Mark J. Mohrmann, M.D.
Orthopaedic Concierge Care

Mark J. Mohrmann, M.D.
Orthopaedic Surgeon

1-212-484-2663
16 Park Place,
New York, NY 10007
www.mjmmd.com

PERSONAL INFORMATION

SSN:___-___-___ PREFIX:_____ GENDER: M F Decline

FIRST NAME:_____MI:_____SURNAME:_____

Marital Status Single-Married-Divorced-Widowed DOB___/___/___

Employed-Unemployed-Retired Employer:_____

Emergency Contact Name & Telephone:_____

CONTACT INFORMATION:

STREET:_____UNIT:_____

CITY:_____STATE:_____ZIP CODE:_____

EMAIL:_____

CELL:_____ WORK/HOME:_____

Whom may we thank for referring you? ZocDoc - MedRite - PCP - Insurance - Google

REFERRING PHYSICIAN/THERAPIST:_____

PRIMARY CARE PHYSICIAN/FAMILY PHYSICIAN:_____

STREET:_____FAX:_____

CITY:_____STATE:_____ZIP CODE:_____

I authorize MJM Ortho to share these registration forms with SPEAR Physical Therapy for my convenience to avoid completing a separate form should I need any custom bracing, wound care, and/or occupational therapy. I understand these two providers are NOT affiliated and I am responsible for any co-pays; co-insurance and or deductibles for each separately.

SIGNATURE:_____DATE:_____

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BILLING & INSURANCE

PRIMARY

Insurance Company:_____

CITY:_____STATE:_____ZIP CODE:_____

Plan Number:_____ Group Number:_____

Insured's Employer School:_____

Insured's Name (as it appears)_____

Relation to Patient:_____ Insured's Phone:____-____-_____

Insured's Address:_____

City:_____State:_____Zip:_____

Insured's Social Security Number____-____-____Insured's Date of Birth:___-__-____

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HEALTH INFORMATION SHARING

I authorize the person below to release or disclose any information about my healthcare to medical personnel at MJM Ortho. I also authorize MJM Ortho to release medical information about my healthcare to the person/persons below:

Patient/Legal Guardian Signature:_____ **DATE:**_____

Electronic Medication Prescribing

I authorize MJM Ortho to submit my medication prescriptions electronically to the pharmacy below. As of March 27, 2016, ALL controlled and non-controlled substances must be e-prescribed as mandated by the New York State Department of Health (DOH), Bureau of Narcotic Enforcement (BNE).

PHARMACY:_____ PHONE:____-____-____

STREET:_____ FAX:_____

CITY:_____ STATE:_____ ZIP CODE:_____

Patient/Guardian Signature:_____ **DATE:**_____

Patient History & Review of Systems

NAME:_____ **HT.**_____ **WT.**_____

Are you *experiencing* any of the following musculoskeletal symptoms?:

___ARTHRITIS
___BACK PAIN
___GOUT
___JOINT PAIN
___JOINT SWELLING
___JOINT FLUID PRESENT
___LEG CRAMPS WITH EXERTION
___LOSS OF STRENGTH
___MUSCLE ACHES
___MUSCLE CRAMPS
___MUSCLE WEAKNESS
___NUMBNESS
___STIFFNESS
___SWELLING OF HANDS/FEET
___TINGLING
___WEAKNESS

Other Medical Problems:_____

Dominant Hand: ___RIGHT ___LEFT

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REASON FOR VISIT:

PREVIOUS TREATMENT FOR THIS PROBLEM:

RISK FACTORS:

- ARE YOU A SMOKER? YES____ NO____ PACKS PER DAY? _____

  YEAR STARTED:_____ QUIT?_____

- DOES ANYONE SMOKE IN YOUR HOME?_____
- DRUG USE:_____ALOCOHOL USE:_____
- EXERCISE FREQUENCY:_____TYPE:_____

FAMILY HISTORY *(Check all that apply)*

___ARTHRITIS
___ANESTHETIC COMPLICATIONS
___BLOOD CLOTS
___BLOOD TRANSFUSIONS
___DIABETES
___OSTEOPOROSIS
___THYROID DISEASE
___OTHER MEDICAL PROBLEMS:_____

_____

MEDICAL CONDITIONS:

CURRENT MEDICATIONS:

ALLERGIES TO MEDICATIONS:

PREVIOUS SURGERIES:
