PREMIER
ORTHOPAEDICS & SPORTS MEDICINE

ADVANCED CENTER FOR EXCELLENCE IN SPINE
HAND AND TRAUMA INSTITUTE / SPINE AND TRAUMA INSTITUTE

111 Galway Place Suite 300, Teaneck, NJ 07666 Phone: 201-833-9500 Fax: 201-862-0095

www.acespremortho.com

PATIENT REGISTRATION FORM

Rev. 2021

Patient's Last Name: _____ **First** _____ **MI** _____

Address: _____ APT# _____ CITY _____ STARE _____ ZIP _____

DOB: _____/_____/_____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow

Social Security #: _____-_____-_____

Home Phone #: ( ) _____-_____ Work Phone #: ( ) _____-_____

Cell Phone #: ( ) _____- _____ Emergency Phone #: ( ) _____-_____

E-MAIL: _____ Fax#: ( ) _____-_____

Pharmacy Name: _____ Pharmacy Phone#: ( ) _____-_____

If the patient is a minor, please write guardian's name: _____

Guardian's Address: _____

Primary Doctor: _____ Phone #: ( ) _____-_____

Complete Address: _____

Referring Doctor: _____ Phone #: ( ) _____-_____

Complete Address: _____

Attorney Name (If appl.): _____ Phone #: ( ) _____-_____

Complete Address: _____

Primary Insurance: _____ Plan Name: _____

Policy #: : _____ Group #: _____ Co-Pay: $_____

Claim Address: _____

Insured's Full Name (If other than patient): _____

DOB: _____/_____/_____ S.S.# _____-_____-_____ Relationship: ☐ Self ☐ Spouse ☐ Child

Secondary Insurance: _____ Plan Name: _____

Policy #: : _____ Group#: _____ Co-Pay: $_____

Claim Address: _____

Insured's Full Name (If other than patient): _____

DOB: _____/_____/_____ S.S.# _____-_____-_____ Relationship: ☐ Self ☐ Spouse ☐ Child

CK ONE: ☐ WORKMAN'S COMPENSATION / ☐ NO FAULT INFORMATION (MVA)

Employer at time of injury : _____ Phone#: ( ) _____-_____

Complete Address: _____

Insurance Company: _____ Policy/Claim#: _____

Complete Address: _____

Carrier Case: _____ Adjuster: _____ Injury Date: _____

Has the accident been reported to this insurance company: ☐ Yes ☐ No When: _____

I understand it is my responsibility to provide you with the correct information so that you may submit charges to my insurance, and that failure to do so may make me personally responsable for all charges submitted for services rendered to me.

Full Name: _____ **Signature:** _____ **Date:** _____

Assigment Form / Formulario de Asignación

AUTHORIZATION FOR INSURANCE SUBMISSION *(AUTORIZACIÓN PARA SUMISIÓN AL SEGURO)*

I authorize the use of this form on all insurance submissions.
(Yo autorizo el uso de este formulario en todas las presentaciones de seguros.)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (*AUTORIZACIÓN DE SUMINISTRO DE INFORMACIÓN MÉDICA)*

I authorize the release of medical information pertaining to my history, services rendered, or treatment given to me or my dependents for purposes of review of my insurance claim.
(Autorizo la divulgación de información médica relacionada con mi historial, los servicios prestados o el tratamiento que recibí para mí o para mis dependientes a fin de revisar mi reclamo de seguro.)

ASSIGNMENT AUTHORIZATION (*ASIGNACIÓN DE BENEFICIOS)*

I hereby authorize payment of benefits to be made to the physician rendering the services. I understand that regardless of any insurance coverage I might have, I will be held responsible for any costs, which are not covered by my insurance, including any deductible, co-pay, denied or uncovered services.
(Por la presente autorizo que el pago de los beneficios se realice al médico que presta los servicios. Entiendo que independientemente de cualquier cobertura de seguro que pueda tener, seré responsable de cualquier costo que no esté cubierto por mi seguro, incluidos los deducibles, copagos, servicios denegados o no cubiertos.)

