Name: _____

Date: _____

LOWER EXTREMITY QUESTIONS

Chief Complaint: What is the patient here for?

Onset: What brought on this condition?

Duration: When did this condition begin?

Location of pain: (Where is the pain? Does the pain radiate?)

Timing: (Continuous, Intermittent, daily, weekly)

Severity of pain: (on a scale of 1-10)

Associated symptoms: (popping, catching, weakness, numbness, tingling)

Aggravating factors: (walking, running, sitting, standing, etc)

Treatment: (medications, anti-inflammatory, physical therapy, cortisone injections, mri, x-rays)

Is the condition getting better, getting worse or staying the same?

PATIENT REGISTRATION FORM

Patient Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ eMail: _____

Home #: _____ Work #: _____ Cell #: _____

Sex: M F Marital Status: M S W D SEP SSN: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Primary Insurance Information

Insurance Carrier: _____

Policy #: _____ Group #: _____

** *IF Subscriber is different that the patient, please fill in below:*

Subscriber: _____ Phone #: _____

DOB: _____ SSN: _____

Secondary Insurance Information

Insurance Carrier: _____

Policy #: _____ Group #: _____

Injury Information:

Is this related to an **AUTOMOBILE** or **Work injury**? _____

Date of Injury: _____

Auto/WC Insurance & Claim Address:

_____

Adjuster Name: _____

Adjuster Phone #: _____

Claim # _____

Medical History

Name: _____ Age: _____ Height: _____ Weight: _____

Do you have a Latex Allergy? ***YES*** ***NO***

List any medications you are allergic to: _____

_____

Reason for visit: _____

WHEN injury occurred: _____

WHERE injury occurred: _____

HAVE YOU BEEN TREATED ELSEWHERE FOR THIS INJURY? YES NO

If yes, WHERE: _____ X-ray Taken? YES NO

Please list any previous surgeries, including dates: _____

_____

_____

Please list any medications you are taking: _____

_____

_____

INDICATE *YES* OR *NO* FOR THE FOLLOWING *(if YES, please specify):*

Anemia	Y N _____	Leg or Foot Ulcers	Y N _____
Anxiety Disorder	Y N _____	Liver Disease	Y N _____
Arthritis	Y N _____	Lung Disease	Y N _____
Asthma	Y N _____	Migraines	Y N _____
Bleeding Disorder	Y N _____	Osteoporosis	Y N _____
Blood Clots	Y N _____	Pacemaker	Y N _____
Cancer	Y N _____	Peripheral Vascular Disease	Y N _____
Coronary Artery Disease	Y N _____	Pulmonary Embolism	Y N _____
Depression	Y N _____	Rheumatoid Arthritis	Y N _____
Diabetes	Y N _____	Seizures/ Epilepsy	Y N _____
GERD/Reflux	Y N _____	Stroke	Y N _____
Gout	Y N _____	Thyroid Problems	Y N _____
HIV or AIDS	Y N _____	Tuberculosis	Y N _____
Heart Attack (MI)	Y N _____		
Heart Disease	Y N _____		
Heart Problems	Y N _____		
Hernia	Y N _____		
High Blood Pressure	Y N _____		
Kidney Stone/ Disease	Y N _____		

FAMILY HISTORY OF CANCER: _____

FAMILY HISTORY OF HEART DIESASE: _____

HISTORY OF PROBLEMS WITH ANESTHESIA (including fever): _____

ARE YOU A SMOKER? _____

Authorization and Assignment:

I hereby authorize the provider of services to render medical care and furnish information to insurance carriers concerning my condition and treatment and I hereby assign to this provider all payments for medication services rendered to myself and dependents. I understand I am responsible for any amount not covered by insurance including but limited to: co-pays, deductibles, co insurances and prior authorizations not obtained prior to services rendered. I understand that there will be a service charge for any outstanding balances of sixty days or more. I understand there will be a **$25.00** fee for all returned checks.

Medicare: I hereby authorize Michael Elman M.D to furnish formation to Medicare concerning my condition and treatment if applicable and I hereby authorize Michael Elman M.D all payments for medical services. I understand that I am responsible for the deductible, coinsurance and non-covered services and supplies.

Signature: X_____ Date: _____

Notice of Changes in Insurance Coverage

I, the undersigned, understand that it is my responsibility to notify the office staff of Michael V. Elman M.D, P.C. of any changes in my insurance coverage. I also understand that should I fail to notify them of a change, they will bill me directly for anything that the insurance does not cover. This is also true if I did not previously have insurance, and then acquire insurance coverage and do not notify the staff.

Furthermore, I also understand that should I have insurance coverage which required me to have a referral done by my PCP (Primary Care Physician), it is also my responsibility to request the referral be done and to ensure that Dr. Elman's office has received it. I again understand that should I not get a referral or should I not verify that one has been done, I will again be billed for anything that the insurance company denies or does not cover due to lack of referral.

_____
Printed Name of Patient

_____
Patient / Guardian Signature

_____
Date Signed

NO SHOW Policy

I, the undersigned, understand that I am required to give twenty-four hour notice if I am unable to keep a scheduled appointment. If I am unable to keep the appointment and/or notify the office, I agree that I am responsible for the **$40.00** no show fee.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge receipt of Michael V. Elman M.D., P.C. 's Notice of Privacy Practices Policies.

X_____

Patient Signature Date

_____

Patient Representative Date

_____

Representative Relationship to Patient

_____ Patient refused to sign Acknowledgement of Notice of Privacy Policies.