

Name:
DOB:
Chart:
Date:

Setting the Standards for Quality Patient Care.
orthopaedic institute
of Central Jersey

PATIENT INFORMATION: *Please print*

Name: _____ Today's Date: _____

Birth Date: _____ Age: _____ Sex: _____ Marital Status: _____

Address: _____ Town: _____ Zip: _____

Phone: _____ Cell: _____

Social Security: _____ Email: _____

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

Spouse/Parent Name: _____ Phone: _____

Family Physician: _____ Phone: _____

Family Physician Address: _____

INSURANCE INFORMATION

Primary Insurance:

Please present your insurance card(s) to the receptionist with this form.

Is this visit due to an automobile accident? Yes / No **Work related accident?** Yes / No

Insurance Co. Name: _____ Phone _____

Address: _____

ID#: _____ Group No.: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Address (If different than above) _____

Social Security No.: _____ Relationship to Patient: _____

Secondary Insurance (if any):

Insurance Co. Name: _____ Phone _____

Address: _____

ID#: _____ Group No.: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Address (If different than above) _____

Social Security No.: _____ Relationship to Patient: _____

PREFERRED PHARMACY INFORMATION

Name: _____ Phone Number: _____

Address: _____

Name:
DOB:
Chart:
Date:

PATIENT PAIN DRAWING

Name _____ Date _____

Where is your pain now?

Aching

▲ ▲ ▲

Numbness

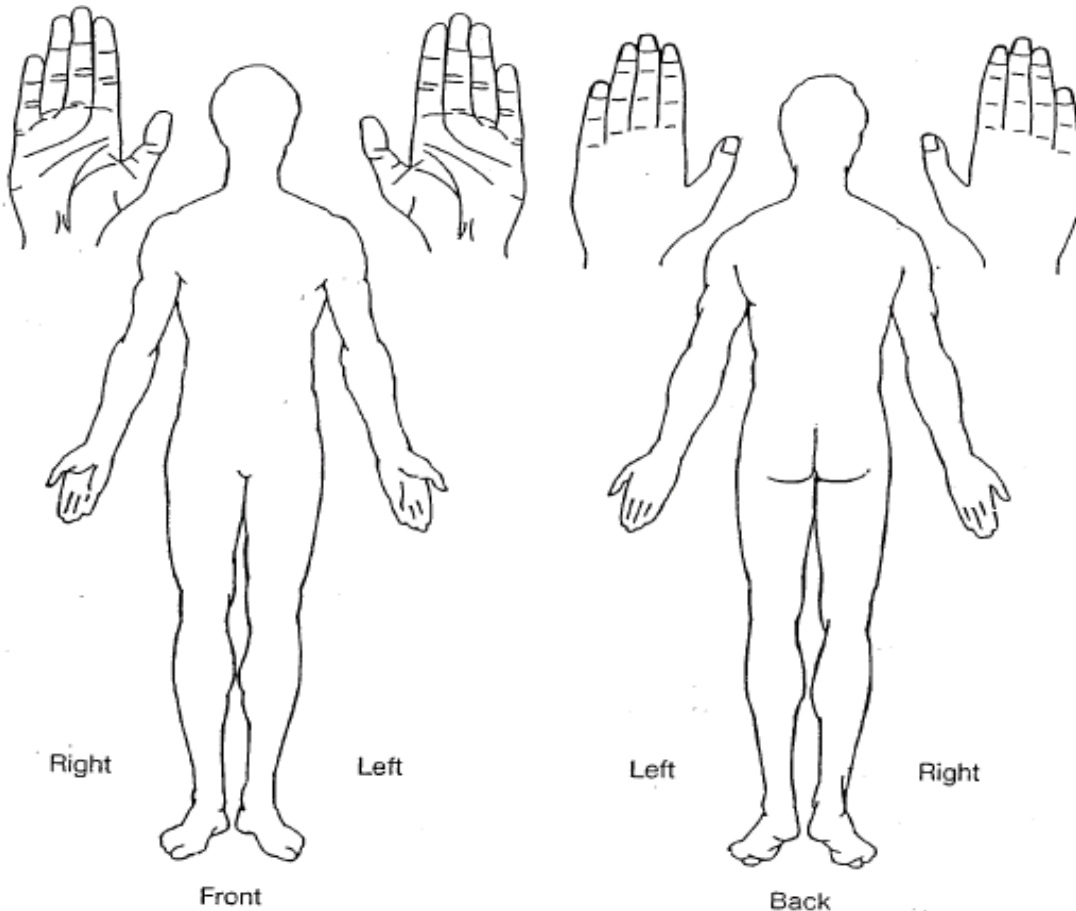
= = =

Pins and needles

o o o

x x x

/ / /



How bad is your pain now?

