KONIGSBERG PEDIATRIC ORTHOPAEDICS

Today's Date:_____

Patient Information:

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

Height:_____ Weight:_____ Additional family members treated by Dr. Konigsberg? Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Please provide at least 2 different contact numbers. Indicate preferred phone number with a **

Email:_____ Race (*optional)*:_____ Referred By:_____

Mother's Name:_____ Father's Name:_____

Parent's Marital Status: ____ Married ____ Single ____ Divorced ____Separated ____Widowed

Custody issues we should be aware of:_____

Pediatrician's Information:

Pediatrician's Full Name:_____ Pediatrician's Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Complaint:

Reason for Today's Visit:_____

How did it occur?_____ Date Problem Began:_____

School Accident - Chronic Condition - Car Accident - Sports Accident - Noted at Birth

Any previous treatment_____ If ER visit, which Hospital_____

Medical History: (*check off all those that apply)*

Patient's Medical Conditions:

- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Cerebral Palsy
- ☐ ADHD or ADD
- ☐ Emotional Disorder
- ☐ Heart Murmur
- ☐ Endocrine/Growth Hormone Treatment
- ☐ Other (please specify)_____

Family History:

- ☐ Rheumatoid Arthritis
- ☐ Osgood-Schlatters Disease
- ☐ Hip Dysplasia
- ☐ Clubfeet
- ☐ Scoliosis (In whom_____)
- ☐ Cancer
- ☐ Other (please specify)
- ☐ _____

Patient's Surgical History:_____

Regular Medications:_____

Is the patient allergic to any meds/foods/animals?_____ _____

Primary Insurance Information:

Primary Insurance:_____ _____ Subscriber ID #:_____

Subscriber (Guarantor):_____Guarantor's Phone #:_____

Relationship to Patient:_____ Guarantor's Birth Date:_____

Address:_____ City:_____ State:_____ Zip:_____

(if different from patient's)

Employer:_____ Occupation:_____

Secondary Insurance Information:

Secondary Insurance:_____ _____ Subscriber ID #:_____

Subscriber (Guarantor):_____Guarantor's Phone #:_____

Relationship to Patient:_____ Guarantor's Birth Date:_____

Address:_____ City:_____ State:_____ Zip:_____

(if different from patient's)

Employer:_____ Occupation:_____

Assignment and Release

I authorize the above noted doctor and/or provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize payment directly to Dr. Konigsberg all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf of my dependents. In the case that my account becomes delinquent, I understand that it will be forwarded to a Debt Collection Agency and that a fee of $50 will be added to my outstanding balance.

Signature of Responsible Party_____

Name of person completing form (please print)_____

Relationship to patient_____

Date_____

KONIGSBERG PEDIATRIC ORTHOPAEDICS

Phone # 201.445.9000
Fax # 201.445.7400

600 Godwin Avenue, Midland Park, NJ 07432

Insurance Information

It is your responsibility to know whether our Practice participates with your particular health plan and program. Please provide this information to us in advance, and we will do our very best to comply with any reasonable requirements that your program may have.

- Some plans require a specific facility be used for your MRI, CT Scans, ultrasounds, or blood test
- Some programs require pre-authorization (We will get authorization for all surgical procedures, as well as MRI, CT Scans and Ultrasounds)
- Some insurance companies require that the PATIENTS notify them of any hospital admissions or trips to the ER.

Receiving Records

You, the patient, are entitled to any and all records that pertain to your medical condition. For medical/legal reasons we never release the original records. Records are only released to the patient or someone that the person specifically designates to receive them. Copies of the office assessments, outside test results, and x-rays are available. Please note that there is a fee for copying records and x-rays.

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information 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 shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change this Notice.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

In order to protect your privacy, and in accordance with Federal Law, we do not leave confidential medical information on answering machines or with anyone other than the patient or patient's legal guardian without prior authorization. Please indicate your preference below:

____ We may leave detailed messages on your voicemail
____ Do NOT leave detailed messages on any voicemail
____ Permission to FAX medical instructions to my child's school

Patient Name:_____ Signature of parent or legal guardian: _____

Date: _____ Relationship to patient: _____