Acct # ________

PATIENT REGISTRATION FORM

Patient Information

Legal First Name ________ M.I. ____ Last Name ________

Address ________ (Street) ________ (City) ________ (State) ________ (Zip)

Home Phone ________ Cell Phone ________ Email ________

Employer ________ Work # ________

Birth Date ____/____/____ Social Security # ________ or Drivers License # ________

Gender: M / F Marital Status: Married Single Divorced Other Preferred Language: English Other ________

Ethnicity: Hispanic/Latino Non Hispanic/Latino Race: Caucasian African American Asian Other ________

Referred by ________ Primary Physician ________

Responsible Party

Legal First Name ________ M.I. ____ Last Name ________

Address ________ (Street) ________ (City) ________ (State) ________ (Zip)

Home Phone ________ Cell Phone ________ Email ________

Birth Date ____/____/____ Gender: M / F

Social Security # ________ or Drivers License # ________

Employer ________ Work # ________

Insurance Information

Primary Insurance Company ________

Address ________ (Street) ________ (City) ________ (State) ________ (Zip)

ID Number ________ Group Number ________

Insured Name ________ Insured DOB ________

Insured Employer ________ Relationship to Patient ________

Secondary Insurance Company ________

Address ________ (Street) ________ (City) ________ (State) ________ (Zip)

ID Number ________ Group Number ________

Insured Name ________ Insured DOB ________

Insured Employer ________ Relationship to Patient ________

Financial Policy: I authorize the release of any information necessary to process claims. I request payment of benefits to Dr. Neustrom Inc I understand I am financially responsible for charges not covered by insurance. I hereby authorize to Dr. Neustrom Inc and its employees and/or agents to release all information, reports and records if necessary for the purposes of treatment, payment and healthcare operations, including a discussion of my medical condition to the insurance provider, rehabilitation provider, employer, hospitals and doctors.

If your plan has a co-payment, deductible and/or co-insurance you will be expected to pay your portion prior to receiving any service. You may be required to pay a minimum of 50% at the time of service until we verify your deductible has been met.

In the case of a divorce situation, the adult accompanying a minor patient is responsible for payment of services. Our office staff will not participate in any disputes which may arise with respect to financial liability due to legal custody agreements.

Payment is due at the time of service unless prior financial arrangements have been made with our business office. Any account balance is expected to be paid in full prior to new services being rendered. Should it become necessary for Dr. Neustrom Inc to utilize the services of an outside collection agency, you may be held liable for collection agency fees and/or attorney fees.

Patient/Responsible Party Signature ________ Date ________

NAME: ______________________ DATE: __________

PERSONAL PHYSICIAN: ______________________ LAST CHECK UP: __________

HEIGHT: __________ WEIGHT: __________ SEX: (M) or (F) D.O.B.: __________

ILLNESS:	Have you ever had: Yes	(or) No	Treatment Required	Family History of: Yes	(or) No
High Blood Pressure	____	____	____	____	____
Heart Disease	____	____	____	____	____
Diabetes	____	____	____	____	____
Asthma	____	____	____	____	____
Pneumonia	____	____	____	____	____
Cancer (of?) ________	____	____	____	____	____
Blood Clots	____	____	____	____	____
Ulcer	____	____	____	____	____
Kidney Disease	____	____	____	____	____
Anemia	____	____	____	____	____
Seizures	____	____	____	____	____
Hepatitis	____	____	____	____	____
Rheumatoid Arthritis	____	____	____	____	____
Arthritis	____	____	____	____	____
Gout	____	____	____	____	____

PAST SURGERIES:

Yes (or)	No		
____	____	**Appendectomy**	**When** ________
____	____	**Gallbladder**	**When** ________
____	____	**Hernia Repair**	**When** ________
____	____	**Hysterectomy**	**When** ________
____	____	**Tubaligation**	**When** ________
____	____	**Coronary (Heart) Catheterization**	**When** ________
____	____	**Coronary Artery Bypass**	**When** ________
____	____	**Pacemaker Placement**	**When** ________
____	____	**Prostate**	**When** ________
____	____	**Back Surgery**	**When** ________
____	____	**Neck Surgery**	**When** ________
____	____	**Foot Surgery**	**When** ________
____	____	**Ankle Surgery**	**When** ________
____	____	**Other Bone Surgery**	**When** ________
____	____	**Joint Surgery**	**When** ________
____	____	**Wound Infections**	**When** ________
____	____	**ANESTHESIA COMPLICATIONS**	**When** ________
____	____	**Post Op DVT or Blood Clot**	**When** ________
____	____	**Other** ________	**When** ________

LIST CURRENT MEDICATIONS ________ DOSE ________ TIMES PER DAY

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

ALLERGIES TO MEDICATIONS: NONE: ________

YES	NO		REACTION	YES	NO		REACTION
____	____	Penicillin	________	____	____	Novacaine	________
____	____	Demerol	________	____	____	Iodine	________
____	____	Morphine	________	____	____	Sulfa	________
____	____	Codeine	________	____	____	Other	________

ALLERGY TO LATEX OR RUBBER

____ ____ Latex ________

ALLERGY TO SUTURE / STITCHES

____ ____ suture ________

SOCIAL HISTORY:

OCCUPATION: ______________________________

MARITAL STATUS: ______ Single ______ Married ______ Divorced ______ Separated ______ Widowed

LIVING: ______ Home ______ Farm ______ Apartment ______ Retirement complex

______ With Spouse ______ Alone ______ Other

HABITS:

Yes (or)	No		
______	______	Currrent Smoker	Packs per day ______ How many years? ______
______	______	Past Smoker	Packs per day ______ How many years? ______ When did you quit? ______
______	______	Alcohol consumed	Average consumption per week ______
______	______	Coffee or Caffeine	Cups / Cans per day ______

REVIEW OF SYSTEMS (ARE YOU EXPERIENCING ANY OF THE FOLLOWING?)

	YES (or)	No	(If yes, please circle each that applies to you)
Constitutional	______	______	fevers, chills, sweats
Constitutional	______	______	loss of appetite, loss of weight
Cardiovascular	______	______	chest pain, shortness of breath, swollen ankles rapid or irregular heartbeat, fainting spells
Respiratory	______	______	persistent cough, cough up blood, difficulty breathing
Gastrointestinal	______	______	heartburn, vomited blood, jaundice, blood in stool
Genitourinary	______	______	blood in urine, painful or burning urination
Neurological	______	______	headache, dizziness, loss of consciousness, head trauma
Psychiatric	______	______	depression, feelings of anxiety
Endocrine	______	______	elevated blood sugars, unexplained weight loss, unexplained weight gains, fatigue, mass in neck, back pain
Hematological	______	______	blood clots, bleeding problems, anemia

PLEASE DESCRIBE YOUR PROBLEM:

____

____

____

RATE YOUR PAIN = SCALE 1 – 10 # ________ (with 1 being the mildest and 10 being most severe.)

DURATION OF SYMPTOMS: ____________ (how long have you been experiencing your symptoms?)

MY PAIN OR DISCOMFORT HAS BEEN: (circle all that apply to you):

CONSTANT INTERMITTENT REMAINS THE SAME HAS WORSENED HAS IMPROVED

****

REVIEWED AND UPDATED	*PHYSICIAN*	*DATE*
	______________	______
	______________	______
	______________	______