

MEDICARE PATIENT REGISTRATION

Name _____ Date of Birth _____ Age _____
Mailing Address _____ SS# _____ Male/Female _____
City _____ State _____ Zip _____ Married Single Divorced Widowed
Home Phone (____) _____
Alternate Address _____ Are you employed? Y N
City _____ State _____ Zip _____ Is your spouse employed? Y N
Home Phone (____) _____ Cell Phone (____) _____
May we e-mail personal medical information to you? Y N Email Address _____
May we leave medical information on your answering machine? Y N
Primary Care Physician _____
In case of Emergency, who should be notified? _____ Phone (____) _____
Do you have a court appointed legal guardian or Power of Attorney? Yes No

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)

Primary Secondary
Insurance Name _____ Insurance Name _____
Policy Holders Name _____ Policy Holders Name _____
Address _____ Address _____
City _____ State _____ Zip _____ City _____ State _____ Zip _____
Phone _____ Date of Birth _____ Phone _____ Date of Birth _____
ID# _____ ID# _____
Relationship of patient to insured _____ Relationship of patient to insured _____

Do you give our office permission to discuss your medical information with family members?

Yes No If yes, please provide their names and phone numbers below.
Name: _____ Relationship: _____
Phone # (day): (____) _____ Phone # (evening): (____) _____
Name: _____ Relationship: _____
Phone # (day): (____) _____ Phone # (evening): (____) _____

I authorize the release of medical information to my primary care referring physician, to consultants, if needed and as necessary to process insurance claims, Insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

I, the undersigned, understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account will be referred to our collection agency, Allied Collection Services, Inc., for collection procedures and I am responsible for all cost including fees, attorney fees, and court costs.

The staff of this office pledges to give the finest care our capacities allow. Complications are seldom seen in the many surgical procedures performed, however, it should be understood that even small surgical procedures can scar, occasionally bleed, and rarely become infected or incite allergic response.

X

Signature Date

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr Byrne/McTigue/Reeck for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X

Signature Date

If you have supplemental/secondary insurance, we are required to keep a separate signature on file:

I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to DCSI for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the above Medigap carrier and information needed to determine these benefits or the benefits payable for related services.

X

Signature Date

MEDICAL HISTORY

Name _____ Date of Birth _____ Date ____/____/____

Are you Allergic to any medications? No Yes (Please List)

Are you allergic to tape or bandaids? No Yes (Please List) _____

Are you allergic to any numbing medications or dental anesthesia? No Yes (Please List) _____

Please List any other Allergies _____

*PLEASE HAVE YOUR LIST OF MEDICATIONS AVAILABLE FOR THE NURSE WHEN ASKED

Do you or have you ever had diseases or conditions of: (please circle)

Lungs

History of Tuberculosis

Emphysema

Asthma

Chronic Cough

Vascular

High Blood Pressure

Chest Pain

Heart Attack

Heart Murmur

Heart Valve Prolapse

Irregular Heartbeat

Pacemaker / Defibrillator

Phlebitis

Bleeding Disorder

Other Systemic

Alzheimers/Dementia

Diabetes

Thyroid

Kidney

Bladder

Stomach

Bowel

Hepatitis or Jaundice

Glaucoma

Arthritis / Joint Deformity

Convulsions, Epilepsy or Seizures

Fainting

Lupus

Cancer (what type) _____

Fibromyalgia

Sexually Transmitted Disease

Other _____

Please answer the following questions:

Do you drink alcohol?	YES	NO	If YES,	drinks per day?
Do you use IV drugs?	YES	NO	If YES, what?	How much?
Have you had or have you been exposed to HIV (AIDS)?	YES	NO		
Do you smoke?	YES	NO	If YES, how much?	
Are you pregnant?	YES	NO	Due Date:	
Do you have artificial joint(s)?	YES	NO		
Do you have a Hearing Aid or impaired hearing?	YES	NO		
Are you required to take antibiotics before minor surgery?	YES	NO		
Have you ever had skin cancer?	YES	NO	Type:	Location:
Has anyone in your family had skin cancer?	YES	NO	If YES, who?	
Have you had any skin diseases?	YES	NO		

please list: _____

List type and dates of previous surgeries you have had: _____

What are your hobbies? _____

Signed by Physician

Date