PATIENT REGISTRATION FORM
(PLEASE PRINT)

Name____ Home Phone(____)____________________
Last First Middle

Address ____ Work Phone(____)____________________

City ____________________________ State __________________ Zip Code __________________________

Marital Status: S M D W Date of Birth ___/___/___ Age ______ Sex ______ SS# ____________________

Has any member of your household been seen in this office? ________ Name ______________________________

Primary Care Physician ______________________________________ Phone(___)___________________________

Referring Source: ____ Phone(___)___________________________

Employer's Name, Address, Phone No.____

Is this a work related injury? ( ) Yes ( ) No If yes, has claim been initiated? ( ) Yes ( ) No Claim # ______________

Are you being seen for a second opinion requested by your insurance carrier? ( ) Yes ( ) No

Person to contact in case of emergency who does not live with you:

Name____ Relationship ______________________________

Address ____ Phone Number (___)____________________

If patient is under 21 years of age, please list:

Father's Name: ________________________________ Address____

City _______________________________________ State ________________ Zip Code __________________

Home Phone (___)________________________________ Work Phone (___)________________________________

Mother's Name: ______________________________ Address____

City ____________________________________ State _________________ Zip Code _______________________

Home Phone (___)______________________________ Work Phone (___)__________________________________

PERSON RESPONSIBLE FOR PAYING BILL (IF OTHER THAN PATIENT)

Responsible Party Name _____________________________________ Relationship to Patient ________________
Last First Middle

Address ________________________________ City______________________ State _______ Zip ___________

Home Phone (___)________________________ Work Phone (___)_______________ SS#____________________

Please Turn Over and Fill Out the Back of This Form

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Insurance Name: ______________________________	Insurance Name: ________________________________
Subscriber Name: _____________________________	Subscriber Name: _______________________________
Relationship to Patient: _________________________	Relationship to Patient: __________________________

All professional services rendered by Freiberg Orthopaedics & Sports Medicine are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments, with understanding that the patient is ultimately responsible for all fees. It is customary to pay for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT
(PLEASE READ AND SIGN)

I hereby authorize the release of any medical information necessary to process insurance claims or any medical information that is needed for any utilization review or quality assurance activities. I hereby assign to the physician all the payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I agree to pay any balance due in full no later than 30 days of statement, unless other arrangements have been made in advance.

Signature ____ Date _______________

FINANCIAL POLICY AND PATIENT FINANCIAL RESPONSIBILITY

I. Patient Responsibility

You, as the patient, are ultimately responsible for all fees. We do accept insurance assignment and will file your insurance claim for you; however, you are still responsible for all co-payments or balances as required by your specific insurance plan. You are required to bring your insurance card to each visit. Your appointment will be rescheduled if your insurance card is not available. If your insurance plan requires a referral, this **must** be obtained from your primary care physician prior to coming in to the office. It is your responsibility to obtain this referral. All co-payments and co-insurance are due at the time of service. All patients under 18 years of age must be accompanied by an adult who is responsible for any necessary co-payments, co-insurance, and deductibles.

II. Acceptable Methods of Payment:

We accept cash, check, bankcard or credit card (Visa, MasterCard, Discover).

III. Insurance Benefits Verification

Pre-certification from your insurance carrier (written or verbal) is required in advance for all elective surgery. Our staff will contact your insurance plan for this approval. All co-insurance or deductibles must be paid in advance.

Signature ____ Date _______________

STATISTICAL RESEARCH AUTHORIZATION (OPTIONAL)

I **CONSENT/REFUSE** (Strike the phrase that does not apply) to allow my complete medical records, including any outpatient and inpatient chart to be reviewed for research and education purposes. All records identifying me will be kept confidential and, to the extent permitted by applicable laws and regulations, will not be made publicly available. For research purposes, a special number and initials will identify me. My identity will not be revealed in any publication related to any research study. Specific research related information may be sent to any clinical trial sponsor and its representatives, without my name being revealed. The regulatory authorities (FDA), the Institutional Review Board (IRB) of the hospital reviewing the study, the sponsor and their representatives may have access to my original medical records for verification of my medical procedures and/or data, without violating my confidentiality. I have been given an opportunity to ask questions regarding this consent and my questions have been answered to my satisfaction.

