Forrestal Village ◆ 121 Main Street ◆ Princeton ◆ NJ ◆ 08540 ◆ Tel: (609) 919-9005 ◆ Fax: (609) 919-9002

Patient Agreement

Consent to evaluate and treat:
I do hereby consent to the evaluation and treatment by Premier Sports Medicine. I understand it is my right to accept or refuse treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that be obtained from such treatment.

Financial Responsibility

There will be a $________ Office visit due at each visit which will be applied to your insurance deductible and/or co-insurance responsibility for an out of network visit.

I authorize Premier Sports Medicine to charge my credit card for any charges incurred during my treatment. These charges may include, but are not limited to, co-pays, co-insurance, deductible or supplies.

Type of Card: ❑ Visa ❑ MasterCard ❑ American Express
Cardholder's name as on credit card:_________________________________
Credit Card Number:____
Credit Card Expiration Date:____

________________________________ ______________
Patient/Legal Guardian Signature Date

________________________________ ______________
Witness Date

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Welcome to Our Office

CONFIDENTIAL PATIENT DATA **TODAY'S DATE:_______________**

Please ask if you need assistance completing this form.

Name:____ Date of Birth:______________________

Address:__________________________________ City:________________ State:_____ Zip:________

Home Phone:_______________________Work:____________________Cell:_____________________

E-mail:____________________________

Social Security #:_____________________ ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Other_______________________

Name of Spouse or Nearest Relative:____________________________ Phone:__________________

Patients Occupation:_____________________________ Employer:____________________________

Name of Primary Care Physician:________________________ Phone:_________________________

Name of Specialist (if under the care of one):__________________________ Phone:______________

Referred to This Office By: ❑ Friend/Family Name:____

❑ Mail ❑ Clinic Location ❑ Online ❑ Other:_______________

Are you currently a Member of CanDo? ❑ Yes ❑ No

Insurance Company:__________________________________ Policy Number:___________________

Insured's Name:_____________________________________ Insured's Date of Birth:_____________

Insured's SS #:________________________ Insured's Employer & Phone #:____________________

Are you covered by more than one Insurance Company? ❑ Yes ❑ No

Company Name:_______________________________ Policy #:______________________________

Is this injury or illness work related? ❑ Yes ❑ No

Is this injury or illness due to an automobile accident? ❑ Yes ❑ No

Have you had Physical Therapy this year? ❑ Yes ❑ No If yes, how many visits?_________________

ASSIGNMENT & RELEASE: I, the undersigned, certify that I (or my dependant) have insurance coverage with ___________________________ and assign directly to Premier Sport Medicine all insurance benefits otherwise payable to me for services rendered. I understand that I am fiscally responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ __________________

Signature of Patient or Guardian Date

____

Relationship to Patient

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MEDICAL HISTORY **DATE:____________**

Name:______________________________ Age:_______________

Occupation:_________________________ Leisure Activities:______________________________________

Reason for Today's Visit:____

Date of Injury/Onset of Problem:__________________________ Was the Onset ❑ Sudden ❑ Gradual

How did the problem occur?____

____

Have you had any previous or similar problems? ❑ Yes ❑ No

If yes, please explain:____

Major Complaint(s)

Please rate your complaints (1-10, with 10 being the most serious)

1.____ _____________

2.____ _____________

3.____ _____________

What activities aggravate your problem(s)?____

What activities help relieve your problem(s)?____

How does this problem(s) at its worst interfere with:

Your ability to work?____

Your ability to enjoy hobbies/sports?____

Your ability to enjoy your family or social time?____

Has the problem(s) been getting worse? ❑ Yes ❑ No

Do you have any concerns about having this problem corrected? ❑ Yes ❑ No

If yes, what are they?____

How often do you exercise? ❑ Regularly ❑ Irregularly ❑ Rarely

If so, what type of exercise program are you involved in?_________________________________

Are you under the care of any of the following:

❑ Medical Doctor (MD) ❑ Physical Therapist ❑ Psychiatrist/Psychologist

❑ Doctor of Osteopathy (DO) ❑ Chiropractor ❑ Other________________

If you have seen any of the above during the past three months, please describe the reason (illness, medical condition, physical exam): ____

____

Please list previous surgeries or any other conditions for which you have been hospitalized:

Date (approximate) Surgery/Reason for Hospitalization

________________ ____

________________ ____

________________ ____

Please describe any injuries for which you have been treated:

Date (approximate) Injury

________________ ____

________________ ____

________________ ____

Have you taken any **OVER-THE-COUNTER** medication in the past 2 weeks?

