CALLENBERGER ORTHOPEDIC SPECIALISTS, LLC

# Patient Registration

Today's Date: _____

## Patient Information

Last Name: _____ First Name: _____ MI: _____

If Patient is a minor, please list parent(s) or legal guardian name: _____

Home Address: _____ _____ _____ _____
Street City State Zip

Billing Address: _____ _____ _____ _____
*If different than home*
Street City State Zip

1st Phone Contact #: _____ 2nd Phone Contact #: _____

Email Address: _____ Do you have a living Will? ☐Yes ☐No

Social Security #: _____ - _____ - _____ Driver's License #: _____ State: _____

Date of Birth: _____ Age: _____ Language Primarily Spoken: _____

Ethnicity: _____ Race: _____ Gender: ☐Male ☐Female

Pharmacy Name: _____ Location: _____

Family Physician: _____ Are you referred from your physician? ☐Yes ☐No

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Number: _____

## Insurance Information

Insurance Name: _____ Policy #: _____ Group #: _____

Insurance Address: _____ Insurance Phone #: _____

Name of person financially responsible (if different than patient): _____

Policy holder's Social Security #: _____ Policy holder's Date of Birth: _____

2nd Insurance Name: _____ Policy #: _____ Group #: _____

Insurance Address: _____ Insurance Phone #: _____

Is your current problem work related/accident case/automobile involved: ☐Yes ☐No

Date of injury: _____ Date Reported to Employer: _____

Employer: _____ Supervisor: _____

Workers' Comp Carrier: _____ Contact #: _____

If auto: Auto Insurance: _____ Claim#: _____ Contact#: _____

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Family Physician: _____ Who referred to this office? _____

Employer: _____

## Chief Complaint

Date of Accident or Injury: _____

Is your joint pain on the: ☐ Right ☐ Left ☐ Both ☐ N/A

What joint/extremity: _____

Why are seeing the doctor? Please describe the current injury or conditions:

_____

_____

## Past Personal Medical History

| Answer | Illness | Answer | Illness | Answer | Illness |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | Arthritis | ☐ Yes ☐ No | Blood Clots or Phlebitis | ☐ Yes ☐ No | Bloodstream Infection |
| ☐ Yes ☐ No | Osteoporosis | ☐ Yes ☐ No | Bleeding Problems | ☐ Yes ☐ No | Asthma |
| ☐ Yes ☐ No | Scoliosis | ☐ Yes ☐ No | Pain Syndrome/RDS/CRPS | ☐ Yes ☐ No | TB |
| ☐ Yes ☐ No | Back Injury | ☐ Yes ☐ No | RA/Inflammatory Arthritis | ☐ Yes ☐ No | Cancer |
| ☐ Yes ☐ No | Bone Fractures | ☐ Yes ☐ No | Sleep Apnea/C-PAP | ☐ Yes ☐ No | Cough |
| ☐ Yes ☐ No | Diabetes | ☐ Yes ☐ No | Prostate/Kidney Problem | ☐ Yes ☐ No | Heart Problems |
| ☐ Yes ☐ No | Gout | ☐ Yes ☐ No | Hepatitis/Jaundice | ☐ Yes ☐ No | Low Thyroid/Hypothyroid |
| ☐ Yes ☐ No | Prednisone Usage | ☐ Yes ☐ No | Epilepsy/Seizures | ☐ Yes ☐ No | High Cholesterol |
| ☐ Yes ☐ No | HIV/AIDS | ☐ Yes ☐ No | High Blood Pressure | | |
| ☐ Yes ☐ No | Stroke | ☐ Yes ☐ No | Lower Extremity Bone Infection | | |
| ☐ Yes ☐ No | Stomach Ulcers | ☐ Yes ☐ No | Acute/Chronic Renal Failure | | |

Please include a list of your significant illnesses', accidents, or things you are routinely treated for, or take medication for it not already listed above:

_____

_____

## Past Surgical History

Please list year of procedure, procedure, and complications (if no complications, please enter N/A)

| ***Year*** | ***Procedure*** | ***Complications*** |
|---|---|---|
| | | |
| | | |
| | | |

## Family Medical History

| Answer | Illness | Family Member | Answer | Illness | Family Member |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | Heart Disease | | ☐ Yes ☐ No | Asthma/Emphysemia | |
| ☐ Yes ☐ No | High Blood Pressure | | ☐ Yes ☐ No | Arthritis | |
| ☐ Yes ☐ No | Heart Attack | | ☐ Yes ☐ No | Anesthesia Reaction | |
| ☐ Yes ☐ No | Congestive Heart Failure | | ☐ Yes ☐ No | Diabetes | |
| ☐ Yes ☐ No | Stroke | | ☐ Yes ☐ No | Cancer | |

## Social History

| Answer | Item |
|---|---|
| ☐ Yes ☐ No | Currently Employed |
| ☐ Yes ☐ No | Student |
| ☐ Yes ☐ No | Retired |
| ☐ Yes ☐ No | Do you live alone? |
| ☐ Yes ☐ No | History of substance Abuse? |
| ☐ Yes ☐ No | Do you exercise? |
| ☐ Yes ☐ No | Smoke? |
| | |
| ☐ Yes ☐ No | Do you consume alcohol? |
| | |

Additional Questions

What is your occupation: _____

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

Whom do you reside with? _____

Explain any substance abuse: _____

How often do you exercise: ☐ Daily ☐ Weekly ☐ Monthly ☐ N/A

Year quit smoking: _____

How many packs per day? _____ How many years? _____

If yes, how often do you drink? _____

Drinks per day? _____ Drinks per month? _____

## Medication: dosage, how often, name of medication - bring a list if additional space is needed

## Allergies

☐ Yes ☐ No Are you allergic to any medication? If so, please list

☐ Yes ☐ No Are you allergic to latex, betadine, tape, band aids? If so, please list

☐ Yes ☐ No Women only: Are you pregnant?

