

PATIENT REGISTRATION FORM

Social Security #: _____

Patient Name (last, first, middle): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____

Cell Phone #: _____

Email Address: _____

EMPLOYER INFORMATION

Employer: _____

Occupation: _____ FT _____ PT _____

Employer's Address: _____

Work Phone: _____

GUARANTOR INFORMATION

Please complete for the person responsible for the bills (if other than patient.) Required for patients under 18.

Guarantor Last Name: _____

First Name: _____

Guarantor Social Security #: _____

Guarantor Date of Birth: _____

Guarantor Address: _____

Relationship to Patient: _____

MISCELLANEOUS

Is this visit related to an accident?

___ DOA

___ Automobile

___ Work

___ Other

How were you referred to our practice? _____

Name of Primary Doctor: _____

Address: _____

Date of Birth: _____

Sex: ___ Male ___ Female

Is patient a full-time student? (Y/N)

Marital Status

___ Single ___ Married ___ Separated

___ Divorced ___ Widowed ___ Partnered

Language Preference

___ English ___ Polish ___ Russian

___ Spanish ___ Sign ___ Other

EMERGENCY CONTACT

Name: _____

Address: _____

Phone: *Home:* _____

Work: _____

Relationship to Patient: _____

PRIMATRY INSURANCE INFORMATION

Insurance Company Name: _____

Address: _____

Name of Subscriber: _____

Subscriber Date of Birth: _____

SS# of Subscriber: _____

Co-pay (if applicable): _____

Relationship to Patient: _____

Policy #: _____ GRP#: _____

Effective Date of Policy: _____

SECONDARY INSURANCE INFORMATION

Important! Do you have any other medical insurance?

Insurance Company Name: _____

Name of Insured: _____

Insured Date of Birth: _____

Social Security #: _____

Co-pay (if applicable): _____

Relationship to Insured: _____

Policy #: _____ GRP #: _____

Effective Date of Policy: _____

MEDICAL HISTORY FORM

Name: _____

Age: _____ Height: _____ Weight: _____

Occupation: _____ Date of your last physical: _____

Reason you are here to see the doctor: _____

Specify: ____ Left ____ Right

When did the symptoms begin (date or estimated date): _____

If this a sports injury, which sport? _____

Are you right or left hand dominant? _____

Past History

Are you in good health? Yes No

Have you had any Hospitalizations or surgeries in the past year? Yes No

If yes, specify: _____

Are you now under the care of another physician? Yes No

Are you currently treating for any medical problems? Yes No

If yes, specify: _____

Are you taking any medication, including nonprescription medications? Yes No

If so, what medication(s) are you taking? (include dosage and frequency)

Family History

Is there a family history of:

- | | | |
|----------------------------------|-----|----|
| • Arthritis | Yes | No |
| • Bone or joint disease | Yes | No |
| • Diabetes | Yes | No |
| • HTN (hypertension) | Yes | No |
| • Cardiac or Pulmonary disease | Yes | No |
| • Premature death (MI or stroke) | Yes | No |
| • Medication reactions | Yes | No |

MEDICAL HISTORY FORM, PAGE 3

Genitourinary: kidney stones, urinary tract infections, sexually transmitted diseases, frequency of urination, hesitancy, need to pass urine at night, bladder tumors, kidney abnormalities, blood in the urine, prostate disease, prostate cancer, last prostate specific antigen date and result

Familial Muscular Diseases: muscular dystrophy, malignant hyperthermia, scoliosis, familial skeletal dysplasias, hereditary bone conditions

Skin and Breast: psoriasis, infections, keloids, breast cancer, mastectomy

Neurological/ Psychological: seizures, strokes, neck pain, back pain, weakness, numbness, multiple sclerosis, tremor, unsteady gait, coordination problems, Parkinsonism, Alzheimer's Disease, forgetfulness, depression, anxiety, mania, psychosis, neurosis, history of MAO inhibitor drug use

Endocrine (hormone conditions): diabetes, thyroid disease, parathyroid disease

Hematological/Lymphatic: anemia, leukemia, lymphoma, blood clotting problems, Sickle Cell anemia, Thallesemia, Gaucher's Disease

Allergic/Immunological: HIV infection, AIDS, food allergy, hayfever, LATEX allergy

Patient Signature: _____ Date: _____

Reviewed: _____

Aria Health Physician Services Patient Responsibility Policy

We at _____ of Aria Health Physician Services are pleased you have given us the opportunity to serve your medical needs. We firmly believe that a good physician-patient relationship is based upon understanding and communication and we want you to be aware of our financial policy. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans. If you are not insured by a plan we participate in or are self-pay, payment in full is expected at each visit. We will ask you to present your current valid insurance card at each visit.

Co-payments. Co-payments are expected to be paid at the time of your visit.

Claims submission. We will submit your claims to your insurance and assist you in any way we reasonably can to help get your claims paid. We have agreements with many insurance companies and accept as payment the amount specified in the agreement. You will be responsible for all amounts not paid by your insurance, including amounts applied to deductible or considered non-covered.

Non-covered services. Your health insurance is a contract between you and your insurance company. Please be aware that not all services are covered in all insurance policies. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. In the event your insurance plan determines a service to be not covered, you will be responsible for the complete charge.

Insurance coverage changes. If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits.

Accepted forms of payment. We accept cash, check and credit cards.

Completion of forms. There is a \$_____ processing fee for the completion of forms, which were not part of an office visit.

Missed appointments. Our office requires advance notice if you are unable to keep your appointment. Failure to do so may result in an administrative charge. We request, at least, 24 hours notice (one business day) if you will not be able to keep your appointment. Barring any unusual circumstances, if you fail to show up for more than 3 appointments within 6 months without canceling ahead of time, you may be dismissed from the practice.

Our practice is committed to providing the best treatment to our patients. Our fee schedule is representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the patient responsibility policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date

Printed name of patient or responsible party

Patient Name: _____

Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY

I. I acknowledge receipt of Notice by signature.

Patient/Guardian Name (printed)

Patient/Guardian Signature

Date

II. Signature unable to be obtained due to:

Patient Refused

Patient Incapable of Signing (explain) _____

Other (explain) _____

Office Staff Signature

Date