Department of Orthopaedics,
Pediatric Division
Offices of Dr. Sanjeev Sabharwal / Dr. Folorunsho Edobor-Osula

MR #: _____ Today's Date: _____
CPI _____ (Fecha de hoy)

CONFIDENTIAL PATIENT INFORMATION
(Información confidencial de pacientes)

Patient's Name:_____DOB:_____ Age:_____
(Last Name First) (Nombre del paciente) (Fecha de Nacimiento) (Edad)

Address (Direccion):_____City:_____State:_____Zip:_____

Phone #: (H) _____ (W)_____(cell) _____
(Casa #) (Trabajo #) (Celular #)

Place of Birth (Lugar de nacimiento):_____ Sex: Male / Female
(circle one)

Father's Name (Nombre de padre):_____ SS#_____

Mother's Name (Nombre de Madre):_____ SS#_____

Emergency Contact:_____Relationship:_____Tel#:_____
(Contacto de Emergencia) (Relacion) (Telefono)

INSURANCE INFORMATION
(INFORMACIÓN DEL SEGURO)

Primary Ins. (Segura Primario):_____Address (Direccion):_____

Name of Insured: _____Relationship to patient:_____
(Nombre del Asegurado) (Relación con el paciente)

ID:_____ Group # _____

Secondary Ins. (Seguro Secundario):_____Address (Direccion):_____

Name of Insured: _____ Relationship to patient: _____
(Nobre del Asegurado) (Relacion con el paciente)

ID: _____ Group # _____

Are you covered by any other Health Insurance? Yes or No
Esta usted cubierto por otro seguro medico Si or No

If yes, please include _____
Sign: _____ **Date:** _____

Revised – 1/30/15 JI

AUTOMOBILE OR OTHER ACCIDENT RELATED INJURIES
(VEHÍCULOS u otro accidente Accidentes)

Date of Accident: _____ Location of Accident: _____
(Fecha del Accidente: (Lugar Del accidente)

How did accident occur: _____
(Cómo se producen accidents)

Automobile Insurance Co.: _____

Address: _____ Tel: _____
(Direccion) (Telefono)

Name of Adjuster: _____ Claim #: _____
(Nombre del Ajustador) (Reclamo)

Attorney: _____ Tel #: _____
(Fiscal) (Telefono)

Address: _____
(Direccion)

GUARANTEE TO PAY

I understand that payment is expected at the time of services unless payment will be made directly by either a worker's compensation or auto insurance carrier for the injuries sustained in an accident.

I authorize and request payment of my medical benefits for treatment and /or surgery directly to the University Physician Associates, Department of Orthopeadics. I further authorize my attorney to pay directly any monies due to them on accounts the same to deduct from any settlement made on my behalf. I will direct my attorney to pay the University Physician Associates, Department of Orthopeadics directly any outstanding balance immediately upon settlement or judgment in my case.

I understand that any outstanding balance not covered or paid by my insurance will be my responsibility to pay. If my accounts are turned over to an attorney or collection agency to obtain payment, I shall be responsible for the attorney's fee, court costs, and any other costs incurred by the collection agency.

Legal Guardian/
Patient's Signature: _____ **Date: _____**
(Firma del Paciente) (Fecha de hoy)

Copy of my signature shall have the same force and effect as the original.

Revised – 1/30/15 JI

Patient's Medical Profile

Pediatric Orthopedics

Sanjeev Sabharwal, MD, MPH
Folorunsho Edobor-Osula, MD, MPH

Patient's name: _____ Date: _____
(Nombre del paciente) (Fecha de hoy)
D.O.B: _____ Age: _____
(Fecha de Nacimiento) (Edad)

What is the reason for today's visit? _____
(Cuál es el motivo de la visita de hoy?)

When did this problem first start? _____
(Cuando este problema se inicia por primera vez?)

Since you 1st noticed the problem is it? Better_____ Worse _____ Unchanged _____
(Ya que primero existe el problema, verdad?) (Bien) (Peor) (Sin cambios)

Is there a family history for this problem? Yes_____ No_____
(Hay antecedentes familiares de este problema) (si) (no)

Has this problem been treated previously? _____
(Este problema ha sido tratado con anterioridad?)

Please List all treating Doctors: _____
(Anote todos los médicos que tratan a)

Past Medical History (Historial Médico)

Major illness (Enfermedad grave): Yes ___ No ___ Explain (Explique): _____

Operations (Operaciones): Yes ___ No ___ Explain (Explique): _____

Medications (Medicamentos): Yes ___ No ___ Explain (Explique): _____

Allergies (Alergias): Yes ___ No ___ Explain (Explique): _____

List any medications your child is allergic to: _____
(Enumere los medicamentos que su hijo es alérgico a)

Birth History (Nacimiento Historia)

Birth Weight (Peso al nacer): _____ lbs (Libras) _____oz.