Please mark with an x on the body form where the pain is worst now.

Please mark on the line how bad your pain is now.

No pain _____ Worst possible pain

Name:
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**ALL SURGEONS ARE
BOARD CERTIFIED**

JOINT RECONSTRUCTION
& REPLACEMENT

**JOHN M.
TOZZI, MD**

**GREGORY J.
ROEHRIG, MD**

HAND & UPPER
EXTREMITIES

**CLINT C.
FERENZ, MD**

SPORTS MEDICINE
& ARTHROSCOPY

**MICHAEL A.
SCLAFANI, MD**

**ANTHONY V.
PETROSINI, MD**

**TOBY B.
HUSSLER, MD**

SPORTS MEDICINE
**LAURIE L.
GLASSER, MD**

**PETER G.
GONZALEZ, MD**

PAIN MANAGEMENT
& ANESTHESIOLOGY

**NATHAN
HOLTZBERG, MD**

FOOT & ANKLE SURGERY
**SHANE M. HOLLAWELL,
DPM**

ORTHOPAEDIC SURGERY &
SHOULDER RECONSTRUCTION
NICHOLAS A. JARMON, MD

- Sports medicine
- Pain management
- Joint replacement & arthritis care
- Knee & shoulder injuries
- Wrist & hand injuries
- Foot & ankle injuries
- Spine injuries & back problems
- Neurodiagnostic Testing
- Five locations
- Same-day Emergency Workers' Comp appointments
- Major hospital & Teaching Affiliations

**PEAK PERFORMANCE
PHYSICAL THERAPY**

- Toms River 732-349-4000

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**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____
(Patient Name)

have received a copy of this office's Notice of Privacy Practices.

I authorize communication between this office and

_____ (family member/friend).
(name)

_____ We can leave a message for you at home regarding your care.

_____ We may NOT leave a message for you at home regarding your care.

Comments: _____

Patient Signature

Date

3499 Route 9, Freehold, NJ 07728 • 732-863-4790 • Fax: 732-863-4791
2315 Route 34 South, Suite D, Manasquan, NJ 08736 • 732-974-0404 • Fax: 732-449-4271
365 Broad Street, Red Bank, NJ 07701 • 732-933-4300 • Fax: 732-933-1444
226 Route 37 West, Toms River, NJ 08755 • 732-240-6060 • Fax: 732-240-5329
visit us at : www.oiortho.com

Name:
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orthopaedic institute *of Central Jersey*

Your Name: _____

Your Primary/Family Doctor:

Age: _____

Height: _____

Weight: _____

Occupation: _____

Please circle or answer:

What was the date of your work-related injury?

Approximately what date did your current pain begin?

Please describe the details of how this injury occurred:

Was this injury the result of a fall? Yes No

Have you fallen more than once within the last year? Yes No

Have you had previous work-related injuries?

If yes, please explain:

Are you currently working? YES NO

If YES,...

Light duty?

Full duty?

If NO, when was your last day on the job?

Do you have any other jobs, secondary employment, or part-time employment?

Have you ever been in a car accident? If yes, please list the date, injuries, and physicians that treated you:

How severe is your pain...

Today? (0 - 10) _____

When at its worst? (0 - 10) _____

Is the pain...

Sharp or dull?

Aching or stabbing?

Burning?

Is it painful...

First thing in the morning?

During the day?

At night while sleeping?

What makes the pain better?

Lying down?

Standing?

Sitting?

Walking?

Ice or heat?

What makes the pain worse?

Lying down?

Standing?

Sitting?

Walking?

Exercise?

Stair climbing?

Reaching over head?

Bending?

Coughing/sneezing?

Name:
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Name of the physicians whom have treated
this problem for you before:

Have you ever had (for this problem):

- Xrays?
- CT scan
- MRI?
- EMG?

Have you tried the following for this
problem?

- Oral medications?

Please list: _____

- Physical Therapy?
- Joint injections?

