ATLANTIC MEDICAL ASSOCIATES
PATIENT INFORMATION SHEET

PATIENT NAME:	**SOCIAL SECURITY #:**	**DATE OF BIRTH:**
MAILING ADDRESS:		
EMAIL ADDRESS:		
HOME PHONE #:	**CELL/PAGER #:**	**WORK PHONE #:**
EMPLOYER:		
EMPLOYER'S FULL ADDRESS:		
EMPLOYER'S PHONE #:	**PHARMACY-Location & Phone #:**	

REASON FOR VISIT – WAS THIS INJURY RELATED TO: (CHECK ONE):

WORK RELATED?	**AUTO RELATED?**	**HOME RELATED?**

INSURANCE INFORMATION

COMPANY NAME:	**TYPE: (CHECK ONE)** **WORKERS COMPENSATION** **MEDICAL / AUTO / HOME OWNER'S / OTHER**	
COMPANY ADDRESS:		
ID #:	**GROUP #:**	**CLAIM #:**
Subscriber Name:	**Subscriber Date of Birth:**	**Relation to Subscriber:**
COVERAGE EFFECTIVE DATE:		**DATE OF INJURY: AccidentDate**

GUARANTOR INFORMATION (FOR MINORS, SPOUSE OR GUARDIAN)

RESPONSIBLE PARTY: (FULL NAME)	**RESPONSIBLE PARTY SSN:**	**DATE OF BIRTH:**
ADDRESS:		**TELEPHONE #:**
EMPLOYER:		**RELATIONSHIP TO PATIENT:**

IN CASE OF EMERGENCY NOTIFY: NAME, ADDRESS & TELEPHONE #

HOW WERE YOU REFERRED TO OUR OFFICE? (PLEASE CHECK ONE)

PHYSICIAN (DR.)	**FRIEND/FAMILY**	**INSURANCE COMPANY**	**EMPLOYER**	**OTHER**

I give and assign you, Seaview Orthopaedic & Medical Associates, the right to ask, demand and collect and receive payment for my medical bills from such insurer or from such other sources as may be obligated for payment. I understand that the assignment of these rights by me does not obligate my physician(s) and Seaview Orthopaedic & Medical Associates to take any action to collect or receive payment from an insurer or other source and I understand that any outstanding balance that my insurance does not cover is my absolute responsibility. This responsibility can only be changed if a prior arrangement was made in writing by Seaview Orthopaedic & Medical Associates.

It is hereby understood that if I falsify any information on this sheet, the balance will then become my full responsibility deemed payable upon demand. It is hereby understood that I am responsible for all deductibles, co-payments, co-insurance and/or services not covered by my insurance plan at the time such services are rendered. It is hereby understood and agreed that I will be responsible for an administrative charge of 1% per month that may be imposed on my bill for any unpaid balance beginning thirty (30) days after receipt of services.

It is further understood and agreed that in the event Seaview Orthopaedic & Medical Associates is forced to take legal action to collect any unpaid balance, that I will be responsible for paying Seaview Orthopaedic & Medical Associates for reasonable attorney fees, costs and interest associated with any and all legal actions as a result of the unpaid balance.

Signed: Date:

Public law in the State of New Jersey mandates that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest they may have in a healthcare services. Accordingly, we wish to inform you that certain physicians do have financial interests in the following healthcare services to which we could refer out patients:

Seaview Orthopaedic & Medical Associates

Date:

Parent, Guardian, Insured Authorized Signature

_____

Witness Signature

Atlantic Medical Associates

Sudha Garla, M.D. – Medical Director
Board Certified

Phone: 732-988-6300
Fax: 732-988-4587

Patient Name: _____ Date: _____

COMPLETE BELOW:

1. Describe what happened and what hurts:

_____

_____

_____

_____

_____

_____

2. Was your supervisor notified immediately? ☐ YES ☐ NO

If not immediately, when? _____

3. Did you continue working after you were injured? ☐ YES ☐ NO

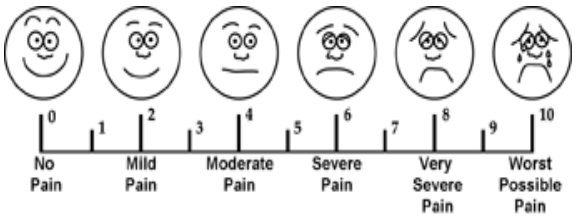
4. Did you go to the emergency room? ☐ YES ☐ NO

5. Were x-rays and/or MRI taken? ☐ YES ☐ NO

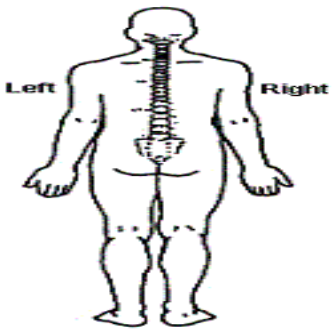
If yes, where? _____

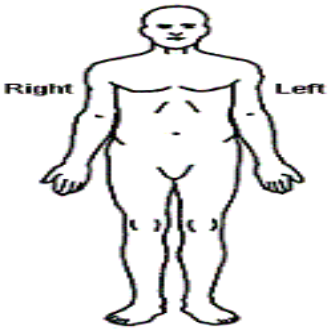
6. Rate your pain today on a scale of 1-10 _____

