Orthopedic Associates of West Jersey, P.A.

NAME (Last, First, Middle Initial)			SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	SEX: **Please Circle**: M F	MARITAL STATUS: S M W D	
HOME PHONE:	WORK PHONE:	CELL PHONE:	
CAN WE LEAVE YOU VOICEMAIL MESSAGES? YES or NO			
EMAIL ADDRESS			
NAME OF EMPLOYER	OCCUPATION		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN	
WERE YOU INJURED IN AN AUTO ACCIDENT: YES or NO WERE YOU INJURED AT WORK: YES or NO			

POLICY HOLDER INFORMATION

NAME OF POLICY HOLDER (Last, First, Middle)			SOCIAL SECURITY #
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH	**Please Circle**: SEX M F	MARITAL STATUS: S M W D	
NAME OF EMPLOYER/PHONE#		OCCUPATION	

PHARMACY NAME & CITY

I HEREBY GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO OBTAIN ANY MEDICAL INFORMATION, PICK UP PRESCRIPTIONS, OR SPEAK ON MY BEHALF:

NAME_____ RELATION _____ PHONE _____

NAME_____ RELATION _____ PHONE _____

I HAVE RECEIVED OR HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY POLICY PRACTICES OF ORTHOPEDIC ASSOCIATES OF WEST JERSEY, P.A.

_____

SIGNATURE DATE

I HEREBY AUTHORIZE ORTHOPEDIC ASSOCIATES, TO RELEASE TO MY INSURANCE CARRIER, OR MY ATTORNEY, MY MEDICAL RECORDS RELATIVE TO MY MEDICAL CARE AND TREATMENT. I FURTHER AUTHORIZE MY INSURANCE CARRIER(S) TO PAY ORTHOPEDIC ASSOCIATES, FOR ALL BILLS FOR SERVICES PROVIDED THEREIN.

_____

SIGNATURE DATE

****PLEASE COMPLETE THE MEDICAL HISTORY FORM USING THE LINK (SENT TO YOU VIA EMAIL) TO OUR WEB PORTAL****

ORTHOPEDIC ASSOCIATES OF WEST JERSEY, P.A.

▪ ABRAHAM H. ROSENZWEIG, M.D. ▪ JOEL H. SPIELMAN, M.D. ▪
▪ LOUIS BOUILLON, M.D. ▪ STEVEN STECKER, M.D. ▪
600 MOUNT PLEASANT AVENUE ▪ DOVER, NJ 07801 ▪ PHONE: 973-989-0888 ▪ FAX: 973-989-0885

FELLOWS AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash with a credit card on file

___ Payment by check with a credit card on file

___ Payment by credit card with a credit card on file

___ No amt due at this time (pt has no copay or balance) Guaranty any amount due not covered by insurance with Visa, MasterCard or American Express.

We will call you 24 hours prior to charging your card.

Please make your choice sign below and return to the receptionist before your treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa, MasterCard or American Express to automatically cover amounts not paid by your insurance.

If none of these apply, please see the Practice Administrator. Thank you for your cooperation in streamlining our payment process.

_____

Print your name here and sign below

X_____

Date_____

Please note we use PCI DSS Compliant equipment and software that only shows the last 4 digits of your credit card. This the same industry standard as using your credit card on line for Netflix, Amazon, Staples, gym memberships, etc.