9001 Broadway, Merrillville, IN 46410 • 219.795.3360 • Fax: 219.756.6500

PATIENT REGISTRATION Please Print

TODAY'S DATE

PATIENT INFORMATION

MRN #:

LAST NAME | FIRST NAME AND INITIAL

PATIENT SS# | SEX | DOB | MARITAL STATUS

PREFERRED LANGUAGE | PCP | REFERRING PHYSICIAN

ADDRESS

CITY | STATE | ZIP

PRIMARY CONTACT HOME PH | WORK PH | CELL PH

EMAIL ADDRESS

EMPLOYER NAME | EMPLOYER ADDRESS

OCCUPATION | EMPLOYMENT STATUS

SPOUSE'S NAME

SPOUSE'S HOME PH | WORK PH | CELL PH

ETHNICITY: ❒ NO, NOT HISPANIC ❒ YES, HISPANIC OR LATINO

RACE:
❒ AMERICAN INDIAN
❒ ALASKAN NATIVE
❒ BLACK OR AFRICAN AMERICAN
❒ WHITE OR CAUCASIAN
❒ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
❒ ASIAN
❒ OTHER
❒ PATIENT REFUSED

NAME OF PRIMARY INSURANCE

POLICY HOLDER NAME | RELATIONSHIP

ADDRESS | CONTACT PHONE

POLICY HOLDER SS# | SEX | POLICY HOLDER DOB

EMPLOYER | EMPLOYER PHONE | EXT

EMPLOYER ADDRESS

NAME OF SECONDARY INSURANCE

POLICY HOLDER NAME | RELATIONSHIP

ADDRESS | CONTACT PHONE

POLICY HOLDER SS# | SEX | POLICY HOLDER DOB

EMPLOYER | EMPLOYER PHONE | EXT

EMPLOYER ADDRESS

EMERGENCY CONTACT INFO

NEAREST RELATIVE OR FRIEND NOT LIVING WITH | RELATIONSHIP

ADDRESS

PRIMARY CONTACT HOME PH | WORK PH | CELL PH

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 Records Diagnosis: I hereby authorize the physician(s) providing service 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, or other category or third party payor, the Social Security Administration under Title IVIII (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 permission to Bone and Joint Specialists and all clinical providers who have provided care for 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 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 hours 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 Health Insurance Portability and Accountability Act of 1996, I acknowledge that a 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 the 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 _____

ADVANCE DIRECTIVE

Have you appointed a Health Care Representative? ❒ Yes ❒ No
Have you given anyone your Power of Attorney? ❒ Yes ❒ No
Do you have a living will? ❒ Yes ❒ No

Is this related to an auto accident? ❒ Yes ❒ No
Is this a work comp injury? ❒ Yes ❒ No

BONE & JOINT
SPECIALISTS
ORTHOPEDIC & SPINE CENTER

Specializing in true minimally invasive spine surgery

9001 Broadway, Merrillville, IN 46410 • 219.795.3360 • Fax: 219.756.6500
801 MacArthur Blvd., Ste 302, Munster, IN 46321 • 219.795.3360
3800 St. Mary Drive, Ste 101, Valparaiso, IN 46383 • 219.795.3360

NEW PATIENT EVALUATION

Zeshan Hyder, D.O. Orthopedic Spine Surgeon

Patient Name: _____ Today's Date: _____

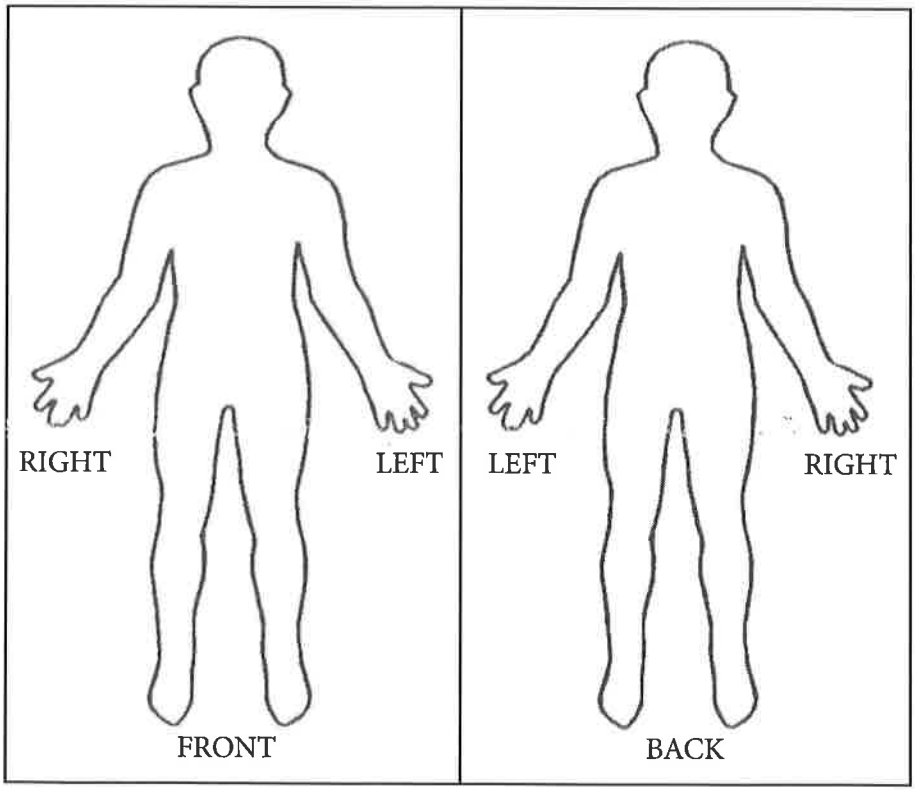
Date of Birth: _____ Age: _____ Gender: O Male O Female Height: _____ Weight: _____

