MARK BERENSON M.D. / ACCESS ORTHOPEDICS

Patient Registration Information

PATIENT INFORMATION

First Name | M.I | Last Name | Date Of Birth | Age | Sex M ( ) F( )

Street Address | Apt. | City | State | Zipcode | Phone Numbers Home: ( ) - Cell: ( ) -

EMAIL:

CURRENT EMPLOYER

Employer | Phone ( ) - Ext

Street Address | City | State | Zipcode

GUARANTOR INFORMATION / (PARENT / GUARDIAN INFORMATION FOR PATIENTS UNDER 18)

First Name | M.I | Last Name | Date Of Birth | Sex M ( ) F( )

Street Address | Apt. | City | State | Zipcode | Phone Numbers Home: ( ) - Work/Cell: ( ) -

Employer

EMERGENGY CONTACT

First Name | M.I | Last Name | Relationship to Patient | Sex M ( ) F( )

Street Address | City | State | Zipcode | Phone Numbers Home: ( ) - Work: ( ) - Cell: ( ) -

PRIMARY INSURANCE INFORMATION

Insurance Name | Address | City | State | Zipcode

ID/Certificate Number | Group ID/Number | Employer/Company

Policy Holder (Subscriber) Name | Subscriber Birth Date | Subscriber Sex M ( ) F( )

SECONDARY INSURANCE INFORMATION

Insurance Name | Address | City | State | Zipcode

ID/Certificate Number | Group ID/Number | Employer/Company

Policy Holder (Subscriber) Name | Subscriber Birth Date | Subscriber Sex M ( ) F( )

REFERRED TO THIS PRACTICE BY

Primary Care Physician | Phone Number ( ) -

Who Referred you to our office?

Was this injury / condition a result of :

Work injury Yes / No   Auto Accident Yes / No   Injury at /on public property Yes / No

I hereby give lifetime authorization for payment of insurance benefits to be made directly to MARK BERENSON, M.D. / ACCESS ORTHOPEDICS, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original.

Date: ____________________   Signature: ____

MARK BERENSON, M.D, P.C. ACCESS ORTHOPEDICS PATIENT HISTORY

Last Name________________________ First Name ________________________ Middle _________

Height : _____________ **Weight:** __________

Chief Complaint : ____ **LEFT / RIGHT / BILATERAL**

How & Where it happened? ____ **Date of Onset:** ____________________

Have you had X-rays? __________ **an MRI?** ___________ **If yes, when and where were they done?** ____________________

On a scale of 0-10 (10 is the worst), How severe is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? ☐ **Sharp** ☐ **Dull** ☐ **Stabbing** ☐ **Throbbing** ☐ **Aching** ☐ **Burning**

The pain is: ☐ **Consistent** ☐**Comes and goes (intermittent)** **Does your pain wake you from sleep ?** ☐ **Yes** ☐ **No**

Have you had a problem like this before? ☐ **Yes (When?)** __________ ☐ **No**

PAST MEDICAL HISTORY : HAVE YOU EVER HAD?

	Yes	No	Don't Know		Yes	No	Don't Know
Anemia	☐	☐	☐	Heart attack	☐	☐	☐
Arthritis	☐	☐	☐	Heart Failure	☐	☐	☐
Asthma					☐	☐	☐
Cancer (location)	☐	☐	☐	High Blood Pressure	☐	☐	☐
COPD				Kidney failure	☐	☐	☐
Diabetes	☐	☐	☐	Liver Disease	☐	☐	☐
Epilepsy	☐	☐	☐	Osteoporosis	☐	☐	☐
Glaucoma	☐	☐	☐	Phlebitis	☐	☐	☐
Gout	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Hemophilia	☐	☐	☐	Stroke	☐	☐	☐
	☐	☐	☐	Thyroid Trouble	☐	☐	☐

LIST ANY PREVIOUS SURGERIES

Date Surgical Procedure Hospital

____

____

____

FAMILY HISTORY Indicate which family member next to the illness M=Mother F=Father S=Sibling C=Child

	M	F	S	C
Arthritis				
Anxiety /Depression				
Cancer				
Diabetes				
Heart Disease				

	M	F	S	C
Hemophilia				
High Blood Pressure				
Kidney Disease				

	M	F	S	C
Liver Disease				
Other:				

SOCIAL HISTORY

Are you ? ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed How many people live with you? _________

Currently working / volunteering ? Yes No ☐ Retired ☐ Student ☐ Disabled Occupation: ____________________

Do you use Tobacco Products? ☐ NO ☐ YES _____Packs per day Alcohol Use ? ☐ None ☐ Socially ☐ Daily ☐ Frequently

