



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 ___

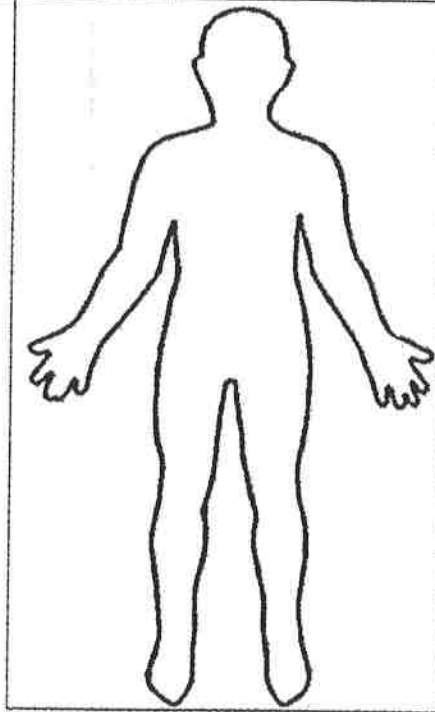
Have you given anyone your Power of Attorney? yes ___ no ___



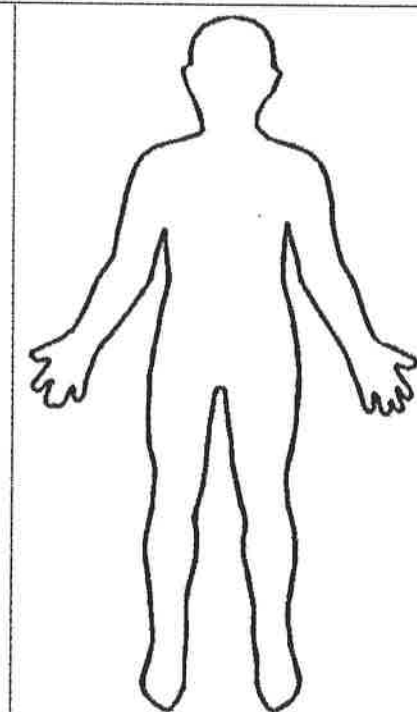
NEW PATIENT EVALUATION

Dr. Zeshan Hyder Orthopedic Spine Surgeon

DATE:			
PATIENT NAME:			
DATE OF BIRTH:			
AGE:	GENDER: MALE	FEMALE	HEIGHT: WEIGHT:
CHIEF COMPLAINT:			
DATE OF INJURY/ PAIN:			
GOALS:			
REFERRAL:			
NAME OF FAMILY PHYSICIAN:			



FRONT



BACK

PLEASE INDICATE MARKINGS ON IMAGE	ACHE= ~~~~~
NUMBNESS= 0000000	PINS AND NEEDLES = *****
BURNING= xxxxxxxx	STABBING= //////////////

How bad is your pain? Place an "X" on each line below to indicate pain.

LOW BACK PAIN

NO PAIN _____ WORST POSSIBLE

LEG PAIN

NO PAIN _____ WORST POSSIBLE

MIDDLE BACK

NO PAIN _____ WORST POSSIBLE

NECK PAIN

NO PAIN _____ WORST POSSIBLE

ARM PAIN

NO PAIN _____ WORST POSSIBLE

Please check how each of the following affects your pain?

	<u>YES</u>	<u>NO</u>
Is your pain worse at night?		
Do your legs tire when you walk?		
If YES= How far can you walk :		
Is there relief when resting your legs?		
Is there relief when bending forward?		
Any <u>tingling or numbness</u> ?		
If yes: hands, arms, legs, feet, etc?		
Any <u>weakness or falling/dropping</u> items?		
If yes: hands, arms, legs, feet etc?		
<u>IMAGING: XRAY, MRI, CT, ER TESTS PAST 6 MONTHS?</u>		

General History

Please check all of the conditions that may apply to you

<input type="radio"/> HEART ATTACK	<input type="radio"/> COLON PROBLEMS	<input type="radio"/> GOUT	<input type="radio"/> ENLARGED PROSTATE
<input type="radio"/> HEART MURMUR	<input type="radio"/> DIABETES	<input type="radio"/> ANXIETY	<input type="radio"/> MENSTRUAL PROBLEMS
<input type="radio"/> ANGINA	<input type="radio"/> HEPATITIS	<input type="radio"/> DEPRESSION	<input type="radio"/> CANCER:
<input type="radio"/> HIGH BLOOD PRESSURE	<input type="radio"/> CIRRHOSIS	<input type="radio"/> EMPHYSEMA	<input type="radio"/> OSEOPOROSIS
<input type="radio"/> STROKE	<input type="radio"/> KIDNEY STONES	<input type="radio"/> TUBERCULOSIS	<input type="radio"/> STOMACH ULCER
<input type="radio"/> VARICOSE VEINS	<input type="radio"/> KIDNEY INFECTION	<input type="radio"/> CHRONIC BRONCHITIS	<input type="radio"/> SEXUAL DIFFICULTY
<input type="radio"/> DUODENAL PROBLMES	<input type="radio"/> DEGENERATIVE ARTHRITIS	<input type="radio"/> FREQUENT PNEUMONIA	<input type="radio"/> BLEEDING TENDENCY
<input type="radio"/> ANEMIA	<input type="radio"/> ASTHMA		

Please list any surgeries that you may have had.