Advil/Motrin/Ibuprofen ❑ Yes ❑ No Antihistamines ❑ Yes ❑ No

Aspirin ❑ Yes ❑ No Decongestants ❑ Yes ❑ No

Tylenol ❑ Yes ❑ No Vitamins/Mineral Supplements ❑ Yes ❑ No

Other:____

Please list any **PRESCRIPTION** medication that you are currently taking (including pills, injections, and skin patches):

1.___________________ 2.___________________ 3.__________________ 4.__________________

ARE YOU ALLERGIC TO LATEX? ❑ Yes ❑ No Please list any other allergies:

1.___________________ 2.___________________ 3.__________________ 4.__________________

FOR WOMEN:

Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

Are you taking fertility drugs? ❑ Yes ❑ No

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall plan of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

				INTAKE
❑ Pneumonia	❑ Mumps	❑ Influenza	❑ HIV/Aids	
❑ Smallpox	❑ Pleurisy	❑ Scarlet Fever	❑ Rheumatic Fever	❑ Coffee
❑ Pollo	❑ Chicken Pox	❑ Heart Disease	❑ German Measles	❑ Tea
❑ Diabetes	❑ Epilepsy	❑ Hepatitis	❑ Tuberculosis	❑ Alcohol
❑ Cancer	❑ Eczema	❑ Mental Disorders	❑ Multiple Sclerosis	❑ Cigarettes
❑Anemia	❑ Arthritis	❑ Kidney Disorder	❑ Rheumatoid	
❑ Measles	❑ Thyroid	❑ Whooping Cough	❑ Muscular Dystrophy	

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST SIX MONTHS:

Musculoskeletal Code

❑ Low Back Pain ❑ Pain Between Shoulders ❑ Neck Pain/Stiffness ❑ Arm Pain
❑Joint Pain/Stiffness ❑ Walking Problems ❑ Difficulty Chewing/Jaw Clicks ❑ General Stiffness

Nervous System Code

❑ Nervous ❑ Numbness ❑ Paralysis ❑ Dizziness
❑ Forgetfulness ❑ Confusion/Depression ❑ Fainting ❑ Convulsions
❑ Stress ❑ Loss of Concentration ❑ Cold/Tingling Extremities ❑ Concussion

General Code

❑ Fatigue ❑ Allergies ❑ Loss of Sleep/ Insomnia ❑ Fever
❑ Headaches ❑ Low Resistance to Colds

Gastrointestinal Code

❑ Excessive Thirst ❑ Frequent Nausea ❑ Poor/Excessive Appetite ❑ Vomiting
❑ Diarrhea ❑ Constipation ❑ Hemorrhoids ❑ Liver Problems
❑ Weight Trouble ❑ Gall Bladder Problems ❑ Gas/Bloating after Meals ❑ Abdominal Cramps
❑ Colitis ❑ Heartburn/Indigestion ❑ Bowel Control Loss ❑ Black/Bloody Stool

Genito-Urinary Code

❑ Bladder Trouble ❑ Discolored Urine ❑ Painful/Excessive Urination

C-V-R Code

❑ Chest Pain ❑ Short Breath ❑ Blood Pressure Programs ❑ Irregular Heartbeat
❑ Heart Programs ❑ Lung Programs ❑ Lung Congestion ❑ Varicose Veins
❑ Ankle Swelling ❑ Stroke ❑ Heart Attack

EENT Code

❑ Vision Programs ❑ Dental Program ❑ Sore Throat ❑ Earaches
❑ Hearing Difficulty ❑ Stuffed Nose ❑ Blurred Vision ❑ Light Bothers Eyes
❑ Buzzing in Ears ❑ Loss of Smell ❑ Loss of Balance ❑ Loss of Taste

Male/Female Codes

❑ Breast Pain ❑ Menstrual Cramps ❑ Vaginal Pain/Infection ❑ Menstrual Irregularity
❑ Breast Lumps ❑ Reproductive Disorders ❑ Prostate Problems ❑ Sexual Dysfunction

Family History: The following members have the same or similar problem(s) as I do:

❑ Mother ❑ Father ❑ Brother ❑ Sister
❑ Spouse ❑ Child

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Acknowledgement of Receipt of Privacy Practices

Name of Patient:_________________________________ Date:__________

By signing below I hereby acknowledge receipt of **Premier Sports Medicine's** Privacy Practices Policy.

____
Signature of Patient or Legal Guardian