Metropolitan Orthopedics
Kent S. Lerner, M.D., FA.C.S.
Fellow American Academy of Orthopedic Surgeons
Phone: 201.991.9019 17 Jauncey Ave., North Arlington, NJ 07031

New Patient/Medicare Information Sheet

General Information

Patient Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Phone: (___)___-_____ Cell: (___)___-_____ Work: (___)___-_____
S.S. #: ___-___-_____ Date of Birth: ___/___/___ Age: ___ Sex: M ☐ F ☐
How did you hear about us? _____

Primary Care Physician

Primary Care Doctor: _____ Phone: (___)___-_____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Information

Subscriber's Name: _____
S.S. #: ___-___-_____ Date of Birth: ___/___/___ Phone: (___)___-_____
Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance Co. Phone: (___)___-_____ Policy No.: _____

Accident Information

Motor Vehicle Accident Y ☐ N ☐ Date of Accident: ___/___/___
Work-Related Accident Y ☐ N ☐ Date of Accident: ___/___/___
Auto Insurance Co.: _____ Phone: (___)___-_____
City: _____ State: _____ Zip: _____
Claim Number: _____

Medical Information

Why are you here to see the doctor? _____
_____
List Allergies: _____ Are you allergic to aspirin? Y ☐ N ☐
List all medications you are currently taking: _____
Incase of an emergency notify: _____

Assignment of Benefits: I hereby authorize payment directly to the physician. The benefits due me for his services as described above. I understand that I am financially responsible for any charges not covered by this authorization. Release of Information: I hereby authorize the physician/supplier to release any information needed or required to process this claim.

Signature _____ Date: ___/___/___

KENT S LERNER, M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A. PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone #_____Social Security #_____

SECTION B: To the patient PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may copy our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person:_____ Phone #_____

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received you revocation, and we may decline to treat you or to continue treating you if you revoke this consent.
Signature: I_____have fully had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representatives Name:_____
Relationship to Patient:_____
You are entitled to a copy of this consent after you sign it
Consent will be stored in Patient's chart.

REVOCATION OF CONSENT:
I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect my action you took in reliance on m, Consent before you received this written Notice of Revocation. I also understand that you may decline