Have you ever had any surgeries on your NECK or BACK before? If Yes= date and surgeon

Please check any TREATMENTS you may have already had.

<input type="radio"/> Chiropractic	<input type="radio"/> Physical therapy	<input type="radio"/> Injections	<input type="radio"/> Psychological exam	<input type="radio"/> other
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If yes, did it make your condition better or worse? _____

How long ago were these treatments and by whom? _____

FAMILY HISTORY

Check all that may apply:

I DO NOT KNOW

MOTHER	FATHER
AGE:	AGE:
DECEASED:	DECEASED:
CAUSE:	CAUSE:

<input type="radio"/> STROKE	<input type="radio"/> HEART PROBLEMS	<input type="radio"/> KYPHOSIS	<input type="radio"/> DIABETES	HIGH BLOOD PRESSURE
<input type="radio"/> LUNG DISEASE	<input type="radio"/> CANCER	<input type="radio"/> BACK PROBLEMS	<input type="radio"/> ARTHRITIS	<input type="radio"/> OTHER

Please list Allergies you may have to Medications?

NAME /LOCATION PHARMACY: _____

Please list any MEDICATIONS you take, including herbal, over the counter, and prescription.

Medication	Reason	How often	Doctor

Social History

Marital Status

<input type="radio"/> Married
<input type="radio"/> Separated
<input type="radio"/> Divorced
<input type="radio"/> Single
<input type="radio"/> Widow/widower

CURRENT WORK SITUATION / OCCUPATION:

<input type="radio"/> FULL-TIME	<input type="radio"/> PART-TIME	<input type="radio"/> <u>RETIRED</u>	<input type="radio"/> <u>OTHER</u>
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PLEASE CIRCLE: TOBACCO USE: YES NO

I SMOKE _____ PACKS A DAY FOR _____ YEARS	FORMER: I DID SMOKE _____ PACKS FOR _____ YEARS
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ALCOHOL USE: YES No

<input type="radio"/> BEER
I. FREQUENCY: NEVER RARELY SOCIALLY DAILY

IS THERE ANYTHING WE HAVE FAILED TO ASK THAT YOU BELIEVE IS IMPORTANT FOR US TO KNOW?

REVIEW OF SYSTEMS FOR THE PATIENT

PLEASE CHECK ALL THAT MAY APPLY:

<input type="checkbox"/> RECENT WEIGHT LOSS OF MORE THAN 10 POUNDS?
<input type="checkbox"/> RECENT WEIGHT GAIN OF MORE THAN 10 POUNDS?
<input type="checkbox"/> FEVER
<input type="checkbox"/> CHILLS
<input type="checkbox"/> NIGHT SWEATS
HAVE YOU SEEN YOUR FAMILY DOCTOR IN PAST YEAR?

<u>SKIN</u>
<input type="checkbox"/> OPEN SORES
<input type="checkbox"/> NEW MOLES
<input type="checkbox"/> POOR HEALING
<input type="checkbox"/> SKIN INFECTION

<u>GENITOURINARY</u>
<input type="checkbox"/> ABNORMAL KIDNEY FUNCTION
<input type="checkbox"/> PAIN WITH URINATION
<input type="checkbox"/> FREQUENT URINARY INFECTIONS

<u>BONES AND JOINTS</u>
<input type="checkbox"/> SHOULDER PAIN
<input type="checkbox"/> WRIST/HAND PAIN
<input type="checkbox"/> HIP PAIN
<input type="checkbox"/> KNEE PAIN
<input type="checkbox"/> LUPUS
<input type="checkbox"/> MUSCLE WEAKNESS
<input type="checkbox"/> FIBROMYALGIA

<u>NERVOUS SYSTEM</u>
<input type="checkbox"/> HEADACHES
<input type="checkbox"/> TREMORS
<input type="checkbox"/> POOR SPEECH
<input type="checkbox"/> CHANGES IN VISION

<u>CARDIAC</u>
<input type="checkbox"/> CHEST PAIN
<input type="checkbox"/> SHORTNESS OF BREATH

<u>RESPIRATORY</u>
<input type="checkbox"/> WHEEZING
<input type="checkbox"/> PNEUMONIA
<input type="checkbox"/> CHRONIC COUGH

<u>GASTROINTESTINAL</u>
<input type="checkbox"/> ABDOMINAL PAIN
<input type="checkbox"/> NAUSEA
<input type="checkbox"/> VOMITING
<input type="checkbox"/> DIARRHEA
<input type="checkbox"/> LIVER PROBLEMS

<u>HEMATOLOGY/ONCOLOGY</u>
<input type="checkbox"/> EASY BRUISING
<input type="checkbox"/> BLOOD THINNING MEDS
<input type="checkbox"/> BLOOD TRANSFUSIONS
<input type="checkbox"/> ORGAN TRANSPLANT

<u>MENTAL HEALTH</u>
<input type="checkbox"/> SLEEP DISTURBANCES
<input type="checkbox"/> FEELING OF HOPELESSNESS

<u>ENDOCRINE</u>
<input type="checkbox"/> THYROID PROBLEMS

