TRISTATE ORTHOPAEDIC TREATMENT CENTER

PATIENT REGISTRATION FORM

Please print or write legibly. All sections must be completed to satisfy the requirements necessary to treat and bill on you behalf. Please complete all areas so your treatment can be properly documented and represented. Thank you for your cooperation.

PATIENT INFORMATION

First Name MI	Last Name	☐ Single ☐ Widowed ☐ Married ☐ Divorced
Street Address / Apt #	City, State, Zip	Telephone Number Cell Phone Number
Birth Date Sex M F	Social Security Number	Email Address
Employer	Address, City, State, Zip	Work Phone Number
Spouse's Name	Spouse's Employer	Employer Phone number

RESPONSIBLE PARTY Please complete with Insured Parent information for minors.

Name ☐ SELF	Relationship to Patient	Birth Date Social Security Number
Street Address / Apt #	City, State, Zip	Telephone Number
Employer	Address, Suite #, City, State, Zip	Telephone Number

PRIMARY INSURANCE

Name of Insurance	Certificate/Policy/ID	Group Number
Subscriber First Name Last Name	Birth Date Social Security Number	Relationship to Patient

SECONDARY INSURANCE **Worker's Compensation/Auto Accident Patients** please list Personal Insurance as Secondary.

Name of Insurance	Certificate/Policy/ID	Group Number
Subscriber First Name Last Name	Birth Date Social Security Number	Relationship to Patient

WORKER'S COMPENSATION/AUTO ACCIDENT **Patient is responsible regardless or insurance benefits or settlement**

BWC Claim Number / Auto Insurance Policy Number	Company/Employer at Time of Accident	Date of Injury/Accident
Insurance Company Name	Phone Number	Have you notified your employer of accident? Y N Have you been treated for this injury? Y N
Attorney Name:		Telephone Number

FAMILY AND REFERRING PHYSICIAN INFORMATION

Referring Physician: First Name	Last Name ☐ NONE	Complete Address Phone Number
Family Physician: First Name	Last Name ☐ NONE	Complete Address Phone Number

PLEASE TURN PAGE OVER. THANK YOU.

EMERGENCY CONTACT

Name of friend or relative who does not live with you	Relationship to Patient
Complete Address	Phone Number

PLEASE CHECK ONE FROM EACH CATEGORY

Marital Status ☐ Single ☐ Married ☐ Unknown ☐ Widowed ☐ Divorced ☐ Separated

Employment Status ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed
☐ Full-time Student ☐ Part-time Student ☐ Homemaker ☐ Disabled

Race ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic
☐ Native American ☐ Other _____ ☐ Unknown

How did you hear about our Physicians or our office?

☐ Family/Friend _____

☐ Other Physician _____

☐ Yellow Page Ad ☐ Mailing to my home ☐ Newspaper Ad ☐ Health Insurance Directory

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ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT:

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I understand that I am fully responsible for all charges incurred, regardless of my insurance status, for professional services rendered. This release is in effect one year from date signed.

Signature: _____ Date: _____
Patient or Authorized Representative

MEDICARE PATIENTS ONLY

Name of Beneficiary: _____ HI Claim Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Tristate Orthopaedic Treatment Center for any services furnished to me by that physician. I authorize any holder of medical information, concerning me, to release this information to the Health Care Financing Administration and its agents. This information will be used to determine payable benefits.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVII of the Social Security Act.

Signature: _____ Date: _____

We will continue to provide quality Healthcare to our patients. We will endeavor to accommodate a patients request, however, due to Tristate Orthopaedic and Treatment Center being a surgical practice, patient emergencies and unforeseen situations are not uncommon and are beyond your doctors control, it my be necessary to reschedule or delay your appointment time. We apologize for any inconvenience this may cause you.

PATIENT INJURY FORM

Name _____ Date of Birth _____ Today's Date:_____

Height: _____ft _____ in Weight: _____lbs. Pulse rate_____ ☐ Regular ☐ Irregular

My injury is: ☐ Work Related from _____/_____/_____ ☐ Due to an Auto Accident from _____/_____/_____

Presenting Problem(s):

A. Area(s) involved: (please circle)

shoulder	arm	elbow	forearm	wrist	hand	back
hip	thigh	leg	knee	ankle	foot	neck

B. Which side is involved? (please circle) Left Right Both

Please check all that apply to this current injury.

