____

For Women Only

Are you on birth control pills? ☐ Yes ☐ No Are you pregnant ☐ Yes(how many weeks): ____ ☐ No

Medication

Medication	Dose	Frequency	How Long	Side Effects

Pharmacy Name:	Town:	Phone: ( ) -

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Patient Examination

Patient Name:	DOB: / /	☐ Female ☐ Male

Surgeries/Hospitalizations

Year	Type of Surgery	Hospital	Comments

Have you ever had general anesthesia? ☐ Yes ☐ No
Have you ever had any problems with anesthesia? ☐ Yes ☐ No
If you answered yes, please describe: _____

Review of Systems

Check off all of the following diseases or medical conditions that you have had at any time:

- ☐ High/Low blood pressure
- ☐ High Cholesterol
- ☐ Anemia/Transfusions
- ☐ Radiation Treatments
- ☐ Blood clots/pulmonary embolus
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hemophilia/Abnormal bleeding
- ☐ Rheumatoid arthritis
- ☐ Artificial bone or joint
- ☐ Bone infections
- ☐ Eyes
- ☐ Ear/Nose/Throat
- ☐ Stomach/Trouble eating
- ☐ Diabetes: Type I ☐ II ☐
- ☐ Asthma/Trouble breathing
- ☐ Shortness of Breath
- ☐ Epilepsy/Seizures/Fainting
- ☐ Pacemaker
- ☐ Heart Murmur/Congenital defect
- ☐ Mitral valve prolapse
- ☐ Kidney/Bladder problems
- ☐ Bowel problems
- ☐ Polio
- ☐ Lower Back Pain/Sciatica
- ☐ Drug/Alcohol abuse
- ☐ Psychiatric problems
- ☐ Cancer type:_____

Describe any additional medical problems that you feel may be relevant to your treatment and we need to know: _____

Social History

Children ☐ Yes (how many) _____ ☐ No Do you live alone? ☐ Yes ☐ No
Exercise: ☐ Daily ☐ Weekly ☐ Rarely ☐ Never Type of Exercise?_____
Are you on a special diet? ☐ Yes (describe) _____ ☐ No
History of substance abuse? ☐ Yes (describe) _____ ☐ No
Do you smoke? ☐ Yes (packs/day)_____ (how many years)_____ ☐ No
Quit smoking? ☐ Yes ☐ this year? ☐ > 1 year? ☐ >10 years?
Do you drink alcohol? ☐ Yes ☐ 1 -2/week ☐ > 2 (how much) _____ ☐ No