



Today's Date: _____

PATIENT INFORMATION

Patient Name _____ Sex _____ Marital Status _____
Date of Birth _____ Age _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
Employer _____ Occupation _____
Employer's Address _____

Spouse's Name _____ Social Security Number _____
Employer _____ Work Phone _____

REASON FOR APPOINTMENT? _____

Is this injury related to: (Circle one) Work Auto Accident Sports Other _____

Date symptoms began or accident happened? _____

Have you seen anyone else for this injury/accident? Y N If yes, who did you see _____

****If this is a work related injury, please fill out work comp information instead of insurance information listed below.**

INSURANCE INFORMATION

Primary Insurance _____ Cardholder _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____	Secondary Insurance _____ Cardholder _____ Relationship to Patient _____ Date of Birth _____ Social Security Number _____
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WORK COMP INFORMATION

Have you reported this injury at work? Yes _____ No _____
How did the injury occur? _____

Contact Person for Employer _____ Phone _____
Work Comp Insurance Company _____
Adjuster _____ Phone _____
Claim Number _____

IF PATIENT IS A MINOR OR STUDENT PLEASE COMPLETE THIS SECTION

Father's Name _____ Mother's Name _____
Address _____ Address _____
Phone _____ Phone _____
Employer _____ Employer _____
Work Phone _____ Work Phone _____
Social Security Number _____ Social Security Number _____
Date of Birth _____ Date of Birth _____

CONTACT INFORMATION

Emergency contact person _____ Relationship _____
Home Phone _____ Cell Phone _____

Who may we release medical information to?

1. _____ Phone Number _____
Relationship _____
2. _____ Phone Number _____
Relationship _____
3. _____ Phone Number _____
Relationship _____

May we leave medical information on an answering machine or voice mail? Y N Work
Home Cell phone

How did you hear about us?

Referring Physician _____ Phone Number _____
Primary Care Physician _____ Phone Number _____

Patient Name _____ Date of Birth _____ Primary Care Physician _____

MEDICATIONS

Medication/Vitamin/Supplement/Herbals	Dose and Frequency	Reason for taking	Medication/ Vitamin/ Supplement	Dose and Frequency	Reason for taking

HEALTH HISTORY (circle all that apply)

- | | | | |
|------------------------|-------------------------|---------------------|---------------------|
| Acid reflux/heartburn | Emphysema | High cholesterol | Shortness of breath |
| Asthma | Eye Problems | Irregular Heartbeat | Sinus Problems |
| AIDS/HIV | Foot/leg cramping | Kidney problems | Sleep apnea |
| Anemia | Gout | Lung disorder | Stroke |
| Arthritis | Heart Attack | Nervous/anxiety | Thyroid disorders |
| Artificial Heart Valve | Heart Disease | Osteoporosis | Tuberculosis |
| Bleeding disorders | Heart Murmur | Pacemaker | Ulcers |
| Cancer | Head Aches | Psychiatric care | None |
| Chest Pain | Hearing problems | Radiation/chemo | |
| Diabetes | Hepatitis/liver disease | Rheumatic fever | |
| DVT/blood clots | High blood pressure | Seizures | |

ALLERGIES (circle all that apply)

- | | | | |
|----------------------|-----------------|--------------|--------------------|
| Adhesive tape | Morphine | Novocain | Penicillin |
| Latex | Shrimp, Iodine, | Other: _____ | No known allergies |
| Sulfa Drugs | Merthiolate | | |
| Advil, Aleve, Motrin | Aspirin | Codeine | |

SURGICAL HISTORY

Surgery	Date	Surgery	Date

FAMILY HEALTH HISTORY (circle all that apply)

- Heart disease High blood pressure Diabetes Cancer Stroke Bleeding disorder

SOCIAL HISTORY

Smoking _____ Packs daily _____ Started _____ Stopped _____
 Alcohol _____ How often? _____ How much? _____
 Exercise? _____ What type? _____ How often? _____

Hand dominance? (please circle) Right handed Left handed Ambidextrous

Patient Signature _____ Date _____

Doctor _____ Date _____

For office use only

Date				
Height				
Weight				

Rezin Orthopedics and Sports Medicine, S.C.

Thank you for choosing REZIN ORTHOPEDICS AND SPORTS MEDICINE, S.C. as your health care provider. Please understand that payment of your bill is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

- All patients must complete our “Patient Registration and Medical Form” prior to seeing the doctor
- Full payment is due at time of service.
- We accept cash, checks, and Visa/Mastercard.

INSURANCE PLANS

If you have a managed care plan (HMO, EPO, POSITIVE, OR PPO), co-payments are due at the time of service in addition to any deductibles or fees for which you are responsible. If you have an indemnity plan (80/20 plan) 20% payment is due at the time of service in addition to any deductibles for which you are responsible. Insurance is a contract between you and your insurance company. We are not party to this contract. By law, insurance companies are required to pay health care providers within 30-45 working days. If they do not fulfill their financial obligations the responsibility will be transferred to the patient. You are responsible for the timely payment of your account.

If this account is assigned to collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees, to which may be added pre-judgment and/or post-judgment interest at the current legal rate. Ninety (90) days after date of service any unpaid amounts will be assessed late payment charges of 0.5% monthly.

COVERED SERVICES

Some health plans do not cover all services. If we are aware that your plan excludes certain services you will need to pay for those services when rendered.

MEDICAID/PUBLIC AID

If Medicaid/Public Aid covers you, you must present medical eligibility proof at the time you register for each service.

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Date: _____

Signature: _____
Patient/Guardian

RELEASE OF INFORMATION and AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize Rezin Orthopedics and Sports Medicine to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that they may require to process my claim for benefits.

I authorize and request that my insurance company pay directly to the above named practice to the amount due in my pending claim for medical treatment or services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing.

I understand and agree that (regardless of my insurance policy) I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the Financial Policy. I certify that, to the best of my knowledge, this information completed on the Patient Information Form is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

Date: _____

Signature: _____
Patient/Guardian

I acknowledge that I was provided a copy of the Notice Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Date: _____

Patient Name (Print): _____

Patient or Authorized Representative (if applicable) Signature