CRAIG H. ROSEN M.D., P.A.

Orthopedic Surgery - Legal Reports

WELCOME TO OUR OFFICE!

Date of original injury: _____

Brief history of how injury occurred: _____

In order for your insurance claim to be processed correctly, it is necessary for you to provide the following information to the best of your ability.

Are you being treated today for an injury resulting from an accident at work?

Circle: *Yes* or *No* (*This includes driving during work hours*)

Are you being treated today for an injury resulting from an automobile accident?

Circle: *Yes* or *No*

Are you being treated today for an injury resulting from a slip and fall outside of your home?

Circle: *Yes* or *No*

Did this happen at home? *Yes* or *No* If so, where? _____

Please state what area of the body was injured: _____

Please state the place in which the injury occurred: _____

Please state if you are seeing an attorney for this injury: _____

Did you seek emergency treatment? *Yes* or *No* If so, where? _____

If this was a WC, MVA, or Slip/Fall injury, our office needs to bill that insurance first.

We need an approval, for treatment from the insurance company and/or a settlement or denial letter. If we send this claim only to your medical insurance, they may pay the claim first but then pull the payment back when they determine the type of injury was one of the listed above. If this occurs, you will be responsible for the payment of that bill.

Please print name: _____

Patient's signature: _____

Date: _____

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Name: _____ Date: _____

Address: _____ Age: _____

SS# _____ DOB: _____ DOI: _____

PAST MEDICAL HISTORY: (Check those that apply)

❑ Hypertension	❑ Diabetes	❑ Rheumatoid Arthritis	❑ Kidney Disease
❑ Heart Disease	❑ High Cholesterol	❑ Reflux, Peptic Ulcers	❑ TB
- Pacemaker - Heart Attack	❑ Asthma	❑ Phlebitis/DVT/Blood Clots	❑ Gout
- Stents - Arrhythmia	❑ Emphysema(COPD)	❑ Cancer	❑ Psoriasis
- Valve	❑ Pneumonia	❑ Thyroid Disease	❑ Stroke
❑ Fractures	❑ Hepatitis/HIV	❑ Arthritis: Where? _____	

PAST SURGICAL HISTORY: ❑ None

_____

_____

MEDICATIONS: (Include vitamins and supplements)

_____

_____

_____

_____

MEDICATION ALLERGIES:

_____

_____

SOCIAL HISTORY:

❑ Drugs: _____ ❑ Smoking: _____ packs/day ❑ Alcohol _____ #/day

Sports/Hobbies/Night & Weekend Activities: (time with each) _____

Last Grade Completed in School: _____

Living Situation: With Someone? _____ Number of Floors/Stairs: _____

FAMILY HISTORY: Any of the conditions noted above in your family? _____

_____

HOSPITALIZATIONS: _____

WORK STATUS: Occupation: _____ Currently Working? Yes or No

Time (and date) Lost From Work: _____

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Name: _____

REVIEW OF SYSTEMS: Include numbness, tingling, weakness, bowel/bladder problems, sexual difficulties, etc. Do you now or have you had any problems related to the following systems? Circle Yes or No.

Explain any YES answers in the space provided. Unanswered questions are considered a NO.

Constitutional Systems
- Fever Y N
- Chills Y N
- Headaches Y N
- Other _____

Eyes
- Blurred Vision Y N
- Double Vision Y N
- Pain, white of eye-Jaundice Y N
- Other _____

Allergic/Immunologic
- Hay Fever Y N
- Drug Allergies Y N
- Other _____

Neurological
- Tremors Y N
- Dizzy Spells Y N
- Numbness/Tingling Y N
- Circle: Upper or Lower Extremities

Endocrine
- Excessive Thirst Y N
- Too Hot/Cold Y N
- Tired/Sluggish Y N
- Other _____

Gastrointestinal
- Abdominal Pain Y N
- Nausea/Vomiting Y N
- Indigestion/Heartburn Y N
- Other _____

Cardiovascular
- Chest Pain Y N
- Varicose Veins/Phlebitis Y N
- High Blood Pressure Y N
- Other Heart Problem Y N
- Stents Y N
- Pacemaker/Difibrillator Y N

Integumentary
- Skin Rash Y N
- Lesions, Spots Y N
- Persistent Itch Y N
- Other _____

Musculoskeletal
- Joint Pain Y N
- Neck Pain Y N
- Back Pain Y N
- Other _____

Ear/Nose/Throat/Mouth
- Ear Infection Y N
- Sore Throat Y N
- Sinus Problems Y N
- Other _____

Genitourinary
- Urine Retention Y N
- Painful Urination Y N
- Urinary Frequency Y N
- Other _____

