

Appointment Date _____ Time _____

South Jersey Sports Medicine Center, PC –
RFB Surgical Plus, 556 Egg Harbor Road, Suite A, Sewell, NJ 08080
Phone 856-589-0650/FAX 856-589-2720

www.southjerseysportsmedicinecenter.com

1004 Haddonfield Road, Cherry Hill, NJ 08002
Phone 856-662-7733/FAX 856-662-7727

WELCOME Please fill in information completely and **present insurance card and photo ID** at the front desk. **If you are under 18 years of age, your parent or guardian must present their photo ID.**

Circle the physician you are seeing: **Dr. Falconiero, Tursi, Donnelly, Vaccaro, Bozic, Lisko**

PERSONAL INFORMATION

Date _____ Name _____ Birth Date _____ Age _____

SS# _____ Driver's License # _____

(Circle) male / female / minor / single / married / divorced / widow / separated

Address _____

City _____ State _____ Zip _____ Phone () _____

Cell Phone Number: _____

Employer (Name) _____ Occupation: _____

Address: _____ Work phone _____

Family Physician: _____

Address: _____ Phone Number: _____

RESPONSIBLE PARTY (if under 18 years of age, parent or guardian must complete)

Name _____

Relationship to Patient _____ Birthdate _____ Age _____

Social Security # _____

Address _____

City _____ State _____ Zip _____ Phone () _____

INSURANCE INFORMATION

PRIMARY

Insurance Company _____

ID # _____

Group # _____

Subscriber Name: _____

Subscriber Address _____

Subscriber DOB _____ Age _____

Relation ___ Self ___ Spouse ___ Child ___ Other

SS # _____

Insurance Provided by ___ Employer ___ Other

Employer _____

Address _____ Phone # _____

SECONDARY

Insurance Company _____

ID # _____

Group # _____

Subscriber Name: _____

Subscriber Address _____

Subscriber DOB _____ Age _____

Relation ___ Self ___ Spouse ___ Child ___ Other

SS# _____

Insurance Provided by ___ Employer ___ Other

Employer _____

Address _____ Phone # _____

ASSIGNMENT AND RELEASE

I authorize my insurance benefits to be paid directly to the physician or facility – I am financially responsible for any non-covered services – I authorize the physician to release medical information required for billing purposes – I authorize any examination, x-ray, laboratory test, splint or cast, injection/aspiration during the course of treatment.

Signature of Patient or Legal Guardian

Date

ASSIGNMENT OF BENEFITS FORM

I irrevocably assign to South Jersey Sports Medicine Center, P.C. all my rights and benefits under any insurance contracts for payment for services rendered to me by South Jersey Sports Medicine Center, P.C. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by South Jersey Sports Medicine Center, P.C. to be released to South Jersey Sports Medicine Center, P.C. I irrevocably authorize South Jersey Sports Medicine Center, P.C. to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to South Jersey Sports Medicine Center, P.C. I irrevocably authorize South Jersey Sports Medicine Center, P.C. to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

Patient Signature

Date

OUT OF NETWORK BENEFITS

If I choose to use my “Out-of-Network” benefits for any South Jersey Sports Medicine Services, I am aware that this may result in a deductible and/or co-insurance payment. I am responsible for any unpaid services/charges that my insurance does not cover.

Patient Signature

Date

CREDIT CARD

We require patients who are scheduling a medical or surgical procedure with our practice to leave a credit card number on file with our office. The card will only be used for those patient accounts that have been delinquent for more than 45 days. We will submit claims to your insurance company and send out monthly statements; however, if we are unable to collect and the account is more than 45 days overdue, we will process the credit card number on file.

Patient Signature

Date

NO-SHOW FEE & LATE ARRIVALS

It is our office policy to charge a \$25.00 no-show fee when a patient does not call to cancel a scheduled appointment. Patient must call 24 hours in advance to cancel a scheduled appointment. If you do not call and do not show up for your appointment, your account will be assessed a \$25.00 fee. No further appointments will be scheduled for you until the \$25.00 no-show fee is paid in full. Any late arrival will be dealt with according to the day's schedule load. If possible, we will accommodate this late visit arrival and if we are unable to do so, a reschedule date will be necessary.

Patient Signature

Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of South Jersey Sports Medicine’s Notice of Privacy Practice.

Patient and/or Personal Representative Signature: _____

MEDICAL INFORMATION/MEDICAL HISTORY

Current Medications

Drug Name	Dosage	Why are you taking it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

____ **I DO NOT TAKE ANY DAILY MEDICATION**

Medical History (circle all that apply)

High Blood Pressure Diabetes Congestive Heart Failure Heart Attack Stroke
Stomach Ulcers Gout Rheumatoid Arthritis Abnormal Heart Beat Thyroid Problem
Asthma COPD Peripheral Vascular Disease

____ **NONE OF THE ABOVE APPLY**

Please list other medical problems: _____

Any previous surgery performed on any part of your body throughout your lifetime – please list below:

____ **I HAVE NEVER HAD A SURGICAL PROCEDURE**

Previous problems with this body part (i.e. prior injury, prior surgery) YES ____ NO ____

When/What? _____

Who treated you? _____

Do you smoke tobacco? ____ YES ____ NO If yes, how much? _____

Do you drink? ____ YES ____ NO If yes, how much? _____

Family History _____

Allergies to Medicines? ____ YES ____ NO If yes, what medication and what happens?

Patient's Signature

Date

Physician's Signature

Date

MEDICAL INFORMATION/MEDICAL HISTORY - continued

Are you having any new problems in any of these areas? Please circle all that apply.

Fever Weight loss Depression Skin Heart Lungs
Anxiety Mucles/Joints Nervous System Kidneys Stomach/Bowels NONE

Height _____ Feet _____ Inches Weight _____ lbs.

What hand do you write with? _____ Right _____ Left

Emergency Contact Name: _____

Phone Number: _____

Who referred you to us: _____

Address: _____ Phone Number _____

If Auto or Workers' Comp – Insurance Adjuster Name: _____

Address: _____ Phone Number _____

Reason for visit? _____

If an injury, how did injury occur?

Worker's Compensation _____ Auto Accident _____ Sports Injury _____ Other _____

Date of Injury/Accident _____

Short Description _____

How long have you had pain? _____

Pain Scale (10 worst pain / 0 no pain)

Pain Level when first started _____ What is your pain level now? _____

What makes pain worse? _____

What makes pain better? _____

Prior Treatments _____ injections _____ physical therapy _____ anti-inflammatory medications

Patient's Signature Date

Physician's Signature Date