



Bone & Joint SPECIALISTS

9001 Broadway, Merrillville, IN 46410
Phone: (219) 795-3360 Fax: (219) 756-6500

PLEASE PRINT

TODAY'S DATE		PATIENT REGISTRATION			MRN #:	
PATIENT INFORMATION						
LAST NAME		FIRST NAME AND INITIAL				
PATIENT SSN#		SEX	DOB	MARITAL STATUS		
PREFERRED LANGUAGE		PCP	Referring Physician			
ADDRESS						
CITY				STATE	ZIP	
PRIMARY CONTACT #	HOME PHONE	WORK PHONE	CELL PHONE			
E-MAIL ADDRESS						
EMPLOYER		EMPLOYER'S ADDRESS				
OCCUPATION		EMPLOYMENT STATUS				
SPOUSE'S NAME						
SPOUSE'S HOME PHONE		SPOUSE'S WORK PHONE		SPOUSE'S CELL PHONE		
ETHNICITY: NO, NOT HISPANIC YES, HISPANIC OR LATINO RACE: AMERICAN INDIAN ALASKAN NATIVE ASIAN BLACK OR AFRICAN AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER WHITE OR CAUCASIAN OTHER PATIENT REFUSED						
NAME OF PRIMARY INSURANCE:						
POLICYHOLDER NAME		RELATIONSHIP				
ADDRESS				CONTACT PHONE		
POLICYHOLDER SSN#		SEX	POLICYHOLDER DOB			
EMPLOYER		EMPLOYER PHONE	EXT			
EMPLOYER ADDRESS						
NAME OF SECONDARY INSURANCE:						
POLICYHOLDER NAME		RELATIONSHIP				
ADDRESS				CONTACT PHONE		
POLICYHOLDER SSN#		SEX	POLICYHOLDER DOB			
EMPLOYER		EMPLOYER PHONE	EXT			
EMPLOYER ADDRESS						
EMERGENCY CONTACT INFO						
NEAREST RELATIVE OR FRIEND NOT LIVING WITH				RELATIONSHIP		
ADDRESS						
PRIMARY CONTACT #	HOME PHONE	WORK PHONE	CELL PHONE			

YOU MUST READ AND SIGN THE OTHER SIDE OF THIS FORM

PT. NAME:

MRN #:

Authorization for Treatment – I hereby authorize the physician to conduct such examinations, perform such procedures as are medically required, and administer such treatment and medication as deemed necessary or advisable. I hereby certify that I have read and fully understand this Authorization form. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Release of Information/Medical Record Diagnosis – I hereby authorize the physician(s) providing services and any other authorized person to release to its authorized billing agents, any physician who treated me, my insurance carrier, employer's workmen's compensation insurance company, or other category of third party payor, the Social Security Administration under Title XVIII (18) of the Social Security Act, the Professional Review Organization, or other intermediaries responsible for payment of my charges, a complete report of services rendered including diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for the services rendered. I understand that I may revoke this consent at any time by giving written notice. I understand that if I refuse to consent to the release of information, I will be held personally responsible for payment of all charges for services rendered.

I give my permission to Bone and Joint Specialists and all clinical providers who have provided care to me, along with any billing service, collection agencies, attorney or other agents who may work on their behalf, to contact me on my cell phone and/or home phone using automatic telephone dialing systems or other computer assisted technology.

Authorization for Assignment of Benefits / Financial Obligation – In consideration of medical services provided, I hereby assign and transfer to the physician all of my rights, title and interest to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by my physician, including Medicare Part B. I understand that I will be fully responsible for payment of any and all charges not covered by medical insurance. I understand that if I do not pay the balance in full my account will be placed for collection and I will be responsible for all collection expenses including reasonable attorney's fees and court costs. It is our policy to charge a fee for any check that is returned due to Insufficient Funds.

Co-payments – I understand that if my medical insurance requires a co-pay or encounter fee the payment is due AT THE TIME OF SERVICE.

No Show Policy – Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to high patient demand, and limited availability of appointments we have instituted a **\$35 no show fee. You must give 24 hour advanced notice to cancel appointments. Failure to do so will result in a \$35 fee charged to your account. By signing below, I acknowledge that I have read and understand this policy.**

Prerecertification – If my insurance requires prerecertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the prerecertification is not obtained.

Advance Directive – Information regarding advance directives is provided in the Patient Information Guide.