PATIENT NAME: ______________________ D.O.B ______________

REVIEW OF SYSTEMS:

	CIRCLE ANY CONDITION BELOW THAT YOU HAVE OR CHECK			NONE	Describe
M/S			Back Pain	☐	
		Fracture Which bone?			
GI	Heartburn	Nausea Vomiting	Blood in Stool	☐	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	☐	
CONST	Weight Loss	Frequent Fever	Loss of appetite	☐	
EYE	Blurred Vision	Double Vision	Vision loss	☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	☐	
C-VASC	Chest Pain	Palpitations		☐	
RESP	Chronic Cough	Shortness of Breath		☐	
GU	Painful Urination	Blood in Urine		☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	☐	
NEURO	Headaches	Dizziness		☐	
PSYCH	Drug / Alcohol Problem	Depression		☐	
HEME	Easy Bleeding	HIV / AIDS		☐	

MEDICATIONS

MEDICATIONS LIST ALL YOUR MEDICATIONS BELOW INCLUDING VITAMIN OR HERBAL SUPPLEMENTS.

1. Atenolol ________	6. Coumadin ________	11. Insulin ________	16. Naproxen ________	21. Simvastatin ________
2. Allopurinol ______	7. Flexeril ________	12. Levoxyl ________	17. Paxil ________	22. Synthroid ________
3. Aspirin 81 mg ____	8. Fosamax ________	13. Lipitor ________	18. Percocet ________	23. Vicodin ________
4. Celexa ________	9. Glucophage ________	14. Lisinopril ________	19. Prilosec ________	24. Xanax ________
5. Crestor ________	10. HCTZ ________	15. Metformin ________	20. Procardia ________	

Other : ____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? PLEASE LIST

____________ ________________ ________________ ____________________

Name /Address of Preferred Pharmacy: ________________________________

MEDICATION / NARCOTICS POLICY

You must take your medication only as prescribed. Supplementation, early refilling of your prescription, requesting prescriptions from any other physician or practice, prescriptions taken from family or friends, overuse or abuse of medications subjects you to immediate dismissal from the practice. If you are to have a prescription refilled from our office, you may need to make an appointment during standard business hours. Prescriptions will not be filled outside of normal business hours

****

This is to certify that I, the undersigned(1) Consent to the administration upon the patient named above, such medications and treatments as may be considered necessary or advisable, (2) Authorize the release of any information from this record as required by my attorney, an insurance company or other reimbursing agency, (3) am responsible for obtaining any **referrals** and / or pre-authorizations that may be required by my insurance company (4)Authorize payment directly to Albert Franchi, M.D any benefits otherwise payable to me for services rendered (5) have read and understand the MEDICATION/ NARCOTICS POLICY. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE RELATIONSHIP DATE WITNESS PHYSICIAN'S INITIALS / DATE

Patient Office Visit Attestation

1. In the past 10 days have you had

❑ Fever or Chills	❑ Cough
❑ New onset headache	❑ Sore throat
❑ New loss of taste or smell	❑ Unexplained muscle aches

❑ NONE OF THESE

2. Do you have severe shortness of breath or difficulty breathing ?

❑ Yes ❑ No

3. Have you been diagnosed with Coronavirus (COVID-19) within the past 10 days ?

❑ Yes ❑ No

4. In the past 14 days, have you been within 6 feet for more than 15 minutes of someone with suspected or confirmed coronavirus (COVID-19)?

❑ Yes ❑ No

Patient Name (Printed) / Signature Date

MVA / WORKER'S COMP INFORMATION

AUTO ACCIDENT

DATE OF ACCIDENT: ______________________ DRIVER OR PASSENGER (CIRCLE)

DID YOU SUBMIT YOUR P.I.P. (PERSONAL INJURY PROTECTION) FORMS TO YOUR AUTO INSURANCE CARRIER ? YES NO

AUTO INSURANCE CARRIER: ____

INSURANCE ADDRESS / TEL # ____

CLAIM # ____________________________ ADJUSTER: ____________________________

ATTORNEY NAME: ____

ATTORNEY ADDRESS / TEL #: ____

****

WORKER'S COMP INFORMATION

DATE OF INJURY: ______________________

DID YOU FILE YOUR FIRST REPORT OF INJURY WITH YOUR EMPLOYER? YES NO

WORKER'S COMP INSURANCE CARRIER: ______________________________________

INSURANCE ADDRESS / TEL # ____

CLAIM # ____________________________ ADJUSTER: ____________________________

ATTORNEY NAME: ____

ATTORNEY ADDRESS / TEL # : ____