



Patient Registration (Please Print)



Responsible Party Information

Responsible Party Name, Mailing Address, Residence Address, Home Phone, Work Phone, Cell Phone, Social Security #, Birthdate, Relationship to Patient, Employer, Occupation, No. Yrs. Employed, Spouse's Name, etc.

Confidential Patient Information

Patient's Name, Address, Home Phone, Cell Phone, Work Phone, Birthdate, Social Security #, If Patient is a minor, give parent's or guardian's name

Insurance Information

To avoid potential denial of claims by your insurance please complete the following information in full. We will scan a copy of your insurance card(s) to assist in the processing of your claim. Is This a Workers' Compensation Claim? Claim#, Date of Injury, Name of Claims Manager, Phone #, Place of Injury, Address, City, State, Zip, Primary Insurance, ID#, Group #, Address, City, State, Zip, Subscriber's Name, Subscriber's Date of Birth, Rel. to insured, Secondary Insurance, ID#, Group #, Address, City, State, Zip, Subscriber's Name, Subscriber's Date of Birth, Rel. to insured

Physician Information

Referring Physician, Phone #, Primary Care Physician, Phone #

Emergency Contact

Name of nearest relative (or friend) not living with you, Phone #, Relationship

Signature

I certify that I have read and understand the above information. To the best of my knowledge the above questions have been accurately answered.

Patient, Parent or Guardian X

Date



Medical History



Date: _____

Patient Name: _____

Reasons you are seeing the doctor today? Right Left
Current problem is a result of: Car Accident Work accident Other. Check all that apply.

Medications	Dose	Reason for Medication

What pharmacy do you prefer? _____ When was your last Tetnus vaccination? _____

Allergies	Reaction

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

	Yes	No	Describe all <u>Yes</u> responses		Yes	No	Describe all <u>Yes</u> responses
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Immune System	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose or Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary/Prostrate	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____	HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke/Brain injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____

Past Medical History

Surgeries:	Year	Complications:

Any Hospitalizations? _____

Any Anesthesia Problems? Yes No If yes, please explain

Family History

Has anyone in your family had any of the following?	Yes	No	Who?
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

Social History

Right handed Left Handed
Do you work? Yes No Occupation _____
 Former occupation if retired _____
 Single Married Widowed
 Children? Yes No How many? _____
 Do you live alone? Yes No
 Smoke currently? Yes No _____ Packs per day for _____ yrs
 Previously smoked? Yes No _____ Packs per day for _____ yrs
 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
 Are you currently living in a nursing home? Yes No

Patient Signature: X _____ Date: _____

PATIENT AGREEMENT
STRAIT ORTHOPEDIC SPECIALISTS

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize 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 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 cancelled 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 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

HIPAA Privacy Policy: By my signature below I acknowledge receipt of the notice of Privacy Practices of Strait Orthopedic Specialists, P.S.

Signature of Patient or authorized individual

Print Patient's Name

Date

(This person) _____ has my permission to receive my medical information.

