Patient Information

Appointment Date: _____

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A Division of OrthoNJ

First Name: _____ Last Name: _____ Middle Initial: _____

SS#: _____ Birth Sex: ◯ Male ◯ Female Gender Identity: ◯ Male ◯ Female ◯ Other Date of Birth: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino **Language:** _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Employer Address: _____

Referring MD: _____ Referring MD Address: _____

PCP: _____ PCP Address: _____

Employment: ◯ Full Time ◯ Part Time ◯ Not Employed ◯ Self Employed ◯ Retired ◯ Military Duty ◯ Permanently Disabled

Current Occupation: _____ and/or **Student:** ◯ Full Time ◯ Part Time

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Parent Information for Minors:

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SS#: _____ Date of Birth: _____ Birth Sex: ◯ Male ◯ Female Gender Identity: ◯ Male ◯ Female ◯ Other

Employer: _____ Employer Address: _____

Email Address: _____

Primary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Employer Group: _____ Patient's Relationship to Subscriber: _____

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

ID#: _____ Group#: _____

Secondary Insurance:

Insurance Company: _____ Specialist Copay: _____ Effective Date: _____

Employer: _____ Patient's Relationship to Subscriber: _____

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

ID#: _____ Group#: _____

Worker's Compensation or Auto Accident Information *(Complete this section, if applicable)*

Coverage Type: ◯ Worker's Compensation ◯ Auto Accident

Insurance Company: _____ Date of Injury: _____

Claim ID#: _____ Body Part Injured: _____

Proceed to 2nd page for Completion and Signature

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Emergency Contact:

Name: _____ Relationship to Patient: _____

Phone: _____

Patient Affirmation:

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize treatment by the providers at University Orthopaedic Associates, LLC.

Signature: _____ Date: _____

Authorization for Assignment of Benefits

Please accept this Assignment of Benefits as a blanket Assignment of Benefits for charges on services rendered and submitted by University Orthopaedic Associates, LLC on my behalf. I, the undersigned, authorize and request that.

_____

Signature

	Initials
Medical-Legal Reports/Testimony: I acknowledge this office's policy regarding medical-legal reports and testimony. The providers do not testify, nor make court appearances. Permanency evaluations and narrative reports are prepared at their discretion. If this policy is unacceptable to me or my attorney, I am aware that I should seek orthopaedic treatment elsewhere.	
Workers' Compensation and Auto Accidents: It is the patient's responsibility to clearly identify those medical injuries/conditions which he/she believes are due to a motor vehicle or work related injury at the time of the initial visit on all required documentation. Failure to do so can result in patient liability.	
Motor Vehicle (PIP) Claims: Injuries involving Motor Vehicle accident/injuries must be submitted to my Motor Vehicle (PIP) carrier and cannot be billed to my private insurance unless PIP coverage has been denied, does not exist or private insurance was selected as the primary carrier. I am responsible for any deductible or co-payments under my PIP coverage. I agree to a promissory note enactment for any open balances owed to UOA, LLC in relation to my accident/injuries.	

Dear University Orthopaedic Associates Patient,

We kindly request your email address so that we can extend to you the opportunity to provide us with feedback regarding your care, and access to information regarding what's new at University Orthopaedic Associates, in the form of patient satisfaction surveys and newsletters.

Your email address will not be sold or made available for use by any other organizations.

PLEASE PRINT CLEARLY:

Name: _____ Email: _____

Signature: _____ Date:_____