Mechanism of pain onset:

- ☐ suddenly
- ☐ gradually
- ☐ lifting
- ☐ twisting
- ☐ fall
- ☐ bending
- ☐ pulling
- ☐ injured at work
- ☐ hit in back
- ☐ sports
- ☐ no apparent cause
- ☐ motor vehicle accident (car)

What activities make the pain worse?

- ☐ during exercise
- ☐ after exercise
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ bending forward
- ☐ bending backward
- ☐ coughing
- ☐ sneezing
- ☐ bowel movements

What *reduces* your pain?

- ☐ lying down
- ☐ sitting
- ☐ standing
- ☐ walking
- ☐ manipulation
- ☐ physical therapy
- ☐ pain pills
- ☐ muscle relaxants
- ☐ aspirin
- ☐ nothing
- ☐ other _____

Have you had any *diagnostic studies* other than routine x-rays? Yes ☐ No ☐

If yes, please check the appropriate tests below with date of tests if you know them

☐ CAT scan	date_____	☐ discogram	date_____
☐ myelogram	date_____	☐ MRI	date_____
☐ EMG	date_____	☐ Bone Scan	date_____

Do you have any *back pain*?	Yes ☐ No ☐	If yes, how long? _____years	_____months	_____weeks
Do you have any *neck pain*?	Yes ☐ No ☐	If yes, how long? _____years	_____months	_____weeks
Do you have any *leg or joint pain*?	Yes ☐ No ☐	If yes, how long? _____years	_____months	_____weeks
Do you have any *arm or joint pain*?	Yes ☐ No ☐	If yes, how long? _____years	_____months	_____weeks

What other *types of doctors* have you seen for your back or neck problem (for example; chiropractors)?

_____

Do you have any *additional information*, which would be helpful to understand your problem?

_____

_____

PLEASE TURN PAGE OVER. THANK YOU.

Physician Signature _____ Date _____

PAIN ASSESSMENT

How bad is your back/neck pain now?

0 _____ 10

no pain worst possible

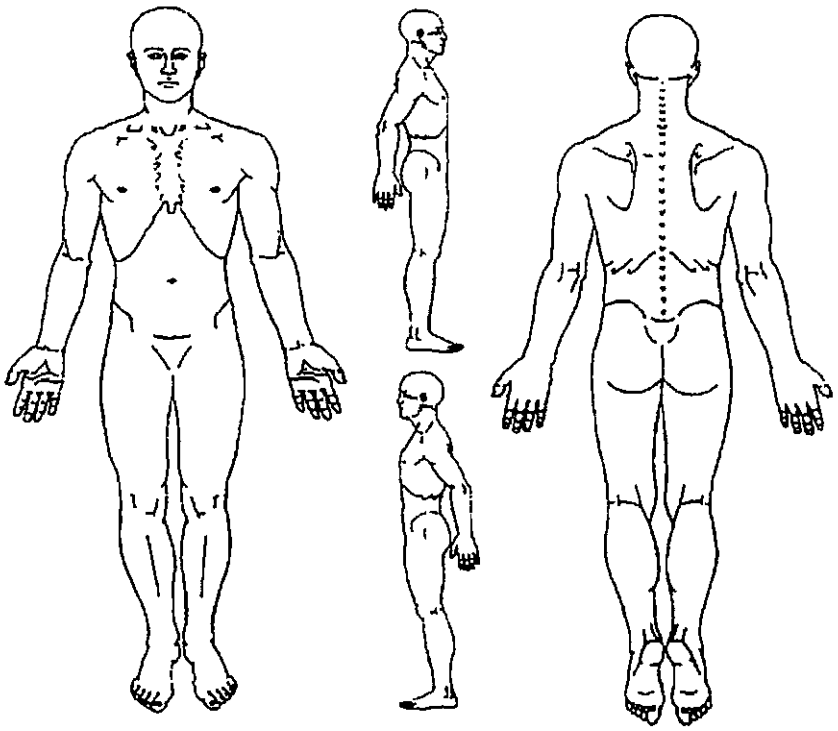
How bad is your leg/arm pain now?