H.H.S. Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of NOTICE OF PRIVACY PRACTICES:

_____ Patient Signature	_____ Date	_____ Responsible Party Signature	_____ Date
_____ Witness Signature	_____ Date	_____ Relationship to Patient	

(Section 1) I give consent & authorization for the medical, or billing staff of my physicians office to release information regarding my medical care to:

_____ (Name/ Relationship)	_____ (Name/ Relationship)
_____ (Name/ Relationship)	_____ (Name/ Relationship)

(Section 2) AUTHORIZATION TO REQUEST SERVICE OR TREATMENT OF A MINOR

I give my consent and authorization for persons I list below to have the right and privilege to request service and treatment for all minors listed on the other side of this form, should I not be present or available by telephone. This authorization is subject to revocation at any time and must be done in writing, except to the extent that action has already been taken in reliance on the consent.

Name _____	Relationship _____
Name _____	Relationship _____

I understand I may revoke this privilege listed in (Section 1) and (Section 2) at any time by submitting my request in writing to this office.

Patient/Parent/Guardian Signature _____ DATE _____

ADVANCED DIRECTIVE

Have you appointed a Health Care Representative? yes ___ no ___ Do you have a living will? yes ___ no ___

Have you given anyone your Power of Attorney? yes ___ no ___



James Hong DPM

9001 Broadway, Merrillville, IN 46410
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PATIENT HISTORY

Referred By: _____

Date: _____ Patient Name _____

Age: _____ Sex: M / F Hand Dominance: R / L

Occupation: _____

PRESENT ILLNESS

Reason for visit: _____

Date of onset/injury: _____

Mechanism of injury: _____

Pain

- ◆ Where does it hurt: _____
- ◆ Describe the pain: _____
- ◆ Severity (1-10, 10 being very severe): _____
- ◆ How often: _____
- ◆ How has it changed over time: _____

What makes it better? _____

What makes it worse? _____

Associated symptoms: _____

Prior Treatment

- ◆ Physician: _____
- ◆ Medications: _____
- ◆ Injections: _____
- ◆ Therapy: _____
- ◆ Tests/Imaging: _____

Occupational Injury Y / N Work missed? Y / N Last date worked: _____

Return to work (date): _____ with (full / light) duty

Pharmacy (Name and location): _____

List all Current Medications: _____

Are you claustrophobic? [] mild [] moderate [] severe [] NO

Drug Allergies and Reaction: _____

Anesthesia Complications: _____

PAST MEDICAL HISTORY: circle all that apply

CV: Heart attack, chest pain, congestive heart failure, arrhythmia, high blood pressure, murmur, varicosities, blood clots

Respiratory: Asthma, emphysema, chronic bronchitis, pneumonia, asbestosis

GI: Ulcers, esophagitis, gastritis, hiatal hernia, hepatitis, GERD

Renal: Kidney infections / failure, kidney stones, UTI

Cancer: _____

Hematologic: Anemia, hemophilia, or other bleeding disorder

Endocrine: Hypo/Hyper thyroidism, diabetes, pituitary gland disorder

Rheumatologic: Gout, rheumatoid arthritis, Lupus, scleroderma, rheumatic fever, psoriasis, fibromyalgia

DVT Risk Factors: Varicosities, heart disease, HBP, obesity, stroke, previous blood clot, diabetes

History of MRSA or Staph infection

PAST SURGICAL HISTORY: please list

FAMILY HISTORY: please include mother, father, siblings, grandparents

Anesthesia Complications: _____

Cardiovascular: _____

Cancer: _____

Hematologic: _____

Musculoskeletal: _____

Renal: _____

Diabetes/thyroid problems: _____

SOCIAL HISTORY

Tobacco: Current/Nonsmoker/Former _____ years quit

Alcohol: Frequent / Social / Occasional / Rare / None

Illicit Drug Use: Type _____ Amount _____ Frequency _____

Do you have any personal preferences/beliefs that would prevent you from receiving a blood transfusion? _____

REVIEW OF SYSTEMS: please circle all that apply

Constitutional: Chills, fevers, night sweats, weight loss, weight gain

Eyes: Near-sightedness, far-sightedness, astigmatism, double vision, glaucoma

Ears: Hearing loss, tinnitus, vertigo

Nose, Mouth, Throat: Rhinorrhea, congestion, sore throat

CV: Chest pain, heart palpitations, edema

Respiratory: Cough, wheezing, difficulty breathing, coughing blood, shortness of breath

GI: Nausea, heartburn, bowel irregularities, hemorrhoids

GU: Frequency/hesitancy, blood in urine, incontinence, irregular menstrual cycle

Musculoskeletal: Muscle aches, joint swelling, neck pain, back pain

Integumentary: Skin lesions (stable / changing), acne, rashes

Neurological: Headaches, loss of consciousness, seizures, tingling/numbness, gait disturbance

Psychiatric: Depression, mood-swings, hallucinations, anxiety

Endocrine: Excessive thirst/frequent urination, hyperactivity, difficulty sleeping

Hematologic: Easy bruisability, anemia, bloody noses, excessive blood loss, HIV risk

Height: _____ **Weight:** _____