## Review of Systems: if yes to below answers, please explain.

☐ Yes ☐ No In the last 2 weeks have you had a fever, chills, illnesses, night sweats?

☐ Yes ☐ No **Head:** Headaches, dizziness, change of vision, abnormal nasal drainage, hearing loss, sore throat, change in voice?

☐ Yes ☐ No **Lungs:** Shortness of breath, wheeze, asthma, emphysema?

☐ Yes ☐ No **Heart:** Chest pains, palpitations, murmur, high blood pressure, blood clots?

☐ Yes ☐ No **GI:** Chronic nausea, vomiting, diarrhea, constipation, abdominal pain?

☐ Yes ☐ No **GU:** Pain with urination, frequent urination, loss of bowels or bladder, blood in urine or stool?

☐ Yes ☐ No **Musculoskeletal:** (pain in joints other than what you listed initially on page 1) chronic joint pain, decreased range of motion, decreased strength or arthritis?

☐ Yes ☐ No **Neuro/Psych:** Recent history of memory loss, personality change, difficulty with sleep?

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____

CALLENBERGER ORTHOPEDIC SPECIALISTS, LLC

# Consent to Treat, Insurance Assignments, Authorization to Release Medical Information, Financial Agreement Acknowledgement/Authorization to leave telephone messages

**CONSENT TO MEDICAL/ SURGICAL PROCEDURES and Rx History**

The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider. Which may include but is not limited to laboratory procedures, x-ray examination, medical or surgical treatment, review of prescription history or procedures, anesthesia, or other services rendered the patient under the general and special instructions of the patient's physician. _____**- INITIALS**

**ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION**

In consideration of services rendered, I hereby transfer and assign to Dr. Callenberger all rights, title, and interest in any payment due to me for services described herein as provided in the above mentioned policy or policies of insurance. The office may disclose all or any part of the patient's record including psychiatric, alcohol and drug abuse, family member or employer of the patient for all or part of the office's charge, including but not limited to medical service companies, insurance companies, workmen's compensation carriers, welfare funds or the patient employer _____**- INITIALS**

**FINANCIAL AGREEMENT**

The undersigned agrees whether he/she signs as agent or as patient that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the office in accordance with the regular rates and terms of the office. Should the account be referred to collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms. _____**- INITIALS** I understand that certain insurance claims may be filed as a **COURTESY.** However, if the claim is denied for any reason, I am responsible for the payment. Please remember that insurance is considered a method of reimbursing the physician for the services rendered to the patient. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charges. **I UNDERSTAND IT IS MY RESPONSIBILITY TO PAY MY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE OR THIRD PARTY PAYOR WITH A REASONABLE PERIOD OF TIME NOT TO EXCEED 60 DAYS.** _____**- INITIALS**

**MEDICARE/MEDICAID PATIENTS ONLY**

*Patient's certification authorization to release information and payment request*: I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Administration Act is correct. I authorize that any holder of medical or other information about me to release to Social Security Administration/Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the office treating me. _____**- INITIALS** I permit a copy of these authorizations and assignments to be used in place of the original. _____**- INITIALS**

**Limited Authorization for communications to the Patient via Voicemail:**

I authorize Callenberger Orthopedic Specialists, LLC to disclose the following information I checked below by leaving by leaving it on the following answering machine:

☐ My personal/home answering machine #: _____ ☐ Leave no message

☐ Work voicemail #: _____ Cell phone voicemail #: _____

☐ Email at: _____

Description of information that may be disclosed:

☐ Appointment Information ☐ Billing Information ☐ Medical Information

***I have read all the above terms and acknowledge and agree to said terms.***

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

# HIPAA Privacy Practices

**333 W Cocoa Beach Causeway, Suite E**
**Cocoa Beach, FL 32931**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand I have a right to a paper copy of this notice.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

## Release of Medical Information

**If you would like to release your records to a relative or other person(s) please sign the release below otherwise leave blank.**

I, _____ Understand my HIPAA Rights, give Callenberger Orthopedic Specialists, LLC permission to release my medical records and medical status to

_____.

Signature: _____ Date: _____

CALLENBERGER ORTHOPEDIC SPECIALISTS, LLC

## Does your insurance require a referral?

As a courtesy, we will work with you and your primary care doctor to obtain a referral/authorization as deemed necessary by your insurance. **It is the patient's responsibility** to inform our staff and verify we have your authorization/referral in the chart prior to your office visit.

Any denials by insurance for failing to obtain a referral will be the financial responsibility of the patient.

I have read the above statement and agree to and understand.

Name: _____

Signature: _____ Date: _____