NEW PATIENT ortho REGISTRATION

Dominic L. Gross

Registration Date: _____ Appointment Date: _____ Time: _____

PATIENT INFORMATION

Patient Name: _____ Parent Name: _____

Phone Home: _____ Cell: _____

Date of Birth: _____

Reason for visit / Injury: _____ Right _____ Left _____

Date of ER visit: _____

Referred by: _____ Friend

_____ Self

_____ Physician: _____ Phone: _____

_____ I went to an ER/Urgent Care: _____

INSURANCE

Primary: _____ Phone Number: _____

Policy Holder: _____ Date of Birth: _____

Relation to patient: _____

Policy Number: _____ Group Number: _____

Health Connection Referral: _____

_____

_____

Additional Notes: _____

_____

☐ Dominic L. Gross M.D.

Date / /	**PATIENT DEMOGRAPHIC FORM**	New ☐	Update ☐

Patient's Legal Name (Last, First, Middle)			E-mail Address		
Address		City	State	Zip Code	Sex (M/F)
Home Phone	Cell Phone	Birthdate	SSN	Nickname	Marital Status
Patient's Employer/Occupation (if applicable)			Whom may we thank for referring you?		
Employer Address (if applicable)			Work Telephone ( )		
Responsible Party's Legal Name (if different from patient)			SSN		Birthdate
Address (if different from above)			Home Telephone ( )		
Employer			Work Telephone ( )		
Spouse's Legal Name (if applicable)			SSN		Birthdate
Address (if different from above)			Home Telephone ( )		
Employer			Work Telephone ( )		
Emergency Notification (Last, First, Middle)		Relationship to Patient	Telephone		

INSURANCE INFORMATION (Please print information about the patient's insurance here)

Is your visit the result of an accident? ☐ YES ☐ NO Date of Injury			*Is this a Worker's Compensation Claim?* ☐ YES ☐ NO Claim #		
Please indicate method of payment today: ☐ Visa ☐ Mastercard ☐ Discover ☐ Amex ☐ Check ☐ Cash					
Responsible Insurance Company	☐ Medical ☐ Worker's Comp		Secondary Insurance Company	☐ Medical ☐ Worker's Comp	
Insurance Company's Address			Insurance Company's Address		
City	State	Zip	City	State	Zip
Group Plan Number	Subscriber Number		Group Plan Number	Subscriber Number	
Responsible Party's Name (First, MI, Last)	Date of Birth / /		Responsible Party's Name (First, MI, Last)	Date of Birth / /	
Who is the patient's Family Physician?			City/State		
Who is the patient's Referring Physician?			City/State		

AUTHORIZATION AND ASSIGNMENT

I HAVE READ AND UNDERSTAND THE PATIENT FINANCIAL POLICY.
I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including private insurance and other health plans to Horizon Health. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the practice to appeal any incorrect insurance payment. I authorize Horizon Health to use my e-mail address for the express purpose of contacting me regarding my account.

x _____ Date _____

AUTHORIZATION AND ASSIGNMENT FOR MEDICARE PATIENTS

I request that payment of authorized Medicare services be made either to me, or on my behalf to Horizon Health for any 'medically necessary' service(s) furnished to me by an Horizon Health physician. If a service is not deemed 'medically necessary' as per current Medicare guidelines I understand that it will be necessary for me to sign an *Advance Beneficiary Notice* (ABN) outlining the specific circumstances, prior to treatment. I hereby authorize Horizon Health to use my e-mail address for the express purpose of contacting me regarding my account.

x _____ Date _____

PATIENT QUESTIONNAIRE - *Confidential*

Name _____ Date of Visit _____ Age _____

Date of Birth _____ Height ____ feet ____ inches Weight ____lbs

Primary Physician/Family Doctor _____

Who may we thank for referring you? _____

What is the reason you are being seen at clinic today? _____

Body Part Effected: _____ ☐ Right ☐ Left ☐ Both Date of Injury/Onset: _____

How did injury occur? Please give specifics:

_____

_____

Please indicate type of testing/treatments and the location of those tests/treatments.

_____

_____

Please list any current or previous medical problems.

_____

_____

Have you or any family member had problems with surgical anesthesia? ☐ Never had it ☐ No ☐ Yes (please describe below)

_____

Previous Surgery	Treating Facility
_____	_____
_____	_____
_____	_____

What medication do you take? (Please list each medication and dosage)

_____	_____
_____	_____

Do you have any known allergies? (Please list and include the reaction you experienced with each)

_____	_____
_____	_____

Family History	Present Age	Age at Death	Medical Problems/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sister	_____	_____	_____
Brother	_____	_____	_____
Son/Daughter	_____	_____	_____

Patient Name _____ DOB: _____ Date: _____

Social History (Check one)

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

Exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What type of exercise? _____

Tobacco Use: ☐ No ☐ Chew ☐ Smoke _____ pack/day for ____ years

Alcohol Use: ☐ No ☐ Daily ☐ 1-2x/week ☐ 1-2x/month ☐ 1-2x/year

Do you have risk of Hepatitis B/ Hepatitis C/ Tuberculosis (TB) or HIV infection?

☐ Yes ☐ No (Please circle any that apply)

Do you have a history of Substance abuse? ☐ No ☐ Yes (If yes, what? _____)

System Review (Do you have or have you ever had any of the following?)

Vascular
- ☐ Nose bleed
- ☐ High blood pressure
- ☐ Anemia/blood deficiency
- ☐ Blood clots

Endocrine
- ☐ Thyroid Disease
- ☐ Hormone Therapy

Neurological
- ☐ Convulsion/seizure
- ☐ Paralysis

Skin
- ☐ Wound healing problems
- ☐ Skin ulceration/breakdown

Muscoskeletal
- ☐ Muscle/joint weakness
- ☐ Pain with walking
- ☐ Difficulty walking
- ☐ Flu-like aches/symptoms
- ☐ Stiff neck

Body Systems
- ☐ Gall bladder disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Kidney disease

Cardiac
- ☐ Heart Attack
- ☐ Chest pain or angina
- ☐ Heart Murmur/arrhythmia

Optical
- ☐ Loss of vision
- ☐ Double vision
- ☐ Glaucoma

Miscellaneous
- ☐ Recent weight gain
- ☐ Cancer: _____
- ☐ Flu-like symptoms
- ☐ Sinus infection
- ☐ Immune deficient
- ☐ Psychiatric problems
- ☐ Steroid use

Pulmonary
- ☐ Asthma
- ☐ Pneumonia or bronchitis

Any other medical problems?

_____

_____

_____

Who completed this form? ☐ Patient ☐ Other (Please specify) _____

The information provided in this history is true and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

Both sides of this form have been reviewed by the physician: _____ Date: _____