Patient Information -*Please Print* Today's Date: _____/_____/_____

Last Name: ____ First Name: ____________________________ MI: _______

Address: ____ Apt/Floor__________________

City: ____ State: _________________ Zip Code: __________

Date of Birth: ____/_____/_____ Age: _____ Sex: ____M ____F Social Security #______/_____/_______

Home Phone: _____-______-________ Cell Phone: _____-______-________ Work Phone: _____-______-________

E-mail: __________________________________ Working Status: ___Working ___Not Working ___Retired ___Disabled

Pharmacy Name: _____________________________________ Phone: _________________________________

Address: ____

Referring/Primary Care Physician: ____ Phone: ______-_______-_________

Occupation: ____ Employer: _________________________________

How did you hear about us? ____

Insurance Information -*Please give Insurance Card to Receptionist*

Type of Insurance: ____Workers Comp ____MVA ____ Commercial/Other

Primary Insurance: ___________________________________ ID #: _________________________ Group #: __________

Subscriber Name: ____ Subscriber DOB: ______/______/______

Patients Relationship to Subscriber: ____Self ____Spouse ____Child ____Other

Secondary Insurance: ________________________________ ID #: __________________________ Group#: __________

Subscriber Name: ____ Subscriber DOB: ______/______/______

Patients Relationship to Subscriber: ____Self ____Spouse ____Child ____Other

Work Comp/MVA:

Insurance Company: ____ Policyholder: __________________________

Billing Address: ____

Adjuster/Case Manager: ____ Phone: _____-_______-________

Claim #: ___________________________ Policy #: ___________________________ Date of Loss: _____/_____/______

Assignment of Benefits Agreement:

1. *I, the undersigned, hereafter referred to as "the patient", do hereby assign all of my rights and interests to Jeffrey Augustin, MD, hereafter referred to as "Medical Provider" to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include, but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey. In addition, I appoint the Medical Provider as my Designated Authorized Representative. Should my insurance carrier require additional forms relating to this designation, I agree to sign them and return the originals to the Medical Provider's office.*
2. *I, the patient, do hereby acknowledge that I have an obligation to comply with reasonable requests made of me by the insurance carrier.*
3. *For any balances owed by me, not covered by my insurance policy, or monies not turned over that are paid directly to me, I will be liable for all costs of collections, including, but not limited to, an additional fee of 35% of the outstanding balance if my account is forwarded to a collection agency for collection; and, if my account is forwarded to any attorney for legal proceedings, I agree to be liable for an additional attorney fee of up to 50 % of the outstanding balance.*
4. *I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.*
5. *I, the patient, authorize my Insurance Carrier to pay directly to the Medical Provider any monies due on my account.*
6. *The Medical Provider will comply with the decision point review request as required by the plan.*
7. *The Medical Provider shall submit disputes to the personal injury protection dispute arbitration if the decision point review requires same.*

By signing below, I hereby indicate that I have read and understand the terms of the Assignment of Benefits Agreement.

____ Date: ______/______/________

Patient/Guardian Signature

Patient Name (*print*): ____

Privacy Information: *please indicate what your privacy preferences are regarding the method in which the following information is relayed.*

	Appointment Information		**Medical Information**	
On home phone	_____No	_____Yes	_____No	_____Yes
On cell phone	_____No	_____Yes	_____No	_____Yes
On your office Voice Mail	_____No	_____Yes	_____No	_____Yes
With another person	_____No	_____Yes	_____No	_____Yes
Send via Mail	_____No	_____Yes	_____No	_____Yes
Send via Email	_____No	_____Yes	_____No	_____Yes
Send via Fax (private only)	_____No	_____Yes	_____No	_____Yes

If you have answered YES to allowing us to discuss your appointment and/or medical information with another person, please list their names and phone numbers below:

Name	**Relationship**	**Phone**	**Cell Phone**

Purpose of Your Visit/Consult

Was injury/pain the result of an accident? ____Yes ____ No If Yes, ___Work Related ___Auto ___Other: _________

What is the conditions for which you are seeking medical attention? ____

Site of injury (body part): ____ Side: ____Right ____Left

Date of injury or onset: ______/______/______ Having pain since: ______/______/______

How did pain first start? ____

Does the pain radiate from this part of your body to another area? ____No ____Yes If yes, where__________________

Circle which words best describes your pain:

ACHING HOT SHOOTING SHARP COLD BURNING NUMB SEVERE STABBING TINGLING

On a scale of 1 to 10, with 1 being no pain and 10 being the most severe, how would you rate your pain? __________

Please circle if your pain is: CONSTANT INTERMITTENT

Is it brought on by aggravating factors: WALKING SITTING CLIMBING STAIRS OTHER: _____________________

Is there a time of day when your pain is usually better or worse? Better? AM/PM Worse? AM/PM

What makes the pain better?____

Have you had any previous treatment for the pain? INJECTIONS PHYSICAL THERAPY MEDICATION

CHIRORACTOR OTHER: _______________________________

Do you use an assistive device to get you around? CANE WALKER WHEELCHAIR SCOOTER

Personal History

Height: __________ Weight__________ Do you exercise? ____Occasionally ____Regularly ____Rarely ____Never

Do you smoke? ___Yes ___ No If Yes, how many packs per day? _____ For how many years? _____

Are you allergic to Latex? ___Yes ___No

Do you have any food or medication allergies? ___Yes ___No If yes, please list __________________________________

List any medication(s) you are currently taking:____

Do you have a history of substance abuse? ___Yes ___No Do you drink alcohol? ___Yes ___No

AUGUSTIN ORTHOPEDICS
ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTICE OF PRIVACY PRACTICES

I acknowledge that I read and/or received a copy of the **Augustin Orthopedics** Patient Notice of Privacy Practices effective September 23, 2013.

____

Signature of Patient or Guardian, if applicable Date

Review of Systems/History of Present Illness please check if applicable

	Yes	No	Date, if Applicable	Family History of	Description, if Applicable
Anemia					
Anxiety/Depression					
Arthritis					
Asthma/Breathing Difficulties					
Bleeding Problems					
Bowel/Bladder Difficulties					
Cancer					
Chest Pain/Angina					
Circulation Disorders					
COPD					
Depression/Psychiatric Disorder					
Diabetes					
Epilepsy					
HIV					
Headaches/Dizziness					
Heart Disease or Heart Attack					
Heart Palpitations/Arrhythmias					
Hepatitis					
High Blood Pressure					
High Cholesterol					
Kidney Problems					
Lung Disease					
Metal Implants					
Numbness/Tingling					
Osteoporosis					
Pacemaker					
Pregnancy					
Problems with Eyesight/Hearing					
Pulmonary Embolism/Blood Clots					
Rheumatoid Arthritis					
Seizures					
Skin Abnormalities					
Stomach Ulcers					
Stroke/Transient Ischemic Attack					
Substance Abuse					
Thyroid Problems					