IRA CHERNOFF, M.D.
MARC CHERNOFF, M.D.

Dear Patient:

Please take a few minutes to read the following information. With today's constantly changing insurance regulations, this may apply to you.

1. You may need written authorization from your Primary Care Physician to be examined.

2. You may need written authorization from your Primary Care Physician for All the follow up visits.

   **It's your responsibility to obtain this authorization.
   **You must be aware of the number of visits allowed and the date of expiration.

3. You may need authorization form your Primary Care Physician, this office or directly from your insurance company for any of the following procedures ordered by our Physicians.

   **Physical Therapy, MRI, CT Scan, Bone Scan, Blood Tests, etc.

4. Most insurance companies DO NOT pay for durable soft goods applied here in the office; for example: splints, air casts, etc. Payment for these items is the responsibility of the PATIENT.

We will do our best to try and help you comply with all the new regulations. Please do not hesitate to ask which of the above apply to you.

I have read and understand the above information.

_____ _____

SIGNATURE DATE

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ M.I. _____
STREET ADDRESS 1 _____ HOME # _____
STREET ADDRESS 2 _____ WORK # _____
CITY _____ STATE _____ DATE OF BIRTH _____
ZIP _____ MARITAL STATUS _____ SEX (M) (F) SOCIAL SEC.# _____
EMPLOYER/SCHOOL _____ PHONE# _____
EMPLOYER ADDRESS _____
REFERRING PHYSICIAN _____ TELEPHONE # _____
ADDRESS _____

PRIMARY INSURANCE

INSURANCE COMPANY _____
INSURANCE CO. ADDRESS _____
INSURANCE CO. CONTACT & PHONE NUMBER _____
POLICY # _____ GROUP # _____
PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____
ADDRESS _____
INSURER'S EMPLOYER _____ SS# _____
EMPLOYER'S ADDRESS: _____ DATE OF BIRTH ___/___/___

OTHER INSURANCE

INSURANCE COMPANY _____
INSURANCE CO. ADDRESS _____
INSURANCE CO. CONTACT & PHONE NUMBER _____
POLICY # _____ GROUP # _____
PERSON RESPONSIBLE FOR ACCOUNT _____ RELATIONSHIP _____
ADDRESS _____
INSURER'S EMPLOYER _____ SS# _____
EMPLOYER'S ADDRESS _____ DATE OF BIRTH___/___/___

FOR MEDICARE PATIENTS: IS THIS A MEDIGAP? YES ___ NO ___
IN CASE OF EMERGENCY PLEASE CONTACT: _____

WAS INJURY RELATED TO EMPLOYMENT, CAR ACCIDENT, SCHOOL INJURY OR OTHER LIABILITY?
_____.
WHERE DID INJURY OCCUR? DESCRIBE DATE, LOCATION AND HOW INJURY OCCURRED:
_____.
ARE YOU PURSING LEGAL ACTION? YES ___ NO ___

ASSIGNMENT OF BENNEFITS: I IRREVOCABLY ASSIGN/AUTHORIZE DRS. IRA/MARC CHERNOFF THE FOLLOWING: A) ALL MY RIGHTS AND BENEFITS UNDER MEDICARE OR INSURANCE CONTRACTS FOR PAYMENT OF SERVICES RENDERED TO ME BY HIM B) ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO CLAIMS TO BE RELEASED TO HIM C) TO FILE INSURANCE CLAIMS ON MY BEHALF INCLUDING MEDIGAP, IF APPLICABLE, FOR SERVICES RENDERED TO ME D) DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO HIM) TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIM PRACTICES TO THE PROPER REGULATORY AUTHORITIES F) AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION NECESSARY TO SUBSTANTIATE A CLAIM. ANY QUESTIONS I MAY HAVE CONCERNING THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND IT'S NATURE AND EFFECT.

PATIENT SIGNATURE _____ **DATE:** ____/____/____

(IF MINOR PARENT OR GUARDIAN SIGNATURE) _____ **DATE:** ____/____/____

_____

PLEASE FILL OUT PAGES 1 – 2 – 3

PLEASE PRINT

DATE: ____/____/____

HOME#: _____ WORK#: _____

PATIENT'S NAME: _____ AGE: _____

REFERRING DR: _____ PHONE#: _____

ADDRESS: _____

LIST IN ORDER YOUR MAIN COMPLAINTS:

1. _____
2. _____
3. _____

WHEN PROBLEMS STARTED: _____

HOW: _____

IS LITIGATION INVOLVED? (Y) (N) _____

DETAIL YOUR PROGRESS TO DATE: _____

_____

DETAIL YOUR TREATMENT TO DATE IN ORDER: _____

_____

PAST HISTORY: OPERATIONS: _____

MEDICAL ILLNESSES: _____

_____

DRUG ALLERGIES: _____

LIST CURRENT MEDICATIONS: _____

FAMILY ILLNESSES (PARENTS, ETC.): _____

TYPE OF WORK/RECREATION: _____

DO/DID YOU SMOKE? (Y) (N) IF YES, HOW MUCH? _____ HOW LONG? _____

DO YOU DRINK ALCOHOL? (Y) (N) IF YES, HOW MUCH? _____

MARITAL STATUS: MARRIED SINGLE DIVORCED OTHER _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITITONS?

_____ STOMACH PROBLEMS _____ CANCER

_____ DIABETES _____ HEART

_____ ARTHRITIS _____ EPILEPSY

_____ GOUT _____ WEIGHT LOSS

_____ SEXUAL DIFFICULTIES _____ WEIGHT GAIN

_____ BOWEL/BLADDER _____ BLEEDING

_____ THYROID _____ HEPATITIS

_____ FEVER/NIGHT SWEATS _____ HIV

OTHER PLEASE EXPAIN _____

DO YOU HAVE ANY COMPLAINTS WITH REFERENCE TO YOUR:

APPETITE ____HEAD____EYES____EARS____NOSE____HEART/LUNGS____ KIDNEYS____

FEMALE PATIENTS: DATE OF LAST MENSTRUAL PERIOD/MENOPAUSE: ____/____/____

ARE YOU CURRENTLY BREAST FEEDING? YES NO

ANY POSSIBILITY OF PREGNANCY? YES NO

ANY PROBLEMS WITH YOUR JOINTS?

HIPS___KNEES___ANKLES___FEET___SHOULDERS___ELBOWS__WRISTS__HANDS__

WERE X-RAYS TAKEN? YES NO IF SO, WHERE/WHEN _____

PLEASE CIRCLE THE DIAGNOSTIC TEST(S) YOU HAVE HAD:

CT SCAN MYELOGRAM DISCOGRAM MRI EMG BONE SCAN DATE: ___/___/__

NAME AND TELEPHONE OF FACILITY: _____

DO YOU PLAN TO BE AT YOUR REGULAR JOB IN SIX MONTHS? YES NO

HAVE YOU EVER BEEN INCAPACITATE AND UNABLE TO WORK? YES NO

IF YES, FROM ____/____/____ TO ____/____/____

NAME/ADDRESS OF ATTORNEY YOU WOULD LIKE YOUR REPORTS SENT TO: _____

_____.

PATIENTS SIGNATURE: _____

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MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS.

ACHE ^^^^
^^^^
^^^^

NUMBNESS oooo
oooo
oooo

PINS & NEEDLES ====
====
====

BURNING XXXX
XXXX
XXXX

STABBING ////
////
////