PERSONAL INJURY PROTECTION

Dear Patient:

Thank you for making your appointment with Princeton Regional Orthopaedics, P.A. Enclosed are the forms that you will need to fill out prior to your scheduled appointment. Please bring these forms with you to your scheduled appointment. Please complete all forms to the best of your ability.

In addition to the completed forms, you will need to bring the following items:

1) Police report of accident
2) Insurance cards (motor vehicle & personal health)
3) Motor vehicle insurance policy (specifically needed is a copy of the declaration page)
4) Driver's license
5) Copy of PIP application (if this has not been done, we have enclosed one for you to complete)

Due to the newly enforced personal injury protection rules mandated by the State of New Jersey, it has become necessary to request these items in advance.

We thank you in advance for your cooperation, and we look forward to seeing you in our office. If you have any questions, please call our office at the above phone number.

PRINCETON REGIONAL ORTHOPAEDICS, P.A.
WOODLANDS PROFESSIONAL BUILDING
256 BUNN DRIVE, SUITE 2
PRINCETON, NEW JERSEY 08540-2851
(609) 924-9229
FAX (609) 924-4701

LEON N. COSTA, M.D.
MICHAEL S. GRENIS, M.D.
~~RONALD J. WISNESKI, M.D.~~

DIPLOMATES AMERICAN BOARD OF ORTHOPAEDIC SURGERY

PATIENT'S NAME: ______

Please fill out the enclosed paper work and bring it with you to the office at the time of your appointment.

Please also bring: All MRIs and their reports
All x-rays and their reports

Insurance cards
Referrals (if needed)

Please arrive one-half hour before your scheduled appointment.

If you have any questions, please call (609) 924-9229.

Thank you.

PIP Application

Name	Policyholder	Date of Accident	File Number

TO: ______________________________

Claim Department

Your Name		Phone (Home)	Business
Your address (No., street, city or town, state and zip code)		Date of Birth	Social Security No.
Date and Time of Accident a.m. p.m.	Place of Accident (Street, City or Town, State)		

Brief Description of Accident:

____

Are there other autos in your household? Yes ____ No ____

If yes, list Owners Insurers Policy #

Owners	Insurers	Policy #

Were you the owner of the automobile? Yes ____ No ____
Were you a passenger in the automobile? Yes ____ No ____
Were you a pedestrian? Yes ____ No ____
Were you a member of automobile owner's household Yes ____ No ____

As a result of this accident, were you injured? Yes ____ No ____

If your answer is yes, please complete the form on the following page.
If your answer is no, sign here and return this form to us.

______________________________ Date ______________________

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ASSIGNMENT OF BENEFITS / INDEPENDENT MEDICAL EXAM FORM

Patient's name: ______________________________

I irrevocably assign to Princeton Regional Orthopaedics all my rights and benefits under any insurance contracts for payment for services rendered to me by Princeton Regional Orthopaedics. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by Princeton Regional Orthopaedics to be released to Princeton Regional Orthopaedics. I irrevocably authorize Princeton Regional Orthopaedics to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to Princeton Regional Orthopaedics. I irrevocably authorize Princeton Regional Orthopaedics to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

I authorize release of any INDEPENDENT MEDICAL EXAM report regarding orthopaedic treatment to Princeton Regional Orthopaedics.

Patient's signature: ________________________

Date: ___________

Describe your injury

Were you treated by a doctor?
Yes ____ No ____

Doctor's name and address

If you were treated in a hospital, were you an inpatient ______ outpatient _______

Hospital's name and address

Amount of medical bills to date: __________

Will you have more medical expense? Yes ___ No ___

At time of your accident, were you in the course of your employment? Yes ____ No ____

Did you lose wages or salary as a result of your injury? Yes ___ No ___

If yes, amount lost to date: ________

What is your average weekly wage or salary? ______

If you lost wages: Date Disability from work began ________________

Date you returned to work ________________

Have you received or are you eligible for benefits under:

1) Any workmen's compensation law? Yes ____ No ____
2) Employees temporary disability benefit statute? Yes ____ No ____
3) Medicare? Yes ____ No ____

If yes, amount
$____________
per week______
per month ______

List the names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer and address	Occupation	From	To
Employer and address	Occupation	From	To

As a result of your injury, have you had other expenses? Yes ____ No____
If yes, explain on reverse side.

"Any person who knowingly and with intent to defraud any insurance or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime subject to criminal prosecution and civil penalties."

SIGNATURE: ______________________________

MVA INFORMATION SHEET CONTINUED

Description of accident: ______________________________

____

____

____

____

____

____

Address of accident: ______________________________

____

PATIENT INFORMATION

PATIENT

NAME AGE SEX

BIRTH DATE MARITAL STATUS SS# - -

ADDRESS CITY STATE ZIP

HOME PHONE ( ) WORK PHONE ( ) CELL PHONE ( )

NAME OF SPOUSE SPOUSE'S EMPLOYER WORK PHONE ( )

EMPLOYER

NAME OCCUPATION

ADDRESS CITY STATE ZIP

PHONE ( ) FAX ( )

EMERGENCY CONTACT

NAME RELATION

ADDRESS CITY STATE ZIP

HOME PHONE ( ) WORK ( )

REFERRED BY *(please include complete address if referred by physician)*

NAME

ADDRESS PHONE ( )

MEDICAL HISTORY

ALLERGIES

PREVIOUS SURGERY

MEDICAL ILLNESSES

PRESENT MEDICATIONS

CURRENT PROBLEM

DATE OF INJURY FAMILY PHYSICIAN

TYPE OF INJURY *(check one)* AUTO ______ WORKER'S COMPENSATION ______ LEGAL ______ OTHER ______

PLEASE NOTE: INSURANCE POLICIES ARE CONTRACTS BETWEEN YOU, THE SUBSCRIBER,AND THE INSURANCE COMPANY. THE DOCTOR CAN IN NO WAY ALTER THE CONTRACT NOR GUARANTEE YOUR PAYMENT BY THE INSURANCE COMPANY. THE PATIENT OR GUARDIAN IS RESPONSIBLE FOR ALL FEES WHICH ARE DUE AND PAYABLE AT THE TIME THAT SERVICES ARE RENDERED (UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE). PRINCETON REGIONAL ORTHOPAEDICS RESERVES THE RIGHT TO IMPOSE A 1.5%/MONTH FINANCE CHARGE ON ANY PAST DUE ACCOUNTS.

SIGNATURE ______________________________ DATE ______________

***PLEASE FILL OUT INSURANCE INFORMATION ON REVERSE SIDE.**

FINANCIALLY RESPONSIBLE PARTY

NAME *(Parent if Minor)*	BIRTH DATE	SS# – –	
ADDRESS	CITY	STATE	ZIP
HOME PHONE ( )	WORK ( )		

INSURANCE INFORMATION

PRIMARY CARRIER:		ADDRESS	
PHONE ( )	POLICY #	GROUP #	SUBSCRIBER
DEDUCTIBLE		CO-PAY	
SECONDARY CARRIER:		ADDRESS	
PHONE ( )	POLICY #	GROUP #	SUBSCRIBER

TYPE: AUTO: ______________ WORKERS COMP ______________ OTHER ________________

CLAIM # ________________________

ACCIDENT DATE &
DESCRIPTION OF ACCIDENT

IS CONDITION A RESULT OF ACCIDENT ________________ PRE-EXISTING CONDITION _______________

UNABLE TO WORK FROM ________________________ OTHER TREATING PHYSICIANS _______________

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