



# Mercer-Bucks Orthopaedics



## Patient Information

SSN: \_\_\_\_\_ Name: \_\_\_\_\_

Gender: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race:  White  Black/African American  Asian  Other  Declined Ethnicity:  Latino  Not Latino  Declined

Primary Language:  English  Spanish  Indian  Russian  Other  Declined

Address (no PO Box please): \_\_\_\_\_

Email: \_\_\_\_\_

Primary #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Extension #: \_\_\_\_\_

Do you have a Primary Care Physician?  Yes  No

Primary Care Physician: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have a preferred pharmacy?  Yes  No

Preferred Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

\* By indicating my pharmacy above, I agree that Mercer Bucks Orthopaedics may request and use my prescription medication history from other health care providers or third party pharmacy benefit payors for treatment purposes.

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

**Parent/Guardian's information - if the patient is under 18**  Address is the same as the patient

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**Financial Guarantor's information**  Parent/Guardian's is the guarantor  Address is the same as the patient  
**(if the patient is under 18)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

## Insurance Information

Body part(s) injured? \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**(Policyholder's information - if it is different than the patient)**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

SSN#: \_\_\_\_\_ Relation to Insured: \_\_\_\_\_

## Authorization/Release of Medical Information

This authorization or photocopy thereof will authorize Mercer Bucks Orthopaedics to furnish all information they may have regarding my condition, while under their observation or treatment, to any party who may be responsible for payment to Mercer Bucks Orthopaedics, including history obtained, X-ray and physical findings, diagnosis, and prognosis. I designate the following persons listed below as persons acceptable to receive information. **Please include yourself.** I also understand that I may change this at any time in writing. I understand that Mercer Bucks Orthopaedics will not disclose health information to any person not designated except in case of an emergency. In the event a physician or an employee is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I hereby consent to having my blood tested for the AIDS virus (HIV test) so that any necessary treatment of the physician or employee can begin without delay.

Name: \_\_\_\_\_ DOB (required as identifier) \_\_\_\_\_

Name: \_\_\_\_\_ DOB (required as identifier) \_\_\_\_\_

Name: \_\_\_\_\_ DOB (required as identifier) \_\_\_\_\_

I, patient \_\_\_\_\_ or guarantor \_\_\_\_\_ agree to sign forms electronically.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**Financial Responsibility Agreement**

●I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my visits. This includes any Medical service visit, Radiology, EMG, OMT, DME, Therapy or any other services ordered by my physician or my physician’s staff.

●I understand and agree it is my sole responsibility and not the responsibility of the provider of services, hospital, surgery center, therapists or supplier to know if my insurance will pay for my Medical service or visit, Radiology, EMG, OMT, DME, Therapy or any other services ordered by my physician or my physician’s staff.

●I understand and agree it is my sole responsibility to know if my insurance has any Deductible, Referral Requirement, Co-payment, Co-insurance, Out-of-Network amount, Usual and Customary Limit or any other type of benefit limitation for the services I receive, and I agree to make full payment promptly.

●I understand that it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out-of- pocket expense to me. I understand this and agree to be financially responsible and make full payment promptly.

● I understand and agree it is my responsibility to know if my PCP choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment promptly. If I am being seen under a motor vehicle claim, I must provide active health insurance as a supplement to the motor vehicle claim and will be held

responsible for any balance not paid through my motor vehicle claim and health insurance.

●I request that payment of authorized insurance benefits be made either to me or on my behalf to Mercer Bucks Orthopaedics for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize Mercer Bucks Orthopaedics to release to any information needed to determine benefits payable for related services.

● In Medicare assigned cases only, Mercer Bucks Orthopaedics agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services.

●I agree that if my check is returned from the bank for “Insufficient Funds” or any other reason I will be responsible for an additional returned check fee imposed on Mercer-Bucks Orthopaedics by the bank of thirty dollars (\$30.00).

●I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional collection fee of fifty dollars (\$50.00) or 35% of the balance owed, whichever amount is greater.

●By signing below, I agree to accept full financial responsibility as a patient or as the responsible party for a minor patient who is receiving Medical services, Radiology, EMG, OMT, DME, Therapy or any other services. MBO or its affiliates may contact you via phone unless express written consent advises otherwise. My signature verifies that I have read the above disclosure statement, understand my responsibilities, and agree to these terms.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that a copy of the Privacy Practices has been made available to me via a hard copy in the office as well as an electronic copy at [www.mbirtho.com](http://www.mbirtho.com). This policy explains your rights including your right to see and copy your records, to limit the disclosure of your protected health information and to request an amendment to you record.

**Patient/Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

VISIT ALL OUR LOCATIONS

Hamilton, NJ

Lawrenceville, NJ

Princeton, NJ

Marlton, NJ

Langhorne, PA



# MERCER-BUCKS ORTHOPAEDICS PC MEDICAL HISTORY FORM



Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Cardiologist/Specialist: \_\_\_\_\_

How did you hear about us:  Friend/Family  Advertisement  Referral from medical facility/ER  Website  Other

Were Xrays/MRI taken?  Yes  No If yes, what facility? \_\_\_\_\_

Primary Body part to be seen \_\_\_\_\_

Side:  Right  Left  Bilateral

Other Body part to be seen: \_\_\_\_\_

Are there religious/cultural needs related to your care?  No  Yes

Please explain: \_\_\_\_\_

Date How Injury Occurred?

Is this problem due to an injury?  No  Yes \_\_\_\_\_

Is this injury work related?  No  Yes \_\_\_\_\_

Is injury related to an Auto Accident?  No  Yes \_\_\_\_\_

Have you had a fall in the last year?  No  Yes Did the fall result in an injury?  No  Yes

**PAST MEDICAL HISTORY: (Select all current and previous illnesses)**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Depression       | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Fibromyalgia     | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Shingles         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> GERD             | <input type="checkbox"/> Neuropathy          | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Liver Disorder      | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Clot        | <input type="checkbox"/> Gout             | <input type="checkbox"/> Lyme Disease        | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Colitis           | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Paget's Disease     | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> COPD/Lung Disease | <input type="checkbox"/> HIV/AIDS         |  | <input type="checkbox"/> None             |

**CANCER**  Yes  No

Select Type of Cancer:

- |                                  |                                   |                                   |                                     |                                  |
|----------------------------------|-----------------------------------|-----------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Breast   | <input type="checkbox"/> Liver    | <input type="checkbox"/> Prostate   | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Blood   | <input type="checkbox"/> Cervical | <input type="checkbox"/> Lung     | <input type="checkbox"/> Stomach    | <input type="checkbox"/> Uterine |
| <input type="checkbox"/> Bone    | <input type="checkbox"/> Colon    | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Testicular |                                  |
| <input type="checkbox"/> Brain   | <input type="checkbox"/> Kidney   | <input type="checkbox"/> Pancreas | <input type="checkbox"/> Throat     |                                  |

If Other, Please mention here : \_\_\_\_\_

Heart Disease:  Yes  No

Pacemaker:  Yes  No

Arthritis:  Yes  No

What type:  Rheumatoid  Osteoarthritis  Osteoporosis



**MERCER-BUCKS ORTHOPAEDICS PC  
MEDICAL HISTORY FORM**



**Hepatitis**     Yes     No    If Yes, Select the Type?     Type A     Type B     Type C  
**Diabetic**     Yes     No    If Yes, Select the Type?     Type I     Type II  
 Illegal drug use?     Yes     No    **Had Bone Density test (Dexa-Scan)?**     Year : \_\_\_\_\_  
**Sleep Apnea:**     Yes     No    **C-Pap use:**     Yes     No  
**Possibility of Pregnancy:**  Yes     No  
 Any Other Medical Conditions : \_\_\_\_\_  
 Pain Level: (0-10) 0 = No pain, 10 = Worst possible pain: \_\_\_\_\_

**ALLERGIES**

Do you have any Allergies?     Yes     No  
 List of Allergies: *(Please be sure to include any allergies to Medications, Antibiotics, Latex, Iodine, Shellfish, Seafood or Metal)*

**MEDICATIONS:**

**PAST SURGICAL HISTORY**

Do you have any past surgeries?     Yes     No

*If yes, Please select all that are applicable from the list below:*

- |  |  |
|--|--|
| <input type="checkbox"/> Appendectomy        | <input type="checkbox"/> Hysterectomy                |
| <input type="checkbox"/> Back Surgery        | <input type="checkbox"/> Hernia Repair               |
| <input type="checkbox"/> Cataract Surgery    | <input type="checkbox"/> Knee Replacement            |
| <input type="checkbox"/> Cesarean Section    | <input type="checkbox"/> Prostate Surgery            |
| <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Rotator Cuff Repair         |
| <input type="checkbox"/> Hip Replacement     | <input type="checkbox"/> Thyroid Surgery             |
| <input type="checkbox"/> Hemorrhoidectomy    | <input type="checkbox"/> Tonsillectomy/Adenoidectomy |
| <input type="checkbox"/> Heart Surgery       | <input type="checkbox"/> Surgery related to Cancer   |

Type of Other Surgery: \_\_\_\_\_



# MERCER-BUCKS ORTHOPAEDICS PC

## MEDICAL HISTORY FORM



### FAMILY HISTORY

	Father	Mother	Brother	Sister	Son	Daughter	None
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any other family member with a major illness to report?  Yes  No If Yes, Explain: \_\_\_\_\_

### SOCIAL HISTORY

**Marital Status**     Single                       Married                       Widowed                       Divorced                       Legally Separated  
**Use of Alcohol**     Never                       Rarely                       Moderate                       Daily  
**Use of Tobacco**     Never                       Previously but quit                       Current packs/day: \_\_\_\_\_  
 Are you right or left handed?     Left                       Right                       Ambidextrous  
 Living Situation:     Alone                       with Friends                       with Spouse                       with Family  
 What is your employment status?     Working full time                       Working part time                       Unemployed                       Retired from work  
 What is the type of work you do? \_\_\_\_\_

### SYSTEMS REVIEW *(Did you have any of the following symptoms within the past 6 months?)*

Good general health lately?     Yes                       No

#### Constitutional Symptoms

- Fatigue
- Fever
- Recent weight change
- None

#### Musculoskeletal

- History of fractures
- None

#### Gastrointestinal

- Abdominal pain
- Heartburn
- Loss of appetite
- Nausea
- Vomiting
- None

#### Neurological

- Dizziness
- Light-headedness
- Paralysis
- Tremors
- None

#### Hematologic/Lymphatic

- Phlebitis
- Past blood transfusion
- None

#### Psychiatric

- Confusion
- Insomnia
- Memory loss
- Nervousness
- None