Steroid (cortisone)

Synvisc/Orthovisc/Euflexxa

- Epidural injections
- Chiropractic care
- Surgery

Your Medical History:

(check or circle all that apply)

Heart disease

- High blood pressure
- High cholesterol
- Heart attack
- Congestive heart failure
- Arrhythmia/atrial fibrillation

Endocrine disease

- Diabetes
- Thyroid condition

Vascular disease

- Blood clots
- Pulmonary embolism
- Varicose veins
- Peripheral vascular disease

Neurologic/Spine disease

- Stroke/mini-stroke
- Peripheral neuropathy
- Spinal stenosis
- Herniated disc

Kidney disease

Gastrointestinal disease

- GERD
- Ulcers
- Bleeding ulcers

Bleeding/Clotting disorders

Lung disease

- Asthma
- COPD
- Emphysema
- Sleep apnea

Cancer

- Please list: _____

Rheumatologic conditions

- Rheumatoid arthritis
- Psoriatic arthritis
- Ankylosing spondylitis
- Lupus

HIV/AIDS

Hepatitis - please circle type: **A B C**

Mental illness

- Depression
- anxiety

Other: please list _____

No Medical Problems

Review of Systems/Symptoms

(check or circle all that apply)

- fevers/chills/sweats
- rapid recent weight loss
- headaches
- vision problems
- hearing problems
- skin problems/rashes/psoriasis
- easy bruising/nose bleeds
- chest pain or palpitations
- short of breath/cough/wheeze
- reflux/heartburns
- diarrhea/constipation
- bladder problems
- kidney stones
- sexual difficulties
- numbness/tingling
- balance/coordination problems
- back pain
- neck pain
- swelling of the legs or feet
- anxiety

Name:
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Medications:

(include vitamins, supplements, herbs)

Allergies:

Have you had the current season's Influenza vaccine? Yes _____ No _____ If yes, date: _____
Have you ever had a Pneumonia vaccine? Yes _____ No _____ If yes, date: _____

Have you ever had anesthesia? YES or NO
If YES, what type? General Spinal Epidural

Have you ever had problems or complications with anesthesia?
If YES, please describe:

Past Surgery

(and year performed)

Family History:

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)				
Grandfather (mom's)				
Grandmother (dad's)				
Grandfather (dad's)				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Social History? Currently working? YES NO Retired? YES NO
Are you on disability? YES NO

Smoking Currently? No Yes _____ packs per day for _____ years Start date (year): _____
Quit Smoking? > 1 year > 5 years > 10 years _____ packs per day Start date (year): _____
Quit date (year): _____

How much alcohol do you drink each day? _____

Any history of other drug use? YES NO

Do you have a spouse or partner? YES NO

How many children do you have? _____ Who lives in your home with you?

Doctor initials: _____ Date: _____

Name:
DOB:
Chart:
Date:

ORTHOPAEDIC INSTITUTE OF CENTRAL JERSEY
HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____

I hereby authorize: **OICJ** _____ to disclose my protected health information in accordance with this authorization.

Please disclose my protected health information, as set forth below, to: _____

Please indicate the information or types of information to be disclosed (including dates if necessary):

*The purpose(s) of this authorization is: _____

This authorization may be revoked by me at any time except to the extent that the person(s) and/or organization(s) listed above have already acted in reliance upon this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it to _____

_____. If not revoked by me, this authorization will terminate on: _____ (include date or event).

I understand that I may inspect and/or copy the information to be disclosed.

I understand that this authorization is voluntary. I understand that I do not need to sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits. I also understand that if I have any questions regarding the use or disclosure of my health information, I may contact the privacy officer at the health care provider authorized to disclose this information.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and will no longer be protected by the federal regulations protecting privacy of an individual's health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations") and other applicable federal and state law.

I understand that the information in my health record may include information or references to the existence of and/or treatment for **drug and/or alcohol abuse, mental health, (psychiatric records, psychological records, etc.) sexually transmitted diseases, tuberculosis, genetics, Hepatitis B or C, or human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS)**. This information will also be released unless I indicate by checking below that I do not want such information released:

DO NOT RELEASE _____

Photocopies and facsimile copies of this Authorization shall be deemed to be originals.

Patient or Legal Representative

Date

Representative's authority to act on behalf of individual

Witness