James W. Cahill, M.D.

MEDICAL INFORMATION

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

Present Symptoms: _____ Start of Symptoms (Date): _____

Pharmacy Name and Telephone #: _____

Family Physician: _____ Referred By (MD, Family, Friend): _____

M.D. Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

TREATMENT TO DATE, PLEASE FILL IN ALL THAT APPLY: **(Please darken circle completely)**

O MRI O CT Scan O X-ray O Therapy O Surgery O Other: _____

HEIGHT: _____ **WEIGHT:** _____

SOCIAL HISTORY

Are you a smoker? O Yes O No If so, how many packs per day? O 1-2 O 3-5 O 5+

Do you consume alcohol? O Yes O No If so, how many drinks per week? O 1-2 O 3-5 O 6+

ALLERGIES (darken the circles that apply completely) Do you have any allergies: Yes____ No ____

Antibiotics	O	List: _____	
Drug Allergies	O	List: _____	
Adhesives	O	Latex	O
Iodine/ Shell Fish	O	Contrast Dye	O
Hay Fever/ Seasonal	O	Local or General Anesthesia	O

PAST MEDICAL HISTORY Do you have a history of any of the following?

Asthma	O	Yes	O No	Recurrent Infections	O	Yes	O No
Hypertension	O	Yes	O No	Ulcer	O	Yes	O No
Bleeding Disorder	O	Yes	O No	Cancer	O	Yes	O No
Diabetes	O	Yes	O No	Circulation Disorders	O	Yes	O No
Kidney Disease	O	Yes	O No	Stroke	O	Yes	O No
Heart Disease	O	Yes	O No	Blood Clots	O	Yes	O No
(pacemaker ( ) or implanted defibrillator ( ) or cardiac or other stents ( ) or anticoagulation ( ).				Sleep Apnea	O	Yes	O No
Pulmonary Disease		Yes	No	Thyroid Disorder	O	Yes	O No

Other: _____

PLEASE LIST PRESENT MEDICATIONS

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY PAST SURGICAL PROCEDURES

_____

James W. Cahill, M.D.

87 Summit Avenue
Hackensack, New Jersey 07601
201.489.0022
201.489.6991 fax

PATIENT INFORMATION
(PLEASE PRINT)

LAST NAME: FIRST NAME: MI:

HOME ADDRESS: APT NUMBER:

CITY: STATE: ZIP:

EMPLOYER: WORK ADDRESS:

CITY: STATE: ZIP:

MARITAL STATUS: SEX: **EMAIL:**

HOME PHONE: CELL PHONE: WORK PHONE:

BIRTHDATE: SOC. SEC. #: AGE:

IF THE PATIENT DOES NOT WORK, IS A MINOR, OR A STUDENT, PLEASE PROVIDE THE FOLLOWING INFORMATION

RESPONSIBLE PARTY NAME: SOC. SEC. #:

BIRTHDATE: HOME PHONE: CELL PHONE:

ADDRESS:

CITY: STATE: ZIP:

EMPLOYER: RELATIONSHIP TO PATIENT:

EMPLOYER ADDRESS: WORK PHONE:

CITY: STATE: ZIP:

INSURANCE INFORMATION

PRIMARY INSURANCE: ADDRESS:

CITY: STATE: ZIP:

MEMBER ID #: GROUP #:

SUBSCRIBER NAME: SUBSCRIBER DOB:

SECONDARY INSURANCE: ADDRESS:

CITY: STATE: ZIP:

MEMBER ID #: GROUP #:

SUBSCRIBER NAME: SUBSCRIBER DOB:

ACCIDENT INFORMATION

HOW DID THIS INJURY OCCUR?

WHERE DID IT OCCUR?

WHEN DID IT OCCUR?

WERE YOU INJURED AT WORK? ☐ YES ☐ NO PLEASE EXPLAIN BRIEFLY:

WERE YOU INJURED IN AN AUTO ACCIDENT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

ADJUSTER: PHONE #: FAX #:

WORK COMP INSURANCE CARRIER: CLAIM #:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BELHALF TO ORTHOPEDIC SPECIALISTS OF NEW JERSEY, P.A. FOR ANY SERVICES FURNISHED ME BY THESE PHYSICIANS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYBLE FOR RELATED SERVICES.

SIGNATURE:_____ DATE:_____

PLEASE NOTE: THE PATIENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE AND/OR FOR ANY OUTSTANDING BALANCE ON THEIR ACCOUNT REGARDLESS OF INSURANCE COVERAGE. WE WILL MAKE EVERY EFFORT TO ASDSIST YOU IN ORDER THAT YOU MAY RECEIVE INSURANCE REIMBRUSEMENT. PLEASE BE AWARE THAT IT IS THE PATIENT'S OBLIGATION TO UNDERTAND HIS/HER BENEFIT REQUIREMENTS, RESTRICTIONS, AND SPECIFIC LIMITATIONS.

Cahill Orthopedic Sports Medicine and Joint Replacement
87 Summit Avenue
Hackensack, New Jersey 07601

(201) 489-0022 Fax: (201) 489-6991

DATE:_____

PATIENT'S NAME:_____

MEMBER ID#:_____

PRESENT SYMPTOMS:_____

IS THE CONDITION WORK-RELATED?_____

IS THE CONDITION AUTO-RELATED?_____

IS THERE A LAW SUIT PENDING?_____

IF THIS IS AN ACCIDENT?

1) **HOW DID IT OCCUR?**_____

_____

2) **WHERE DID IT OCCUR?**_____

3) **DATE OF INJURY:**_____

PLEASE BE ADVISED THAT THIS INFORMATION WILL BE FORWARDED TO YOUR INSURANCE CARRIER TO HELP EXPEDITE YOUR CLAIM.

PATIENT'S SIGNATURE:_____

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Hackensack, New Jersey 07601

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by request.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

In addition, Federal law precludes us from sharing information about your medical services (including treatment, payment, insurance details, appointment scheduling, etc.) without your written consent. Please provide us with the names and telephone numbers of people with whom we are at liberty to share your information.

Please include your spouse, family members or other authorized representative(s). Thank you.

NAME:_____

PHONE #:_____

NAME:_____

PHONE #:_____

NAME:_____

PHONE #:_____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE IN RELATION TO THE ABOVE? YES ( ) NO ( )

PATIENT NAME (PLEASE PRINT):_____

PATIENT SIGNATURE*
*OR PARENT/GUARDIAN OF MINOR CHILD_____

DATE:_____

(jwcpatinf.doc)