

PATIENT REGISTRATION (PLEASE PRINT)
STRAIT ORTHOPEDIC SPECIALISTS

PATIENT

Last Name _____ First _____ M.I. _____
Mailing Address _____ City _____ State _____ Zip _____
Home Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____
Social Security # _____ Marital Status (Circle) S M W Male Female
Employer _____ Date of birth _____ Age: _____

Spouse's Name _____ Spouse's Date of Birth _____
Spouse's Social Security # _____
Spouse's Employer _____ Spouse's Work phone _____

EMERGENCY CONTACT PERSON (not living with you)

Name _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR BILL (If not patient or spouse)

Address _____ City _____ State _____ Zip _____
Home phone _____ Work phone _____
Social Security # _____ Relationship _____
Employer Name _____ Occupation _____
Employer Address _____

REFERRING PHYSICIAN:

PRIMARY CARE PHYSICIAN:

INSURANCE INFORMATION: To avoid potential denial of claims by your insurance, please complete the following information in full. We will attach a copy of your insurance card(s) to assist in processing of your claim.

IS THIS AN L&I CLAIM? : Y or N. Claim # _____ Date of injury _____
Name of Claims Manager _____ Phone# _____ Place of injury _____
Address: _____ City _____ State _____ Zip _____

PRIMARY INSURANCE: _____ ID# _____
Address: _____ City _____ State _____ Zip _____
Phone : _____ Cardholder's Name: _____ Cardholder's Date of birth: _____

SECONDARY INSURANCE: _____ ID# _____
Address: _____ City _____ State _____ Zip _____
Phone: _____ Cardholder's Name: _____ Cardholder's Date of birth: _____

*Please bring your insurance card(s) so that we may copy them to speed processing of your claim.
Thank you!*

Name: _____ Date: _____

Why are you seeing the Doctor today? _____

Right _____ Left _____

Current problem is the result of : _____ Car accident _____ Work accident
_____ accident _____ other. Check all that apply.

| <u>Medication</u> | <u>Dose</u> | <u>Reason for Medication</u> |
|-------------------|-------------|------------------------------|
| | | |
| | | |
| | | |

Allergies

Last Tetnus Vaccination _____

Are you currently having problems or have you had problems with the following?

| | Circle | Describe all Yes responses |
|---------------------------|--------|----------------------------|
| Fever | Yes No | _____ |
| Weight Loss | Yes No | _____ |
| Eyes, Ear, Nose or Throat | Yes No | _____ |
| Heart Attack | Yes No | _____ |
| Irregular Heartbeat | Yes No | _____ |
| Heart Valve Disorder | Yes No | _____ |
| Circulatory | Yes No | _____ |
| High Blood Pressure | Yes No | _____ |
| High Cholesterol | Yes No | _____ |
| Lung | Yes No | _____ |
| Stomach | Yes No | _____ |
| Gynecological | Yes No | _____ |
| Urinary/Prostate | Yes No | _____ |
| Skin | Yes No | _____ |
| Neurological/Nerve | Yes No | _____ |
| Psychiatric | Yes No | _____ |
| Thyroid/Endocrine | Yes No | _____ |
| Diabetes | Yes No | _____ |
| Blood or Lymphatic | Yes No | _____ |
| Immune System | Yes No | _____ |
| Cancer | Yes No | _____ |
| Arthritis | Yes No | _____ |
| Hepatitis | Yes No | _____ |
| Tuberculosis | Yes No | _____ |
| HIV | Yes No | _____ |
| Fibromyalgia | Yes No | _____ |

Name: _____

Date of Birth: _____

Past Medical History

Surgeries

Year

Complications

Any Hospitalizations?

Any Anesthesia Problems?

Family History

Has anyone in your family had any of the following?

| | | | |
|----------------------|-----|----|-------|
| Osteoarthritis | Yes | No | _____ |
| Rheumatoid Arthritis | Yes | No | _____ |
| Fibromyalgia | Yes | No | _____ |
| Heart Disease | Yes | No | _____ |
| Lung Disease | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Diabetes | Yes | No | _____ |
| Bleeding Disorders | Yes | No | _____ |
| Hypertension | Yes | No | _____ |
| High Cholesterol | Yes | No | _____ |

Social History

Do you work? Yes No Occupation _____

Former occupation if Retired _____

Single Married Widowed , Children No Yes , How Many ____

Do you live alone? Yes No

Smoke currently? Yes No Packs per day for _____ years.

Previously smoked? Yes No _____ packs per day for _____ years.

How long ago did you quit? _____ Years

Alcohol Use? Yes No How many drinks per week?

History of substance abuse? Yes No What? _____

IV Drug use? Yes No

Patient Signature _____ Date _____

PATIENT AGREEMENT
STRAIT ORTHOPEDIC SPECIALISTS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize the Strait Orthopedic Specialists to request on my behalf and to collect directly, all public and private insurance coverage due for products and services supplied by Strait Orthopedic Specialists. In the event that benefits are paid directly to me, I will endorse to Strait Orthopedic Specialists all checks for such payments.

EXTENDED MEDICARE ASSIGNMENT: I certify that the information given by me under Medicare (Title XVIII, Social Security Act) and/or any other insurance is correct.

1. The patient, if physically or mentally competent, must sign on his behalf. If he cannot sign for himself, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of signatory's authority should be stated, e.g. Social Security Representative Payee, court appointed guardian, etc.
2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 form and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may upon conviction be subject to fine and imprisonment under federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information about himself to release to the Social Security Administration, or its intermediaries or carrier, any information needed to process related Medicare claims. He further permits a copy of the authorization to be used in place of the original.
3. On assigned claims, the provider agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be canceled by mutual agreement of the provider and the patient at any time by written notice to the Medicare carrier. I request payment under the Medical Insurance Part of Medicare to be made directly to Strait Orthopedic Specialists for services furnished to me during the effective period of this authorization. I have read and I agree to the release of information as specified in paragraph 2 above.

MEDICAL CONSENT: I give my consent for all routine, usual and customary tests, exams and procedures as prescribed by the attending physician of Strait Orthopedic Specialists for myself or my minor child or as legal guardian.

RELEASE OF MEDICAL INFORMATION: I authorize Strait Orthopedic Specialists to release any health care information necessary to facilitate processing of claims, audit of payments, and routine professional medical communication with my referring and/or primary care physicians. Strait Orthopedic Specialists maintains a record of health care services provided to you. You may ask to see and obtain copies of that record at any time. Strait Orthopedic Specialists will otherwise not disclose your records or personal confidential information to others unless you direct us to in writing or unless required by law.

THE PATIENT HEREBY AGREES THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED: I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or any subsequent visits or procedures, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and interest for overdue payments. I hereby authorize Strait Orthopedic Specialists to release information necessary to secure payment of benefits or fees. **I also acknowledge that it is my responsibility to obtain a referral if my insurance company or HMO requires one.**

Signature of Patient/Guarantor

Date

Printed Name of Patient