_____ _____

Patient/Guardian Signature (*Firma del Paciente o Guardián)* **Date** *(Fecha)*

_____

Please print your name (*Por favor escriba su nombre*)

NO FAULT/ WORKER'S COMPENSATION ASSIGNMENT AUHORIZATION
(ASIGNACIÓN DE BENEFICIOS COMPENSACIÓN DE TRABAJO/ACCIDENTE DE AUTO)

In consideration of services rendered or to be rendered, I hereby authorize payment directly to the provider of health–services and/or his/her assignees for any and all first party No-Fault automobile insurance/Worker's compensation benefits to which I may be entitled. In the event that the provider's charges are outstanding, and I fail to file an Application for Benefits, I hereby authorize the provider to file such claim on my behalf so that he/she may obtain payment for services rendered to me. I understand that if the provider does not receive payment from the insurer, I am personally responsible and liable for the payment of his/her charges.
(En relación a los servicios suministrados o que serán suministrados, por esta firma, yo autorizo que los beneficios de la Compañía de Seguro de Automóvil primaria/u otra, o beneficios de Compensación de Trabajo a los que sea acreditado el derecho, se hagan pagar directamente al proveedor de servicios médicos y/o a sus asignados. En el caso que los cargos del proveedor de servicios médicos estén pendientes y yo no haya sometido una Aplicación de Beneficios, autorizo con mi firma al proveedor a someter el reclamo en mi nombre para que el pueda recibir los pagos por los servicios suministrados a mi persona. Comprendo que si el proveedor no recibirá pagos de la compañía de seguro, yo seré personalmente responsable por los pagos de los cargos.)

_____ _____

Patient/Guardian Signature (*Firma del Paciente o Guardián)* **Date** *(Fecha)*

_____

Please print your name (*Por favor escriba su nombre)*

FOR FEMALE PATIENTS *(PARA LAS PACIENTES FEMENINAS)*

I understand that in a course of my treatment I may have x-rays (radiographs); I agree to inform the doctor if I am or may be pregnant.
*Entiendo que para el tratamiento médico se puedan necesitar radiografías y por lo tanto informaré al médico si estoy o puede ser que esté **embarazada**.*

_____ _____

Patient/Guardian Signature (*Firma del Paciente o Guardián)* **Date** *(Fecha)*

_____

Please print your name (*Por favor escriba su nombre)*

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by **Premier Orthopaedics & Sports Medicine, P.C. (Premier) and/or Spine and Trauma Institute (STI) and/or Advanced Center for Excellence in Spine Surgery (ACES)** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Premier/STI/Aces.** This consent is exclusive, unless I notify you otherwise, of referrals to healthcare providers via text and or emails within **Premier/STI/ACES** and or out the practice, i.e. name, contact information and diagnosis.

_____
INITIALS

I understand that diagnosis or treatment of me by **Premier/STI/ACES** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Premier/STI/ACES** is not required to agree to the restrictions that I may request. However, if **Premier/STI/ACES** agrees to a restriction that I request, the restriction is binding on **Premier/STI/ACES**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Premier/STI/ACES** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

My protected health information may be released to my immediate family members unless I request otherwise.

_____
INITIALS

I may be contacted at home or at work. Messages may be left on my answering machine unless I state otherwise.

_____
INITIALS

I understand I have a right to review **Premier/STI/ACES** Notice of Privacy Practices prior to signing this document.

The **Premier/STI/ACES** Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Premier/STI/ACES**

The Notice of Privacy Practices for **Premier/STI/ACES** is provided at:

- ☐ **663 Palisades Avenue Cliffside Park, NJ 07010**
- ☐ **1255 Broad St, Bloomfield, NJ 07003**
- ☐ **403 Grand Ave, Englewood, NJ 07631**
- ☐ **3196 Kennedy Boulevard Union City, NJ 07087**
- ☐ **586 Kearny Ave, Kearny, NJ 07032**

This Notice of Privacy Practices also describes my rights and the duties of **Premier/STI/ACES** with respect to my protected health information.

