Premier Orthopaedics & Sports Medicine, P.C.
111 Galway Place
Suite 300
Teaneck, NJ 07666
201-833-9500
201-833-0095
Appt@AcesPremOrtho.Com
AcesPremOrtho.Com

1. Patient Demographic Information

First Name: _____ Last Name: _____

Social Security #: _____ Date of Birth: _____

Birth Sex:
○ Male ○ Female

Preferred Language: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone
○ Home Phone
○ Work Phone ○ Email

Home Address: _____

Address Line 2 (Apartment/Unit #) _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name _____ Emergency Contact Relation: _____

Emergency Contact Phone Number _____

2. Who Referred you to our office?

○ Doctor	○ Insurance	○ Our Website
○ Google Search	○ Attorney	○ Hospital
○ Friend/Family	○ Workers Compensation	○ Other

3. What category is most appropriate for why you're being seen here today?

- ○ Chronic/ Age Related Issues
- ○ Injury- Sports Related
- ○ Injury- Employment/Work Related
- ○ Injury- Motor vehicle Accident (Employment/Work Related)
- ○ Injury- Motor vehicle Accident (Not Employment/Work Related)
- ○ Other:

4. Employment

Current Employment Status:

Name of Employer:

Employer Phone Number:

Employer City:

Employer State:

Insurance information

5. Medical Insurance Information

Primary Insurance Company

Member ID / Policy #

Group Number

Type of Insurance Coverage

Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name:

Insured Date of Birth

Insured Gender
○ Female ○ Male

Insured Phone #

Insured City

Insured Street Address

Insured Address Line 2(Apartment/Unit):

Insured City

Insured State

Zip Code

Do you have another insurance card/carrier?

6. Secondary Insurance

Secondary Insurance Company

Member ID / Policy #

Group Number

Client Relationship to Insured

○ Self ○ Spouse ○ Child ○ Other

Insured Name

Insured Phone #

Insured Date of Birth

Insured Gender

○ Female ○ Male

Insured Street Address

Insured City

Insured State

Zip Code

Medical History

7. Pharmacy Information:

Name of your Preferred Pharmacy

Address of Pharmacy (If known)

City of Pharmacy | State of Pharmacy | Zip Code of Pharmacy (If known)

Pharmacy Phone Number (If known)

8. Primary Care Doctor Information **If you don't have a Primary doctor, provide the name of the last doctor you saw**

	Name of Doctor	Phone Number	Office City/Location	Date of Last Visit (Month/Year)
1				
2				

9. Have you ever been treated by an Orthopedic/ Spine/ or Pain Management Doctor before?

○ Yes ○ No

10. Please provide the Orthopedic/ Spine/ or Pain Management Doctor's Information

	Name of Doctor	Phone Number	Office City/ Location	Date of Last Visit (Month/Year)
1				
2				

11. Have you had any previous X-rays, Cat Scans, or MRIs?

○ Yes ○ No

12. If "Other" body part, Please explain:

13. X-ray, Cat Scan, or MRI Information

	Name of Facility	City/Location	Phone Number	Date of Imaging (Approximately
1				
2				

Past Medical History

14. MEDICAL HISTORY

Height: Weight

Cardiovascular History: Please check the boxes for any condition(s) you have experienced or are experiencing:

☐ High blood pressure ☐ Low blood pressure ☐ Chronic congestive heart failure ☐ Heart attack
☐ Stroke/CVA ☐ Phlebitis/varicose veins ☐ Heart disease ☐ Pacemaker or similar device(s)
☐ OTHER: (Explain below) ☐ NONE

Please provide any other "Other" Cardiovascular History :

Respiratory History: Please check the boxes for any condition(s) you have experienced or are experiencing:

☐ Chronic cough ☐ Shortness of breath ☐ Bronchitis ☐ Asthma ☐ Emphysema ☐ COPD
☐ OTHER: (Explain below) ☐ NONE

Please provide any other "Other" Respiratory History :

Endocrinological Diseases: Please check the boxes for any condition(s) you have experienced or are experiencing:

