Mahwah Valley Orthopedic Associates

Nicholas Alexander, M.D., F.A.A.O.S.

Diplomate American Board of Orthopaedic Surgery
Fellow of the American Academy of Orthopaedic Surgeons
Fellowship Training in Total Joint Replacement and Surgery of the Knee and Hip

400 FRANKLIN TURNPIKE, MAHWAH, NJ 07430 OFFICE: (201) 818-4344 • FAX: (201) 818-2710

PATIENT INFORMATION

Today's Date:____________

Name:__________________________ Age:_____ Sex: M F Date of Birth: ___/___/____

Address:_____________________City_____________State_______Zip Code: _________

Home Telephone_______________ Work Tel. ______________ Cell Phone: ____________

Spouse's Name: ______________ Parent/Guardian: ___________________________

Marital Status: S M W D (circle) Occupation: ___________________________

Soc. Security: _______________ Referring Doctor: ___________________________

Is today's visit related to: **Motor Vehicle Accident** YES NO (circle)
Workmen's Compensation Injury YES NO (circle)

Do You Have X-Rays with you today? YES NO

Date of Accident: ________________ How Did It Happen?______________________

Body Parts Injured:____

ALLERGIES to MEDICATIONS: NO YES If yes to which: _______________

Indicate if you have or have had any of the following conditions: If NONE then Please check here ☐

☐ High Blood Pressure	☐ Liver Problems	☐ Colitis	
☐ Aspirin Intolerance	☐ Peptic Ulcer Disease	☐ Diabetes	
☐ Gallbladder Problems	☐ Anemia	☐ Glaucoma	HT:_____
☐ Mitral Valve Prolapse	☐ Asthma	☐ Arthritis/ Gout	
☐ Thyroid Disorder	☐ Tumor	☐ Emphysema	WT:_____
☐ Rheumatic Fever	☐ Cancer	☐ Clotting Problems	
☐ Heart Murmur	☐ Bladder	☐ Hiatal Hernia	
☐ Heart Problems	☐ Jaundice	☐ Stroke	
☐ Tuberculosis	☐ Phlebitis	☐ Venereal Disease	

☐ OTHER: (Please List) ____

Have you had surgery in the past?; NONE (If so please list all surgeries):______________

____

Medications you are currently taking: NONE___________________________________

____

Do you smoke? Yes No (circle): If yes, How many years______ Packs per Day ______

Do you use alcohol? Yes No Socially Drinks per Day____________

(PLEASE CONTINUE ON REVERSE SIDE)

INS. INFO ________

Is there a Family History of any Diseases, Hereditary or Otherwise? NO YES If yes please list:____

Name of your medical Physician: ____

Pharmacy Name/Address/Tel.# ____
How Did your hear about Mahwah Valley Orthopaedic Associates?____________________
M.D. Referral: Name__________________Address____________________________
Friend: ____________________________Other Source_________________________

Billing & Insurance Information

Name of Person to Bill for today's Visit____________________________Home Phone________

Street Address________________________________City________State________Zip_________

Relationship to Patient:__________________Date of Birth______________Soc. Security#_______

Name of Employer___________________________City________State________Zip_________

Business Telephone____________________

I hereby agree to be treated by Mahwah Valley Orthopaedic Associates, P.C., -Dr. Nicholas Alexander

PLEASE NOTE: Our office makes supplies available for your convenience. ***All*** medical supplies must be paid for at the time of your visit. You may or may not be reimbursed by your insurance, depending on your type of coverage.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician/surgeon to release **any** medical information to my insurance company.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of any insurance benefits covering these medical charges paid directly to the physician/surgeon.

STATEMENT OF FINANCIAL RESPONSIBILITY: I do hereby agree to pay all medical charges incurred by the above listed patient. I further understand that these charges are my responsibility Regardless of my insurance coverage.

Patients are responsible to pay a 1% per month finance charge on all unpaid balances which exceed 30 days

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE:

Responsible Persons Signature:____________________________________Date:______________________

Reviewed by:___________________ Date:_______________