MERRIMACK VALLEY ORTHOPAEDIC ASSOCIATES

Name: _____ **Date:** _____ **Phone:** _____

Address: _____

Age: _____ **DOB:** _____ **Occupation:** _____ **Right/Left Handed (for writing)**

Ethnicity: Decline to state __ Hispanic or Latino __ Not Hispanic or Latino __

Race: African American __ Asian __ Native American __ Pacific Islander __

Caucasian __ Decline to State __ Other _____

Preferred Language: English __ Spanish __ Khmer __ Portuguese __ Other _____

Primary Care Physician: _____ **Height:** _____ **Weight:** _____

Where is your pain located: _____ **Please circle: Left or Right side**

How long have you experienced the pain: _____

Date of injury _____

History of trama/injury at pain location:_____

Work related injury: Yes ____ No ____ Level of Pain (1-10, 10 being the worst) ____

Is your pain: Sharp __ Stabbing __ Shooting __ Numbness (Pins & Needles) __

Throbbing __ Dull __ Weakness __ Stiffness __ Instability __

Pain is: Constant __ Intermittent Daily __ Intermittent Most Days __ Infrequent __

Mornings __ During the Day __ After Standing __ Night __ With Activity __

Have you been seen at a Hospital or another Physician for this problem? _____

Have you had diagnostic testing? X-ray __ MRI __ EMG __ Labs __ CT/Bone Scan __

Have you had surgery where the pain is located? If yes, please explain _____

Please circle what NSAID you have tried: Aspirin, Ibuprofen, Aleve, Naprosyn? _____

Please circle any applicable methods you have tried for pain relief: Physical Therapy, worn braces, splints, etc? _____

FLIP OVER BACK SIDE ----->

Medical History: Circle all that apply

*High Blood Pressure	*Heart Condition	*Congestive Heart Failure
*Kidney Disease	*Bladder Disease	*Reproductive Disease
*Neuropathy	*Lung Disease/COPD	*Thyroid
*Diabetes	*Cancer	*Sleep Apnea
*Lupus	*Gout	*Rheumatoid Arthritis
*Fibromyalgia	*Psoriasis	*Other _____

*Infectious Disease (Hepatitis B, Hepatitis C, HIV, Tuberculosis, MRSA, other) _____

Surgical History:

Neck/Back Date: _____ Joint Replacement Date: _____

Hand/Upper Extremity Date: _____ Shoulder Date: _____

Knee/Lower Extremity Date: _____ Pacemaker Date: _____

Hip/Pelvis Date: _____ Other: _____

Social History:

Do you drink alcohol? Yes __ No __ How often? _____

Do you smoke? Yes __ No __ If yes, how much? _____ How many years? _____

Cigarettes __ Cigars __ Vape/Electronic __

Pharmacy and Medication Information

Medication Allergies: _____

_____

Latex? Yes ___ No ___ **Contrast Dye?** Yes ___ No ___

Current Medications: _____

_____

_____

_____

Preferred Pharmacy Name & Address: _____

_____

Acct#:_____ Date:_____

Patient Name:_____ Date of Injury: _____

Address: _____ Employer: _____

_____ Address: _____

Home Telephone: _____ _____

Cell Phone: _____ Business Telephone:_____

Age: _____ Date of Birth: ____/____/_____ Male: _____ Female: _____

Marital Status: S ____ M ____ W ____ D _____ Social Security #:_____

Primary Care Physician: _____ Office Telephone: _____

Emergency Contact Person: _____ Telephone:_____

Relationship: _____

MEDICAL INSURANCE	CERTIFICATE NUMBER	SUBSCRIBER	RELATIONSHIP
MEDICARE			
MEDEX			
BLUE CROSS/BLUE SHIELD			
HMO: Name: _____			
MASSHEALTH			
OTHER HEALTH INSURANCE: _____ ADDRESS OF INSURANCE: _____			

WORKERS COMPENSATION / AUTOMOBILE ACCIDENT

Insurance Carrier: _____

Address: _____ Tel #: _____

Claim/File #: _____ Date of Injury: _____

EXTENDED AUTHORIZATION AND CONSENT

I request that payments if medical benefits be made directly to the physician on any unpaid bills for services rendered to me on or after _____.

I further authorize the release of any medical information necessary to process this or related claims. I also request payment of government benefits to the party who accepts assignment. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

O'CONNOR ASSOCIATES

PLEASE READ – YOUR SIGNATURE IS REQUIRED

VERY IMPORTANT INFORMATION REGARDING YOUR INSURANCE AND PRIVACY PRACTICE POLICIES AND PROCEDURES

At each office visit we require your referral and insurance information. This is for your protection. **Without a referral from your insurer, you are responsible for services and/or diagnostic tests. Any non-covered services are your responsibility.**

It is **your** responsibility to provide us with the correct insurance information at the time of service. If there is a problem with your claim, and we do not have a copy of your current insurance card, the balance will become **your** responsibility.

Co-payments are due at the time of service. Any co-payments not paid at this time will incur a $10.00 service charge, at providers discretion.

If you **no-show** your scheduled appointment, you may **or** may not be charged a $25.00 no-show fee, at providers discretion.

If this visit is related to an automobile accident, referrals from your health insurance and co-pays, if applicable, **are still required.**

Thank you,

Merrimack Valley Orthopaedic Associates, LLC.

Your signature below indicates that you have read and understand all of the above information.

_____ ____/____/____

Printed Patients Name Patients DOB

_____ ____/____/____

Signature Date

***If you would like a brochure, please ask one of the receptionists up front.*