Premier/STI/ACES reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

PREMIER
ORTHOPAEDICS & SPORTS MEDICINE

SPINE AND TRAUMA INSTITUTE, P.C. * HAND AND TRAUMA INSTITUTE * ADVANCE CENTER FOR EXCELLENCE IN SPINE SURGERY

Administrative Office:
111 Galway Place * Suite 300 * Teaneck, NJ 07666
Phone: 201.833.9500 * Fax: 201.862.0095
Web site: www.acespremortho.com

- Spinal Surgery
- American Board of Orthopaedic Surgeons
- Sports Medicine
- Adult Reconstructive Surgery

Howard Baruch, MD.
Iris Drey, MD.
Debra Petrucci, MD.
Ravinder Tikoo, MD.
Wesam Mohamed, DO.
Barry S. Finkelstein, DPM.
Charles Ekstein, MD.
Aditya Patel, MD.

AUTHORIZATION TO RELEASE INFORMATION

AUTORIZACION PARA DIVULGAR INFORMACION

To/Para: _____

_____

This will authorize you to prepare medical reports and/or permit the bearers to review, inspect, copy and/or photocopy any or all of the following in your possession or control.

Esto le autorizará a preparar informes médicos y / o le permitirá a los portadores revisar, inspeccionar, copiar y / o fotocopiar cualquiera o todos los siguientes elementos en su posesión o control.

1. **X-Rays, films, and reports.**
   Rayos Xs, placas y reportes

2. **Medical reports, records, charts, and notes.**
   Reportes Medicos, registros, tablas y notas

Photostat copies of this authorization will be considered as valid as the original.

Las fotocopias de esta autorización se considerarán tan válidas como el original.

Patient Name/Nombre del paciente: _____

Signature/Firma: _____

D.O.B. / Fecha de nacimiento: _____/_____/_____ **Date**/Fecha: _____/_____/_____

THIS CONSENT FORM IS PROTECTED BY FEDERAL & STATE LAWS

ESTE CONSENTIMIENTO ESTA PROTEGIDO POR LEYES FEDERALES Y ESTATALES

PREMIER ORTHOPAEDICS & SPORTS MEDICINE, P.C.

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **Height:** _____ **Weight:** _____

Race: O Caucasian O African American O Hispanic O Asian O Other _____

Ethnicity: O Hispanic O Non-Hispanic O Other _____

Preferred Language: O English O Spanish O Chinese O Other

Preferred Pharmacy: _____

Referral Source: Doctor (name): _____ Other (ex. Google search): _____

Are you represented by an attorney? O Yes O No

Attorney Name: _____

Will there be any legal actions with respect to this problem? O Yes O No

Do you have any allergies? O Yes O No If Yes, please list below:

Medication, Relevant Food, or "Seasonal"	**Reaction**

Latex allergy? O Yes O No

Please list all medications you take on a regular basis: O **None**

Medication	**Dosage and Frequency (e.g. 20 mg, once/day)**

Do you have a personal history of any of the following? O **None**

O Aneurysm Where: _____
O Angina (Chest Pain)
O Arthritis Type: _____
O Asthma
O Bone or Joint Infections
O Cancer Type: _____
O Chemotherapy / Radiation
O COPD
O Congestive Heart Failure
O Diabetes Type: _____ Last A1C: _____
O Emphysema
O Epilepsy
O Heart Attack
O Hepatitis Type: _____
O HIV / AIDS
O High Cholesterol
O Hypertension
O Hyperthyroidism
O Hypothyroidism
O Kidney Disease
O Kidney Stones
O MRSA Infection
O Pacemaker
O Phlebitis (Blood Clots)
O Pulmonary Embolism
O Reaction to Anesthesia Type: _____
O Seizures
O Stomach Ulcers
O Stroke / TIA
O Tuberculosis

Please list any other conditions or details of conditions marked above:

_____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**