Signature ____ Date _______________

Freiberg *Orthopaedics & Sports Medicine*

The Freiberg Spine Institute

Name: ______________________________ Date: ________________

REVIEW OF SYSTEMS	(***Must circle Yes or No***)			If any yes answer, please explain below
General	Recent weight change	No	Yes	
Skin	Skin condition / cancer	No	Yes	
Head, eyes, ears, nose & throat (ENT)	Headaches	No	Yes	
	Dizziness / blacking out	No	Yes	
	Eye or hearing impairment	No	Yes	
	Sinus or throat trouble	No	Yes	
	Nosebleeds	No	Yes	
Neck	Thyroid disease	No	Yes	
	Enlarged glands	No	Yes	
Respiratory	Asthma	No	Yes	
	Difficulty breathing	No	Yes	
	Pleurisy or pneumonia	No	Yes	
Cardiovascular	Chest pain	No	Yes	
	Shortness of breath	No	Yes	
	Heart attack	No	Yes	
	High blood pressure	No	Yes	
	Blood clots in legs or lungs	No	Yes	
	Swelling of feet or legs	No	Yes	
	Poor circulation	No	yes	
	Irregular heartbeat	No	Yes	
Gastrointestinal (GI)	Ulcer	No	Yes	
	Gallbladder	No	Yes	
	Hepatitis / liver trouble	No	Yes	
	Bleeding with bowel movements	No	Yes	
	Hemorrhoids	No	Yes	
	Hiatal hernia / reflux	No	Yes	
Genitourinary (GU)	Loss of urine / incontinence	No	Yes	
	Frequent urination	No	Yes	
	Burning, painful urination	No	Yes	
	Blood in urine	No	Yes	
	Kidney stones / kidney disease	No	Yes	
Gynecological (GYN)	Bleeding or other problem	No	Yes	
	Breast masses	No	Yes	
Musculoskeletal	Fractures or other injuries	No	Yes	
	Back or neck pain	No	Yes	
Neurological	Seizures or other conditions	No	Yes	
	Neuropathy	No	Yes	
	Stroke	No	Yes	
	Chronic pain	No	Yes	
	Fibromyalgia	No	Yes	
Psychological	Depression or other problems	No	Yes	
Hematological	Blood disorder or cancer	No	Yes	
	Excessive bleeding after surgery / dental work	No	Yes	

Patient Signature: ______________________ Dr's .Initials: ______ Date: ________

HAVE THERE BEEN ANY CHANGES IN THE LIST ABOVE?

☐ Yes ☐ No Comments: ______________________________
Patient Signature: ______________________ Date: __________ Dr's .Initials: _____ Date: ________

☐ Yes ☐ No Comments: ______________________________
Patient Signature: ______________________ Date: __________ Dr's .Initials: _____ Date: ________

☐ Yes ☐ No Comments: ______________________________
Patient Signature: ______________________ Date: __________ Dr's .Initials: _____ Date: ________

Name: ______________________ Sex: ______ Age: ______ Today's Date: ______________

Name: ______________________ Sex: ________ Age: _______ Today's Date: ______________________

Height: ________ ft. ______ in. Weight: ________ lbs. Recent weight change? ☐ gain ☐ loss ☐ none Are you ? ☐ right-handed ☐ left-handed

WHAT PROBLEM ARE YOU BEING TREATED FOR TODAY? ______________________

Have you been treated by another physician for this problem? ☐ yes ☐ no Who? ______________________

Were x-rays taken? ☐ yes ☐ no Where were x-rays done? ______________________ When? ______________________

PAST MEDICAL HISTORY

Medical Illnesses *(check any illness that you currently have or have had in the past)*

☐ arthritis	☐ diabetes	☐ neuropathy	☐ ulcer disease
☐ asthma	☐ glaucoma	☐ rheumatoid disease	☐ vascular disease
☐ bleeding disorder	☐ heart disease	☐ seizure	☐ others
☐ blood clots	☐ hepatitis	☐ stroke	______________________
☐ cancer	☐ high blood pressure	☐ substance abuse	______________________
☐ cataract	☐ kidney/bladder problem	☐ thyroid	______________________

Past Surgeries *(list type and year performed)*

______________________ ______________________

______________________ ______________________

Your Allergies to Medications *(name medication and reaction)* ______________________

Your Current Medications *(name of medication, dose and how often)*

______________________ ______________________ ______________________

______________________ ______________________ ______________________

FAMILY HISTORY

Mother: ☐ living ☐ deceased Age (now or at death) _________ Cause of death: ______________________

Father: ☐ living ☐ deceased Age (now or at death) _________ Cause of death: ______________________

Has any blood relative had any of the following *(please check and indicate relationship, i.e. mother, father, sister, brother, etc.)*

☐ anesthesia problem	☐ cancer	☐ kidney disease	☐ other
☐ arthritis	☐ diabetes	☐ seizures	______________________
☐ asthma	☐ heart disease	☐ stroke	______________________
☐ bleeding disorder	☐ high blood pressure	☐ tuberculosis	______________________

SOCIAL HISTORY

☐ single ☐ married ☐ widowed ☐ separated ☐ divorced

# of children ___________ and their present health status: ______________________

Your present occupation: ______________________

Do you drink alcohol? ☐ yes ☐ no Do you smoke? ☐ yes ☐ no Packs per day ___________ # of years ___________

Do you use recreational drugs? ☐ yes ☐ no

Patient Signature: **Date:**

Dr's Initials: Date:

For Office Use Only

1. ☐ Yes ☐ No Comments: ______________________
Patient Signature: ______________________ Date: ___________ Dr's Initials: _______ Date: _____________

2. ☐ Yes ☐ No Comments: ______________________
Patient Signature: ______________________ Date: ___________ Dr's Initials: _______ Date: _____________

3. ☐ Yes ☐ No Comments: ______________________
Patient Signature: ______________________ Date: ___________ Dr's Initials: _______ Date: _____________