PAIN SCALE



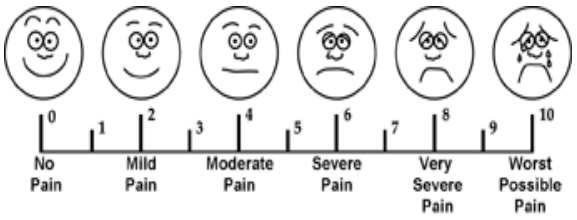
PAIN DIAGRAM:
Place X where you have pain
Place O where you are numb
Place Z where you are weak





7. Have you ever experienced symptoms similar in the past? ☐ YES ☐NO

8. If you answered yes, rate your preinjury pain on a scale of 1-10: _____



9. If yes, were they work related? ☐ YES ☐NO

10. How long have you been employed at your current job? _____

11. What is your current work status?

☐ FULL DUTY ☐ LIGHT DUTY ☐ OUT OF WORK

12. Have you ever been treated by a Chiropractor? ☐ YES ☐ NO

If yes, please provide name and address below:

Chiropractor name: _____

Address: _____

13. Have you ever been in a serious car accident? ☐ YES ☐ NO

If yes, please provide the date, injuries and treating provider:

_____

_____

_____

I hereby certify that all the information I have furnished on both pages of this form is true and correct:

Patient's Signature: _____Date: _____

Reviewed By: _____ Date: _____

Atlantic Medical Associates

Sudha Garla, M.D – Medical Director
Board Certified

Phone: 732-988-6300
Fax: 732-988-4587

Patient Name: _____ Date of Birth: _____ Age: ___ Sex: ___

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for today's visit: _____

_____

_____

How long have you had this problem? *(Days, weeks, months, etc.)* _____

What makes it better or worse? *(Include any prior medical treatments, i.e. medications, physical therapy injections, etc.)* _____

_____

Rate the pain 0 (no pain) – 10 (worst imaginable pain) _____

Are you allergic to any drugs? *Circle one* YES or NO *If yes, please list those drugs below:*

Drug	**REACTION (i.e. rash, hives, palpitations, etc.)**	**Drug**	**REACTION (i.e. rash, hives, palpitations, etc.)**

List all current medications and dosages:

Past Medical History *(Please **circle** all that apply to you):*			Diabetes
High blood pressure	Coronary artery disease	Vascular disease	Emphysema
Heart disease/attacks	Congestive heart failure	Thyroid disease	Depression
Lyme disease	Bleeding disorder	Seizures	Gastric reflux
Multiple Sclerosis	Enlarged prostate	Hepatitis	Liver disease
Osteoarthritis	Rheumatoid arthritis	Stomach ulcers	Kidney disease
Asthma	COPD	Cancer	Scoliosis

Are you Pregnant: Yes_____ No_____

Please list any other medical conditions not mentioned above:_____

_____

Family History *(Please **circle** all that apply to members of your family):*			
Bleeding disorder	Coronary artery disease	Hepatitis	Cancer
Heart Disease/Attacks	Seizures	Lung disease	Rheumatoid arthritis
Kidney disease	Malignant hyperthermia	Scoliosis	Asthma

Please list any medical disease that a member of your family may have that is not mentioned above:

_____

Past Surgical History *(Please **circle** all that apply to you and list the date of surgery)*			
Surgery	Date	Surgery	Date
Knee arthroscopy (Right/Left)		Shoulder arthroscopy (Right/Left)	
Spine surgery (Neck/Back)		Joint replacement surgery	
Hernia repair		Laparotomy	
Eye surgery		Thyroid surgery	
Peripheral bypass surgery		Cardiac catheterization	
Coronary artery bypass graft		Hysterectomy	

Please list any other surgery you may have had in the past not mentioned : _____

_____

Ethnicity: _____ Race: _____ Primary Language: _____

Social History: *Please **circle** one:* Single / Married / Partnered / Widowed / Divorced

- Do you smoke? ___ Current Smoker ___ Former Smoker ___ Never Smoked
  ___ Pipe Smoker ___ Cigar Smoker
  If yes, how much do you smoke? ___ 3 cigarettes or less per day ___ Half a pack per day
  ___ More than a pack per day
- Do you drink alcohol? YES NO
  If yes, how frequent? ___ Social only ___ Several times per week ___ Everyday
- Do you or have you used illicit drugs? YES NO
  If yes, what kind? ___ IV Drugs ___ Pills ___ Marijuana ___ Other

Education Level: ___ Graduate Level ___College ___ Some College ___ HS Diploma ___ Other

Occupation: _____

Sports Participation: Yes No
If yes, which sports? __Golf __Tennis __Football __Soccer __Baseball __Basketball __Run

List any other sports that you play: _____

*Please **circle** any of the following symptoms that you've experienced recently:*			
Constitutional	Fever	Night sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pain	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems checked above: _____

_____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____