Chief Complaint: _____

Date of Injury/Pain Onset: _____

Goals: _____

Referral: _____ Name of Physician: _____



PLEASE INDICATE MARKINGS ON IMAGES

Numbness =
00000000

Burning =
xxxxxxxx

Ache =
^^^^^^^^

Pins & Needles =
****

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?

	YES	NO
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 **tingling or numbness**?		
If yes: hands, arms, legs, feet, etc?		
Any **weakness** or **falling/dropping** items?		
If yes: hands, arms, legs, feet etc?		
IMAGING: XRAY, MRI, CT, ER TESTS PAST 6 MONTHS?		

General History

Please check all of the conditions that may apply to **you**

o HEART ATTACK	o COLON PROBLEMS	o GOUT	o ENLARGED PROSTATE
o HEART MURMUR	o DIABETES	o ANXIETY	o MENSTRUAL PROBLEMS
o ANGINA	o HEPATITIS	o DEPRESSION	o CANCER:
o HIGH BLOOD PRESSURE	o CIRRHOSIS	o EMPHYSEMIA	o OSEOPOROSIS
o STROKE	o KIDNEY STONES	o TUBERCULOSIS	o STOMACH ULCER
o VARICOSE VEINS	o KIDNEY INFECTION	o CHRONIC BRONCHITIS	o SEXUAL DIFFICULTY
o DUODENAL PROBLMES	o DEGENERATIVE ARTHRITIS	o FREQUENT PNEUMONIA	o BLEEDING TENDENCY
o ANEMIA	o 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.

○ **Chiropractic**	○ **Physical therapy**	○ **Injections**	○ **Psychological exam**	○ **other**

If yes, did it make your condition better or worse?_____

How long ago were these treatments and by whom?_____

FAMILY HISTORY

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

Check all that may apply:

I DO NOT KNOW

° **STROKE**	° **HEART PROBLEMS**	° **KYPHOSIS**	° **DIABETES**	**HIGH BLOOD PRESSURE**
° **LUNG DISEASE**	° **CANCER**	° **BACK PROBLEMS**	° **ARTHRITIS**	° **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

o Married
o Separated
o Divorced
o Single
o Widow/widower

CURRENT WORK SITUATION / OCCUPATION:

° FULL-TIME	° PART-TIME	° RETIRED	° OTHER

PLEASE CIRCLE: TOBACCO USE: YES NO

I SMOKE_____PACKS A DAY FOR _____YEARS	FORMER: I DID SMOKE_____PACKS FOR _____YEARS

ALCOHOL USE: YES No

FREQUENCY: NEVER RARELY SOCIALLY DAILY

REVIEW OF SYSTEMS FOR THE PATIENT

PLEASE CHECK ALL THAT MAY APPLY:

° RECENT WEIGHT LOSS OF MORE THAN 10 POUNDS?
° RECENT WEIGHT GAIN OF MORE THAN 10 POUNDS?
° FEVER
° CHILLS
° NIGHT SWEATS
HAVE YOU SEEN YOUR FAMILY DOCTOR IN PAST YEAR?

CARDIAC
° CHEST PAIN
° SHORTNESS OF BREATH

RESPIRATORY
° WHEEZING
° PNEUMONIA
° CHRONIC COUGH

SKIN
° OPEN SORES
° NEW MOLES
° POOR HEALING
° SKIN INFECTION

GASTROINTESTINAL
° ABDOMINAL PAIN
° NAUSEA
° VOMITING
° DIARRHEA
° LIVER PROBLEMS

GENITOURINARY
° ABNORMAL KIDNEY FUNCTION
° PAIN WITH URINATION
° FREQUENT URINARY INFECTIONS

HEMATOLOGY/ONCOLOGY
° EASY BRUISING
° BLOOD THINNING MEDS
° BLOOD TRANSFUSIONS
° ORGAN TRANSPLANT

BONES AND JOINTS
° SHOULDER PAIN
° WRIST/HAND PAIN
° HIP PAIN
° KNEE PAIN
° LUPUS
° MUSCLE WEAKNESS
° FIBROMYALGIA

MENTAL HEALTH
° SLEEP DISTURBANCES
° FEELING OF HOPELESSNESS

NERVOUS SYSTEM
° HEADACHES
° TREMORS
° POOR SPEECH
° CHANGES IN VISION

ENDOCRINE
° THYROID PROBLEMS