Mercer-Bucks Orthopaedics

Patient Information

SSN: ________________ Name: ____

Gender: _________ Date Of Birth:___________ Marital Status: ________________

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other ☐ Declined ☐ American Indian or Alaskan Native
☐ Native American ☐ Pacific Islander

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 (if the patient is under 18) ☐ Parent/Guardian's is the guarantor ☐ Address is the same as the patient

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: ___________

Type of insurance: ____

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), Hepatitis B, and Hepatitis C, 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.

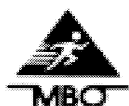
●By signing below, I agree to accept full financial responsibility as a patient or as the responsible party for a minor patient who is receiving Medical services, Radiology, EMG, OMT, DME, Therapy or any other services. MBO or its affiliates may contact you via phone unless express written consent advises 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:** _______________

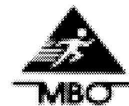
Notice of Privacy Practices

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.mbortho.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:** _______________



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

X-ray/MRI taken? ☐ Yes ☐ No If yes, what facility? ☐

Body part to be seen (For example: Left Knee): ☐

		Date	***How Injury Occurred?***
Is this problem due to an injury?	☐ No ☐ Yes	☐	☐
Onset: ☐			
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)*

☐ Anemia	☐ Depression	☐ High Blood Pressure	☐ Seizures
☐ Anxiety	☐ Fibromyalgia	☐ Kidney Disease	☐ Shingles
☐ Asthma	☐ GERD	☐ Liver-Disorder	☐ Stroke
☐ Bleeding Disorder	☐ Glaucoma	☐ Lyme's Disease	☐ Thyroid Disorder
☐ Blood Clot	☐ Gout	☐ Neuropathy	☐ Ulcers
☐ Colitis	☐ High Cholesterol	☐ Osteopenia	☐ Vascular Disease
☐ COPD/Lung Disease	☐ HIV/AIDS	☐ Osteoporosis	☐ None
		☐ Paget's Disease	

CANCER ☐ **Yes** ☐ **No**

Select Type of Cancer:

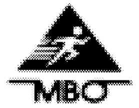
☐ **Bladder**	☐ **Breast**	☐ **Liver**	☐ **Prostate**	☐ **Thyroid**
☐ **Blood**	☐ **Cervical**	☐ **Lung**	☐ **Stomach**	☐ **Uterine**
☐ **Bone**	☐ **Colon**	☐ **Melanoma**	☐ **Testicular**	☐ **Other**
☐ **Brain**	☐ **Kidney**	☐ **Pancreas**	☐ **Throat**	

If Other, Please mention here : ____________________

Heart Disease: ☐ **Yes** ☐ **No** **Pacemaker:** ☐ **Yes** ☐ **No**

Arthritis: ☐ **Yes** ☐ **No** **Type:** ____________________

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

Sleep Apnea? ☐ Yes ☐ No — **C-Pap Use?** ☐ **Yes** ☐ **No**

Had Bone Density test (Dexa-Scan)? ☐ **Yes** ☐ **No** — If Yes, mention the Year :__________

Any Other Medical Conditions :____

Pain Level: (0-10) 0 = No pain, 10 = Worst possible pain:________

ALLERGIES

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

List of Allergies: ____

MEDICATIONS:

Do you take any medications or vitamins regularly? ☐ **Yes** ☐ **No**

____

PAST SURGICAL HISTORY

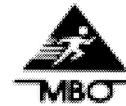
Do you have any past surgeries? ☐ Yes ☐ No

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

- ☐ **Appendectomy**
- ☐ **Back Surgery**
- ☐ **Carpal Tunnel**
- ☐ **Cataract Surgery**
- ☐ **Cesarean Section**
- ☐ **Gallbladder Surgery**
- ☐ **Hip Replacement**
- ☐ **Hemorrhoidectomy**
- ☐ **Heart Surgery**
- ☐ **Hysterectomy**
- ☐ **Hernia Repair**
- ☐ **Knee Replacement**
- ☐ **Knee Scope (meniscus)**
- ☐ **Prostate Surgery**
- ☐ **Rotator Cuff Repair**
- ☐ **Thyroid Surgery**
- ☐ **Tonsillectomy/Adenoidectomy**
- ☐ **Surgery related to Cancer**
- ☐ **Other**

Type of Other Surgery:____

MERCER-BUCKS ORTHOPAEDICS PC
MEDICAL HISTORY FORM



FAMILY HISTORY

	Father	Mother	Brother	Sister	Son	Daughter	None
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Heart Diseases	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐
Arthritis (Osteo/bone)	☐	☐	☐	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐

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:____________________

Have you smoked in the last two months? ☐ Yes ☐ No

Are you right or left handed? ☐ Left ☐ Right ☐ Ambidextrous

Living Situation: ☐ Alone ☐ with Friends ☐ with Spouse ☐ with Family ☐ Other

What is your employment status? ☐ Working full time ☐ Working part time ☐ Unemployed ☐ Retired from work

What is the type of work you do? ____________________

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

Please explain: ____________________

Do you use any recreational drugs? ☐ Yes ☐ No

Treated for Substance Abuse? ☐ Yes ☐ No

Possibility of Pregnancy? ☐ Yes ☐ No

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

Hematologic/Lymphatic
- ☐ Past blood transfusion
- ☐ None

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

Neurological
- ☐ Dizziness
- ☐ Light-headedness
- ☐ Paralysis
- ☐ Tremors
- ☐ None

Psychiatric
- ☐ Confusion
- ☐ Insomnia
- ☐ Memory loss
- ☐ Nervousness
- ☐ None

Musculoskeletal
- ☐ History of fractures
- ☐ None

Signature:____________________