



Patient Registration

Date: / /		Email:		<input type="checkbox"/> Female	<input type="checkbox"/> Male
First Name:		Middle:	Last:		Age:
DOB: / /	Soc. Security No.: - -		Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Home Address:		Apt. #:	City:	State:	Zip:
Home #: () -		Cell #: () -		Language:	
Race:	<input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Asian	Ethnicity:	

Patient Employer Information

Company:	Work Phone: () -	Occupation:			
Address:		City:	State:	Zip:	
Occupation: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self Employed <input type="checkbox"/> Work at Home <input type="checkbox"/> Retired <input type="checkbox"/> Student					

Emergency Contact Information

Last Name:	First:	Relationship:			
Home Phone: () -	Cell: () -	Work: () -			

Primary Care Physician

Name:	Office: () -	Fax: () -			
Address		City	State	Zip:	

Referring Physician

Name:	Office: () -	Fax: () -			
Address		City	State	Zip:	

Primary Insurance

Subscriber Name:		DOB: / /	Social Security No.: - -		
Relationship to Patient:	Carrier:	ID #:	Group #:		

Secondary Insurance

Subscriber Name:		DOB: / /	Social Security No.: - -		
Relationship to Patient:	Carrier:	ID #:	Group #:		



Assignment of Benefits/Release of Information/Financial Responsibility by Patient

I, _____ (Patient Name) hereby irrevocably authorize **Orthopaedic & Sports Medicine Specialists, Inc.** and/or its designees to provide treatment and/or examination, and release any patient information to my physician, insurance company, adjustor or attorney if applicable, and to apply for Medicare/Medicaid, and other health insurance benefits if applicable (No Fault, Personal Injury Protection and Worker's Compensation), on my behalf and to take all necessary steps to collect such benefits, including but not limited to filing for arbitration as provided by statutes. I hereby authorize payment of any/all medical benefits and insurance proceeds be made on my behalf to the above. I certify that the information I have reported with regard to my insurance carrier(s) is correct. I authorize the release of medical information about me to my physician, health insurance carrier and Center for Medicare & Medicaid Services (CMS) agents, and any and all information needed to determine the benefits payable for related service(s).

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable when services are rendered. Any services that are not fully reimbursed by your medical insurance and are indicated on your insurance's Explanation of Benefits to be the patient's responsibility are due and payable upon receipt of a billing statement. Also, please be aware that this center will not forgive patient deductibles, patient co-payments and patient co-insurance payments. It is against the law to do so.

If you do not have medical insurance, financial arrangements will be made prior to services rendered. Otherwise full payment will be expected at the time of services. I agree if my account balance is over 90 days old, I will be responsible for a late fee of fifty dollars (\$50.00). **A charge of \$50.00 will be made for broken and/or no show appointments unless 24 hour notice given.**

COLLECTION:

In the event that this account is placed with an attorney or collection agency because of an unpaid balance remaining on my account, I hereby agree and promise to pay a collection fee of \$50.00 or 20% of the total balance due, whichever is greater.

(Signature of Patient /Parent/Guardian)

Date (MM/DD/YY)

Effective 10/2017

Assignment of Benefits/Authorization to release Information

I, _____ hereby authorize _____
(Subscriber name) (Insurance Company)

TO pay and assign directly to **David V. Lopez, M.D.** or his representatives, all benefits, if any, otherwise payable to me for his services as described in the attached forms. I understand that I am financially responsible for all charges incurred for services rendered by Dr. Lopez, whether or not paid by my Primary or Secondary insurers.

I authorize release of any medical information necessary to process this claim with my Primary and/or Secondary insurers. I further acknowledge that any insurance benefits, when received by and paid to David V. Lopez, M.D. or his representatives will be credited to my account, in accordance with the above assignment.

(Authorized Signature of Subscriber)

Date (MM/DD/YY)



Patient Contact Preferences

I may be contacted in the following manner (please check all that apply):

Telephone Messages	Home	Work	Written Communication	Home	Work
Leave message with information	<input type="checkbox"/>	<input type="checkbox"/>	Mail sent to	<input type="checkbox"/>	<input type="checkbox"/>
Leave message with call-back number	<input type="checkbox"/>	<input type="checkbox"/>	Fax message to this number: ()		-

Disclosure of Patient Information to Individuals other than the Patient

I agree that Dr. Lopez's practice may disclose information on my health and medical insurance billing to a family member, close personal friend, or other caregiver involved in my healthcare or payments relating to my healthcare. Dr. Lopez's practice will disclose only that information which is directly relevant to the person(s) involvement with my healthcare or payment relating to my healthcare.

