



# 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**

<p><b>PRIMARY INSURANCE:</b></p> <p>Insurance Name: _____</p> <p>Subscriber Name: _____</p> <p>Relationship to Patient: _____</p>	<p><b>SECONDARY INSURANCE:</b></p> <p>Insurance Name: _____</p> <p>Subscriber Name: _____</p> <p>Relationship to Patient: _____</p>
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**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 \_\_\_\_\_



Name: \_\_\_\_\_ Date: \_\_\_\_\_

REVIEW OF SYSTEMS	<i>(Must circle Yes or No)</i>		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*)

- |                                            |                                                 |                                             |                                           |
|--------------------------------------------|-------------------------------------------------|---------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> arthritis         | <input type="checkbox"/> diabetes               | <input type="checkbox"/> neuropathy         | <input type="checkbox"/> ulcer disease    |
| <input type="checkbox"/> asthma            | <input type="checkbox"/> glaucoma               | <input type="checkbox"/> rheumatoid disease | <input type="checkbox"/> vascular disease |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> heart disease          | <input type="checkbox"/> seizure            | <input type="checkbox"/> others           |
| <input type="checkbox"/> blood clots       | <input type="checkbox"/> hepatitis              | <input type="checkbox"/> stroke             | _____                                     |
| <input type="checkbox"/> cancer            | <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> substance abuse    | _____                                     |
| <input type="checkbox"/> cataract          | <input type="checkbox"/> kidney/bladder problem | <input type="checkbox"/> 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.*)

- |                                             |                                              |                                         |                                |
|---------------------------------------------|----------------------------------------------|-----------------------------------------|--------------------------------|
| <input type="checkbox"/> anesthesia problem | <input type="checkbox"/> cancer              | <input type="checkbox"/> kidney disease | <input type="checkbox"/> other |
| <input type="checkbox"/> arthritis          | <input type="checkbox"/> diabetes            | <input type="checkbox"/> seizures       | _____                          |
| <input type="checkbox"/> asthma             | <input type="checkbox"/> heart disease       | <input type="checkbox"/> stroke         | _____                          |
| <input type="checkbox"/> bleeding disorder  | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> 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**

- 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: \_\_\_\_\_