0 _____ 10

no pain worst possible

Mark the areas on your body where you feel the *described pain.*

1. numbness	------	**3. stabbing**	//////	**5. deep boring**	######
2. burning	xxxxxx	**4. pins & needles**	oooooo	**6. dull, achy**	yyyyyy



CHECKLIST

Treatment(s) that you *tried* for your orthopaedic problem: (for example; treatment to this point in time)

- ☐ Jogging or Aerobic Exercises
- ☐ Physical Therapy (how long?_____wk_____months)
- ☐ Nonsteroidal Anti-inflammatory Medication (e.g. Ibuprofen, Advil, etc)
- ☐ Epidural Steroids
- ☐ racing
- ☐ Chronic Pain Management Program
- ☐ Muscle Relaxers
- ☐ Traction
- ☐ Biofeedback
- ☐ Vitamin Therapy
- ☐ Calcium
- ☐ Other (list) _____

- ☐ Stop Smoking
- ☐ Chiropractic Care (how long?_____wk_____months)
- ☐ Oral Steroid Like Prednisone
- ☐ Local Office Back or Buttock Cortisone Injection
- ☐ TENS Unit
- ☐ Narcotics Like Codeine, Percocet, Vicodin
- ☐ Surgery (date(s) _____)
- ☐ Massage
- ☐ Yoga/Meditation/Acupuncture
- ☐ Glucosamine (Chondrotin)
- ☐ Estrogen

I have reviewed all pages as part of the patient's visit.

_____ _____

Patient Signature Date

Tristate Orthopaedic
Treatment Center

FINANCIAL POLICY

The physicians of Tristate Orthopaedic Treatment Center (TOTC) participate with many insurance plans. Providing TOTC with your current insurance coverage information will allow us to file claims for services rendered in a timely manner with your insurance carrier.

Insurance contracts and policies are between you, the patient, and your insurance company. ***Any services not paid by your insurance company are your responsibility.*** If your insurance requires you to obtain a referral to see a specialist, it is your responsibility to complete this prior to your visit. If you do not secure the required referral, you will be liable for all charges associated with your visit. Contact your insurance carrier or plan administrator if you have any questions regarding co-payments, referral requirements and benefits or to obtain a list of physicians participating in your plan. Once we receive payment from your insurance company, any outstanding balance is due by you within 30 days.

ALL PAST DUE BALANCES ARE DUE AT TIME OF SERVICE

Payment plans can be arranged by contacting our Business Office. If your account is not paid in a timely manner, the full balance may be placed with an outside collection agency or attorney for further collection efforts. This balance will be reported on your credit report and remain there for seven (7) years. The person responsible for this account will be accountable for all collection costs including collection agency fees, attorney fees and court costs. These fees will be added as a separate charge on the account. If the account has been reported to an outside agency, you must make payment arrangements with that agency, not our office.

WORKER'S COMPENSATION/INDUSTRIAL INJURIES

Effective April 10, 2005, BWC policy no longer fully reimburses for retroactive treatment. If our office is not informed of a related BWC claim at the initial visit, you will be liable for all charges. Also, we will request any other (private medical) insurance coverage information you may have at this time. If a BWC claim is still in process or services are denied by the Bureau, TOTC will bill the private insurance company provided. The patient is then responsible for any remaining balance.

CHILD CUSTODY CASES

The parent accompanying a child to a first appointment assumes full responsibility for the patient account. Our office does not get involved with divorce specifics. It is the parents' obligation to work out any agreement with one another or through the court system.

NO INSURANCE/SELF-PAY PATIENTS/LITIGATION

Payment in full is due at time of service. Payment plans can be arranged by contacting our Business Office. In case of a litigation claim, such as a work injury being contested by an employer or automobile accident, payment in full is also due at time of service.

CANCELLATION POLICY

Patients will be charged $50.00 for any appointment that is not cancelled 24 hours before the scheduled appointment time. This fee will be collected prior to seeing the physician at the rescheduled appointment. Cancellation charges are the patient's obligation and will not be billed to any insurance company.

WE ACCEPT CASH, CHECK, MONEY ORDER, VISA, MASTERCARD AND DISCOVER.
A SERVICE FEE OF $27.00 WILL BE CHARGED FOR CHECKS RETURNED BY YOUR BANK.

I have read and agree to the above financial policy.

Print Patient Name	Patient / Guardian Signature	Date