☐ Hyperthyroidism ☐ Adrenal insufficiency ☐ Cushing syndrome ☐ Diabetes ☐ Pre-Diabetic
☐ Type I Diabetes ☐ Type II Diabetes ☐ Gestational Diabetes ☐ OTHER: (Explain below) ☐ NONE

Please provide any other "Other" Endocrinological Diseases History :

Communicable Diseases: Please check the boxes for any condition(s) you have experienced or are experiencing:

☐ Hepatitis ☐ Skin conditions ☐ TB ☐ HIV/AIDS ☐ OTHER: (Explain below) ☐ NONE

Please provide any other "Other" Communicable Diseases History :

Other Condition(s): Please check the boxes for any condition(s) you have experienced or are experiencing:

☐ Allergies/hypersensitivity? ☐ Mental health ☐ Digestive Conditions ☐ Organ dysfunction
☐ OTHER: (Explain below) ☐ NONE

Do you have any history of Cancer?

Please provide details relating to the type of cancer:

15. Musculoskeletal History

History of Fractures?

☐ Yes ☐ No

If 'yes", please describe:

History of Surgery?

☐ Yes ☐ No

If "Yes", please describe:

History of Arthritis?
☐ Yes ☐ No

If "Yes", Please specify where and onset?

Neck or Back Issues?
☐ Yes ☐ No

If "Yes", Please specify where and onset?

Hand/Shoulder Issues?
☐ Yes ☐ No

If "Yes", Please specify where and onset?

Knee Issues?
☐ Yes ☐ No

If "Yes", Please specify where and onset?

Foot/Ankle Issues?
☐ Yes ☐ No

If "Yes", Please specify where and onset?

16. Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathic(s) and specify the date you started using it and the dosage.

17. Do you have any allergies (medicines, cosmetics, environment, foods)? If 'yes', please describe.

18. Social History

What is your smoking status?

Do you drink alcohol?
☐ Yes ☐ No

Do you use recreational drugs?

If 'yes', what?

Are you involved in any recreational activities(Sports/Exercising)

If yes, What are you involved in?

Accident/Injury Information

19. Problem List/Current Complaints:

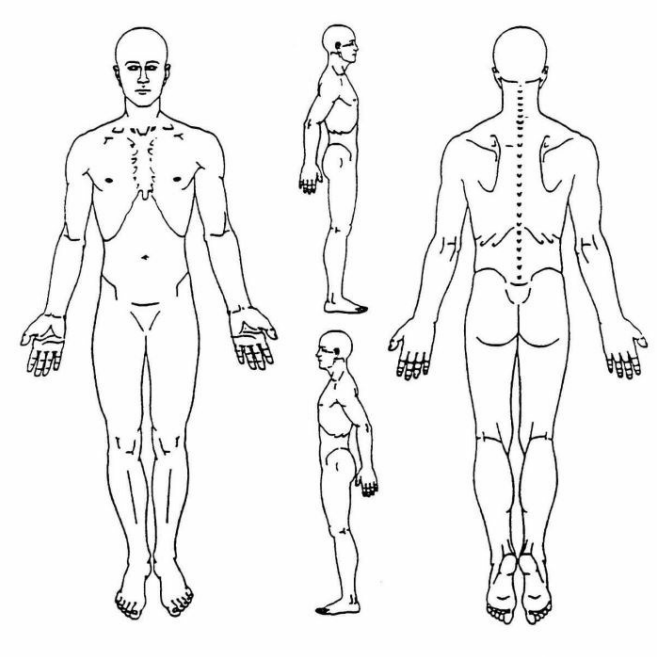
Why are you here today?

What is your main Complaint?(Please note, which side of the body RIGHT or LEFT)

Secondary Complaint?

Rate your pain/Discomfort from 0-10 (0 = No Pain / 10 = Unbearable Pain)
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

20. Please indicate the location of your pain on the diagram. Draw a line to indicate any areas where the pain travels.



21. Previous care for this injury

Have you already seen a physician or other health specialist for this issue?
☐ Yes ☐ No

If 'yes,' please provide their Name, Phone number:

22. Describe any treatment you have received for this issue.