Respiratory
- Wheezing Y N
- Frequent Cough Y N
- Shortness of Breath Y N
- COPD or Asthma Y N
- Other _____

Hematological/Lymphatic
- Swollen Glands/Neck Mass Y N
- Blood Clotting Problem Y N
- Other _____

Psychiatric
- Depression Y N
- Anxiety, Agitation Y N
- Aware of Time, Person, and Place Y N

Comments/Notes: Chief Complaint (in 10 words or less):

Pain Scale: Low (0) & High (10) _____ (0 to 10) Height _____ Weight _____

Examinee's or Patient's Signature: _____

Physician's Signature: _____

PATIENT INFORMATION

Name: _____ DOB: _____ SS#: _____
Address: _____ City: _____ State: ____ Zip: _____
Home/Cell Phone: _____ Work Phone: _____ Driver's License: _____
Employer: _____ Occupation: _____
Chief Complaint: _____ Date of Injury: _____

INSURANCE INFORMATION

Insurance Co.: _____ ID#: _____
Address: _____
Name of Insured: _____ SS#: _____ DOB: _____

WORKERS' COMPENSATION or MOTOR VEHICLE INSURANCE

Please circle one: *Workers' Compensation* (WC) *Motor Vehicle Case* (MVA)

Workers' Compensation Insurance Co.: _____
Address: _____
Claim #: _____ Adjuster: _____ Phone: _____

Motor Vehicle Insurance Co.: _____
Address: _____
Date of Accident: _____ Claim #: _____ Adjuster: _____
Phone: _____ Fax: _____
Are you working: *YES* or *NO* Was PIP notified? *YES* or *NO* Do you have a registered vehicle in NJ? *YES* or *NO* Was there another vehicle involved? *YES* or *NO* If yes, were they at fault? *YES* or *NO*

EMERGENCY INFORMATION

Emergency Contact: _____ Phone: _____
Relationship to Patient: _____

PRIMARY CARE PHYSICIAN and/or REFERRING PHYSICIAN

Name of Physician: _____ Phone: _____
Address: _____

RELEASE & ASSIGNMENT

I authorize and request payment of medical benefits directly to *CRAIG H. ROSEN, M.D., P.A.*. I understand that I am financially responsible for all changes rendered for services provided to me, including the remaining balance after possible insurance benefits. I authorize release of any medical information necessary in the processing of the claim and securing authorization for treatment.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

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PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home telephone _____
- ☐ Cell _____
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with call-back number only
- ☐ Work telephone _____
- ☐ OK to leave a message with detailed information
- ☐ Leave a message with call-back number only

- ☐ Written communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office
- ☐ OK to fax to this number _____
- ☐ Verbal via phone with verification
- ☐ Other _____

_____

☐ Guardian (insurance through guardian) _____

Patient Signature: _____ Date: _____

Print Name: _____ DOB: _____

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

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MEDICATION AGREEMENT

1. I will not share, sell or trade my medication for money, goods or services.

2. I will not attempt to get pain medications from any other health care provider. I must inform any other health care provider that I am taking pain medication. I understand that it is against the law to obtain pain medication from anyone else.

3. I will take the medication exactly as prescribed.

4. Replacements may not be given due to loss, theft, fire or any other reason.

5. I will keep all scheduled appointments with this office and any other specialist involved in my pain management care.

6. If I am a female of childbearing years, I will use appropriate measures to prevent pregnancy during the course of treatment and I will notify this office immediately should I become pregnant.

7. I will use only one pharmacy to fill my medications.

Pharmacy: _____ Phone: _____

Address: _____

8. I agree to waive any applicable privilege or right of privacy or confidentially with respect to the prescribing of my pain medications.

9. I agree to allow the doctor to communicate with my health care providers, i.e. referring physicians, pharmacist, regarding my usage of narcotics.

10. I will follow the advice of the doctor in regards to the cessation of controlled substances if it is felt that this will be necessary.

11. I understand that this treatment may be discontinued if any of the following occur:

- If the doctor feels that the narcotics have not been effectively managing your pain
- If I give away, sell or misuse the drug(s)
- If I develop a tolerance or loss of effect from the narcotics
- If the side effects become intolerable
- If I obtain narcotics from any source other than this doctor

I have read this document. I understand it, and all questions have been satisfactorily answered. I consent to all the terms and conditions stated. I acknowledge that failure to abide by the terms of this agreement will result in termination of the doctor/patient relationship and I may be discharged from the practice.

Patient Signature: _____ Date: _____

Print Name: _____

Provider Signature: _____