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 INTIAL			
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.**

Precertification –If my insurance requires precertification it is my responsibility to make sure it is obtained. I will be held financially responsible if the precertification 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____

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Specializing in Arthroscopic Surgery, Hand Surgery, Foot & Ankle Surgery, Spine Surgery,

Joint Reconstruction, Sports Medicine, Podiatry, Workers Compensation

Scott Andrews, M.D.

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Patient Name: _____ Date of Birth: ___/___/_____

Reason for Visit: _____ R ☐ L ☐

Date pain began: _____ If injured, brief description: _____

If injured, where did it occur? ☐ work ☐ vehicle ☐ home ☐ other _____

If injured, date of injury: _____ Last day worked: ___/___/_____

*List Prior Treatment: (physical therapy, anti-inflammatories, tests and/or injections) _____

_____

Name of family physician: _____ Who were you referred by: _____

Have you been diagnosed or treated for any of the following illnesses? (Please check all that apply)

☐ High Blood Pressure
☐ Diabetes
☐ Bladder/Kidney Disease
☐ Cancer (type:_____)
☐ Heart Disease
☐ Depression
☐ Hepatitis
☐ Thyroid Disease
☐ Asthma
☐ Epilepsy/Seizures
☐ Hearing Problems
☐ Skin Conditions
☐ Arthritis
☐ Other _____
☐ MRSA
☐ TB
☐ HIV

Are you claustrophobic?

☐ no ☐ mild
☐ moderate ☐ severe

Smoking Status

☐ current every day smoker
☐ current some day smoker
☐ smoker, current status unknown
☐ never smoker
☐ former smoker
☐ unknown if ever smoked
☐ decline to answer

All Current Medications: _____

_____

Allergies: _____ ☐ No Known Allergies

Please list any surgeries and their dates:

_____

_____

Patient/Guarantor Signature:

X_____ Date: ___/___/_____

NAME: _____ Date of Birth_____ Today's Date: _____

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 Dyspnea on exertion SOB orthopnea edema claudication
Respiratory	Cough wheezing difficulty breathing hemoptysis
GI	Nausea heartburn bowel irregularities hemorrhoids
GU	Frequency/hesitancy hematuria incontinence dysmenorrheal amenorrhea
Musculoskeletal	Arthralgia effusion neck pain back pain
Integumentary	Skin lesions (Stable/changing) acne
Neurological	Headaches LOC seizures paresthesia gait disturbance
Psychiatric	Depression mood-swings hallucinations
Endocrine	Excessive thirst frequent urination hyperactivity difficulty sleeping
Hematologic	Easy bruisabiity anemia epistaxis excessive blood loss HIV risk

FAMILY HISTORY

	Mother	Father	Brother	Sister	Son	Daughter
Anesthesia Complications						
Cardiovascular						
Cancer						
Hematologic						
Musculoskeletal						
Renal						
Endocrine						

Height _____ Weight _____ Flu Shot? YES NO Pneumonia Shot? YES NO

Pharmacy: Name _____ Address _____

SOCIAL HISTORY

Tobacco: _____ pack/day _____ years (chewing tobacco, pipe, cigar)

Alcohol: Type _____ Amount _____ Frequency _____

Drug use: Type _____ Amount _____ Frequency _____

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Activities of Daily Living: (ADLs) are routine activities that people tend do every day without needing assistance. Please check all that apply from the list of activities that are being AFFECTED by your pain level.

- ☐ Walking- Moving around the house, store, etc.
- ☐ Climbing Stairs- Getting up and down stairs.
- ☐ Bathing- Getting into bath/shower; drying the body.
- ☐ Toileting- Sitting on and getting up from the toilet; wiping.
- ☐ Transferring bed/chair- Getting into and out of bed/chair.

Pain:

Rate the severity from 1-10 (10 being very severe) of your pain level: _____

What makes it worse? _____

What makes it better? _____

Describe the pain: _____

Do you use assistance to help with every day activities? **Y** or **N** (circle one)

If yes, which device do you use? (check all that apply)

- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____

How long have you been using this device(s)?

- ☐ 0-3 Months
- ☐ 3-6 Months
- ☐ 6-12 Months
- ☐ 12+ Months

Patient signature: _____ Date: _____