

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last name: _____ First name: _____ M.I. _____

DOB: _____ Age: _____ Sex: _____ SS#: _____

Address: _____ City _____

State: _____ Zip code: _____ Email address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

May we leave a message? Y/N

Emergency
Contact name: _____ Phone #: _____ Relationship _____

Name/address/phone # of Primary Care Physician: _____

DATE OF INJURY: _____

IF YOU ARE A MINOR:

Parent/Guardian's name: _____

Parent/Guardian's address: _____

IF YOU ARE A STUDENT

Where do you attend school: _____

Your address at school: _____

Your phone number at school: _____

Coach's name and address: _____

PAYMENT INFORMATION

PRESENT ALL INSURANCE CARDS TO FRONT DESK

Insurance Company Name: _____

Policy/ ID Number: _____

Subscriber Name and Date of Birth (if it is not your plan): _____

Customer Service Phone Number: _____

Co-Pay Amount (Specialist): _____

ASSIGNMENT OF BENEFITS/MEDICAL RECORDS RELEASE

Your signature is necessary for us to process insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims as well as sending any medical records to Healthcare professionals to which I am referred to or referred by. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to the above named physician or clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signature

Date

AGREEMENT TO PAY FOR NON-COVERED SERVICES

As you, the patient, are the individual most familiar with your own insurance policy, it is your responsibility, not your Provider of Specialty Services nor your Primary Care Physician's responsibility to obtain referrals. If you obtain specialty services without a written referral from your Primary Care Physician and/or your insurance company you will be responsible for any charges associated with this visit which are not paid by your insurance company. If you have not obtained such a referral, you may reschedule this visit after obtaining a written referral, or sign below, accepting financial responsibility for all services receive during this visit, in the event they are not covered by your insurance company.

Signature

Date

New Hampshire Knee Center

Patient Medical History for: _____ Date: _____
Age: _____ Date of Birth: _____ Occupation: _____

To better evaluate your orthopedic concerns and plan for your treatment, please familiarize us with your medical and surgical history.

1. Have you seen your doctor or been hospitalized during the past 2 years? If yes, for what reason:
_____ Yes No

2. Are you allergic to (i.e. itching, rash, swelling of the hands, feet or eyes) or been made sick by Penicillin, Aspirin, Codeine or any other drugs or medications? If yes, what ones, what type of reaction?
_____ Yes No

3. List all medications you are taking at this time (including dosage and frequency)

4. Other medicines or drugs during the past 2 years?
_____ Yes No

5. List all surgeries with type of anesthesia (general, spinal, local, drug sedation)

6. Have you ever had any excessive bleeding requiring special treatment, blood clots or transfusions? _____ Yes No

7. Do you have any history of smoking, or presently smoke? Yes No

Packs per day _____

Year quit _____

8. Has a doctor ever said you have cancer or a tumor? Yes No

9. History of 1 or more STAPH infections?
_____ Yes No

10. Check appropriate box for each question

YES NO

- Tuberculosis (TB)
- Rheumatic Fever
- Diabetes
- Hepatitis, liver problems
- High Blood Pressure
- Epilepsy or Seizures
- Kidney/Bladder problems
- Hearing problems
- Vision problems
- Limited neck motion
- Thyroid Disease
- Stroke (minor or major)
- Dizziness, balance
- Shortness of breath, cough
- Asthma, Wheezing
- Heart attack/ chest pain
- Heart Murmur-diagnosed
- Abnormal heart rate
- Heart Pacemaker
- Ulcers/stomach problems
- Intestine/Bowel problems
- Skin rashes, lesions, lumps
- Weight loss / weight gain
- Persistent fever
- Anemia (low iron)
- HIV (Positive for AIDS)
- Gout
- Arthritis, joint pain
- Cortisone injection
- Health condition not listed

Give specifics, including dates and related treatments to any "YES" questions