Premature: Yes ___ No ___ Reason (Razon): _____

Problems (Problemas): Yes ___ No ___ Reason (Razon): _____

Breech (Presentación de nalgas): Yes ___ No ___ Reason (Razon): _____

Caesarean (Cesárea): Yes ___ No ___ Reason (Razon): _____

Number of pregnancies for mother: _____
(Número de embarazos de la madre

Number or children: _____
(Numero o ninos)

Your child sat at age: _____
(Su hijo se sentó a la edad)

Your child spoke at age: _____
(Su hijo entró a la edad de)

Your child walked at age: _____
(Su hijo habló a la edad de)

Source of referral: Self _____ Physician_____ Other _____
(Fuente de referencia: Auto)

Do you have a family doctor or pediatrician who should get a copy of your child's medical report?
(Tiene usted un médico de familia o pediatra que debe obtener una copia del informe médico de su hijo?)
Yes: _____ No: _____

Doctor's name: _____
(Nombre del medico)

Doctor's Address: _____
(Dirección del medico)

Doctor's Phone #: _____
(Teléfono del médico #)

SIGNATURE OF PARENT OR GUARDIAN: _____
(FIRMA DEL PADRE O TUTOR)

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ . ___ 3. ____ . ___

2. ____ . ___ 4. ____ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY **AMA** COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

RUTGERS
New Jersey Medical School

North Jersey Orthopaedic Institute
Rutgers, The State University of New Jersey
205 South Orange Ave C 1200
Newark, NJ 07103
Phone: 973-972-2151
Fax: 973-972-2155

Cancer Center
Hackensack Medical Plaza
Overlook Medical Arts Center
Saint Barnabas Medical Center

Consent for Treatment of a Minor
Consentimiento para el tratamiento de un menor

I hereby authorize **Dr._____**, and whomever he may designate as assistant to provide all treatment he/she deems necessary. In order for this child to receive the best of care, I agree to provide this office, to the best of my knowledge complete and accurate information regarding present complaint, past medical history, hospitalizations, medications, and any other prominent information on behalf of the child being treated.

It is my right to terminate treatment at any time; in which case we ask that you inform your physician. This consent follows the guidelines of UMDNJ patient rights and privileges.

Name of Child
(Patient):_____
Nombre del niño (paciente)

Name of Parent or
Guardian:_____
(Nombre del Padre o Tutor)

Signature:_____Date:_____
(Firma) (Fecha)

Witness:_____
(Testigo)

Revised 7/30/13 JI

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AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I _____ authorize the offices of North Jersey Orthopaedic Institute
(Patient name) (Nombre del paciente)

To disclose to_____
(Person to whom disclosure is made) (Persona a la que la divulgación se hace)
My medical records to the following extent: _____
_____
_____(treatment dates, name of health care unit of UMDNJ in which treatment was provided, types of records to be excluded, if any)

For_____.
(Purpose of disclosure) (Propósito de la divulgación)

I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV), that my signing this document authorizes University of Medicine and Dentistry of New Jersey to release that information.

I acknowledge and am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed physician or psychologist and that my signing this form waives this privilege.

This consent may be revoked at any time by writing to – North Jersey Orthopaedic Institute, except to the extent that the North Jersey Orthopaedic Institute has already taken action in reliance on it. If not previously revoked, this consent will terminate upon_____.
(Indicate date or an expiration event.)

North Jersey Orthopaedic Institute will not make decisions concerning treatment, payment, enrollment or eligibility for benefits based on signing, refusing to sign or revoking this authorization.

I acknowledge and understand that uses and disclosures of my health information authorized by this document may be subject to redisclosure by the recipient and may not be protected by privacy and confidentiality laws.

Signature of patient or guardian:_____Date:_____
(Firma del paciente o tutor) (Fecha)

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NEW JERSEY MEDICAL SCHOOL
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

We keep a record of the health care services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your record to others unless you direct us to do so, You are able to obtain more information about it by contacting our office Practice Administrator/Manager.

Our Notice of Privacy Practices describes more in detail, how your health information may be used and revealed, and how you can obtain your information.

You May Refuse to Sign This Acknowledgement

I,_____, have received a copy of this Office's Notice of Privacy Practice's. (Aviso de la Práctica de Privacidad)

Please Print Name (Por favor, Nombre Imprimir)

Signature (Firma)

Date (Fecha)

For Office Use Only (Sólo para uso official)

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

[] Individual refused to sign
[] An emergency situation prevented us from obtaining acknowledgement
[] Other (please specify)

_____

_____

Employee's Signature and Date (Firma del Empleado y la fecha): _____