PHILIP T. REGALA, MD., P.L.

American Board of Orthopedic Surgery

Patient Demographic Information
Today's Date:
Last Name: First Name: Middle Initial:
Male: Female: Date of Birth: Age: Social Security #:
Email:_____ Employer Name:_____
Single:_____ Married:_____ Divorced:_____ Widowed: _____
Race: Ethnicity: Language
Mailing Address:
City: State: Zip:
Home phone: Cell/Alternative: Work:
Referring Physician: Primary Care Physician:
Secondary Mailing Address: (from to)
City: **State:** **Zip:**
Emergency Contact Person
Name: Relationship
Phone:
Address:
City: State: Zip:
Responsible Party ☐ Self
Name:
Phone/Cell: Relationship: Social Security #:
Date of Birth:
Insurance Information: Provide copy of Insurance card
Patients relation to subscriber ☐ Self Pay ☐ Spouse☐ Child ☐ Other: Specify
Name of primary insurance :
Primary insurance address: Insurance phone number
Subscriber name: Subscriber DOB
Subscriber number:
Name of secondary insurance :
Secondary insurance address:
Insurance phone number Subscriber number:
Is your visit related to a motor vehicle injury? Yes/No Is your visit work related? Yes/No
PHARMACY INFORMATION (Required to fill in)
Pharmacy name & location: **Pharmacy number:**

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HIPAA PRIVACY & FINANCIAL AGREEMENT

I understand that I am fully responsible for all charges incurred for services rendered, whether or not paid by my insurance. All co-payments, coinsurance and deductibles are due at the time of service. I understand my insurance will be billed for me as a courtesy for reimbursement. In the event of non-payment, I understand if this account is referred to an outside collection agency, I am responsible for the balance plus 40% and/or court cost and legal fees.

_____ _____

Patient or Parent of minor child Date

MEDICAL RECORDS RELEASE

I hereby authorize PHILIP T. REGALA, MD., P.L. and staff to obtain or release my medical records according to HIPAA Privacy regulations. I have read and/or had access to the privacy policies and grant authorization by my signature here when it concerns my direct care/legal cases that accompany a signed authorization by me or insurance inquiries.

_____ _____

Patient or Parent of minor child Date

MEDICARE, MEDICAID AND/OR INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize PHILIP T. REGALA, MD., P.L. and assign directly to PHILIP T. REGALA, MD., P.L. all medical benefits, if any, otherwise payable to me for services rendered.

_____ _____

Patient or Parent of minor child Date

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Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history. I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Name:_____ **Signature** _____

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Patient Name: _____ Date of birth: _____
Date: _____ Date of Injury_____
Briefly describe your injury/accident/problem:
_____
_____
_____

Past Medical History: If none please write N/A
_____
_____
_____
_____

Past surgical History: If none please write N/A
_____
_____
_____
_____

Social History: Please Circle
Are you a □ Current smoker □ Former smoker □ Never smoked
If you are a current smoker, how often do you smoke?
□ Everyday □ Somedays □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more
If you are a former smoker, How long has it been since you last smoked?
□ less than 1 month □ 1-3 months □ 3-6 months □ 6-12 months □ Greater than 1 yr

Alcohol:
Did you have a drink containing alcohol in the past year? □ Yes □ No
If yes, how often do you drink? □ monthly or less □ 2-4 x's per month □ 2-3 x's per week □ 4 or more
How many drinks do you have per day?
□ 1-2 □ 3-4 □5-6 □ 7-9 □ 10 or more

Do you exercise? □ Yes □ No Are you currently on a diet? □ Yes □ No

PLEASE CIRCLE ALL THAT APPLY

Musculoskeletal:
No complaints
Joint Pains
Joint Swelling
Joint Stiffness

Psychology:
No Complaints
Generally Satisfied with Life
Suicidal Ideation

Neurology:
No Complaints
Tremor/Dizziness/Tingling numbness

Constitutional:
No complaints
Fever/chills
Headache

Ophthalmology:
No complaints
Blurring/double/ pain

Allergy:
No complaints:
Drug allergies

Endocrinology:
No Complaints
Excessive thirst/Heat/Cold intolerance/Fatigue

Gastroenterology:
No Complaints
Abdominal Pain/Nausea/vomiting/Heartburn

Cardiology:
No complaints
Chest pain
No Complaints
High Blood pressure

Dermatology:
No complaints
Rash/Boils/Itch

ENT:
No complaints
Ear infection/ Sore throat/Sinus Problem

Urology:
No Complaints
Urine retention/Painful urination/Frequent Urination

Respitory:
No Complaints
Wheezing/Cough/Short Breath
Hematology/Lymph
Swollen Glands/Blood clotting

Exercise Daily Yes or No
Diet Yes or No

Family History: □ No Family History of Family Medical Problems
Mother □ Alive □ Deceased □ Cancer □ Diabetes □ Hypertension □ Arthritis □ Stroke
Father □ Alive □ Deceased □ Cancer □ Diabetes □ Hypertension □ Arthritis □ Stroke
Siblings □ Alive □ Deceased □ Cancer □ Diabetes □ Hypertension □ Arthritis □ Stroke

Vaccination Status: Have you had the following in the last year?
Pneumonia Vaccine □ Yes □ No If Yes, approximately when? _____
Influenza Vaccine □ Yes □ No If Yes, approximately when? _____
Colonoscopy □ Yes □ No If Yes, approximately when? _____
Mammogram □ Yes □ No If Yes, approximately when? _____

Patient Name_____ Date_____

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Patient Name: _____ **Date:**_____

LIST OF CURRENT MEDICATIONS

MEDICATION	DOSE	HOW OFTEN

ALLERGIES

□ No known Allergies

Allergic to Latex □ Yes □ No

ALLERGY TYPE	DESCRIBE ALLERGIC REACTION

Under Pain Management Contract □ Yes □ No

Pace Maker □ Yes □ No

Spinal Cord Stimulator □ Yes □ No