I designate the following person(s) listed below as persons directly involved with my healthcare relationship and with whom Dr. Lopez's practice may disclose information.

Print Name	Relationship	Involvement with Patient		
		Healthcare	Payments	Both
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Acknowledgement of HIPAA Privacy Notice & Designation of Disclosure

_____ / ____ / ____
 (Patient Name) Date of Birth (MM/DD/YY)

I have had the chance to read and think about the contents of this form, and I agree with all the statements made in this Authorization. I understand that by signing this form, I am confirming my authorization for disclosure of information by Orthopaedic & Sports Medicine Specialists, Inc. as indicated above.

_____ / ____ / ____
 (Signature of Patient/Parent/Guardian) Date (MM/DD/YY):

If this authorization form is to be signed by a personal representative of the patient named herein, provide the following information:

_____ / ____ / ____
 (Print Name) (Signature of representative) Date (MM/DD/YY)



Patient Examination

Today's Date:	Patient Name:	DOB: / /
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Accident Date:	Location:	State:	Claim Number:
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Motor Vehicle Accident: Yes No Driver Passenger Wearing Seatbelt?

Lawyer's Name:	Phone: () -	Fax: () -
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Address:	City:	State:	Zip:
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Workers Compensation Claim: <input type="checkbox"/> Yes <input type="checkbox"/> No	Claim Number:
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Chief Complaint

Describe complaint:

Which side is involved? Right Left Front Back Bilateral

What makes it better?	What makes it worse?
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HEIGHT:	WEIGHT:	BP: /	Taken by:
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The complaint is a result of (check all that apply)

Lifting Pulling Pushing Twisting Falling Bending Reaching
 Squatting Hit by an object Other (explain) _____

Allergies

None
 Aspirin Codeine Penicillin Keflex Latex Sulfa Steroid Injection
 Tylenol Other (explain) _____ Serious effects: _____

For Women Only

Are you on birth control pills? Yes No Are you pregnant Yes (how many weeks): ____ No

Medication

Medication	Dose	Frequency	How Long	Side Effects

Pharmacy Name:	Town:	Phone: () -
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Patient Examination

Patient Name: _____ DOB: / / Female Male

Surgeries/Hospitalizations

Year	Type of Surgery	Hospital	Comments

Have you ever had general anesthesia? Yes No
 Have you ever had any problems with anesthesia? Yes No
 If you answered yes, please describe: _____

Review of Systems

Check off all of the following diseases or medical conditions that you have had at any time:

- | | | |
|--|--|---|
| <input type="checkbox"/> High/Low blood pressure | <input type="checkbox"/> Bone infections | <input type="checkbox"/> Heart Murmur/Congenital defect |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Eyes | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Anemia/Transfusions | <input type="checkbox"/> Ear/Nose/Throat | <input type="checkbox"/> Kidney/Bladder problems |
| <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Stomach/Trouble eating | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Blood clots/pulmonary embolus | <input type="checkbox"/> Diabetes: Type I <input type="checkbox"/> II <input type="checkbox"/> | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma/Trouble breathing | <input type="checkbox"/> Lower Back Pain/Sciatica |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Drug/Alcohol abuse |
| <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Epilepsy/Seizures/Fainting | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Cancer type: _____ |
| <input type="checkbox"/> Artificial bone or joint | | |

Describe any additional medical problems that you feel may be relevant to your treatment and we need to know: _____

Social History

Children Yes (how many) _____ No Do you live alone? Yes No
 Exercise: Daily Weekly Rarely Never Type of Exercise? _____
 Are you on a special diet? Yes (describe) _____ No
 History of substance abuse? Yes (describe) _____ No
 Do you smoke? Yes (packs/day) _____ (how many years) _____ No
 Quit smoking? Yes this year? > 1 year? >10 years?
 Do you drink alcohol? Yes 1 -2/week > 2 (how much) _____ No