



PATIENT REGISTRATION FORM
(Complete All Pages)

PATIENT NAME _____
(Last) (First) (Middle Init.)

STREET OR BOX NO. _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK # _____ CELL # _____ EMAIL _____

MARITAL STATUS: _____ RACE/ETHNICITY : _____

SOC. SEC. # _____ BIRTH DATE _____ AGE _____ GENDER: MALE _____ FEMALE _____

FAMILY PHYSICIAN AND ADDRESS _____

WERE YOU SEEN BY A PHYSICIAN FOR THIS PROBLEM AND REFERRED? YES _____ NO _____ BY WHOM: _____

PATIENT EMPLOYER AND ADDRESS _____

DATE OF INJURY _____ DATE OF SYMPTOMS _____ AUTO ACCIDENT? YES _____ NO _____

APPROVED WORKMEN'S COMPENSATION INJURY? YES _____ NO _____ COVERED BY SCHOOL INSURANCE? YES _____ NO _____

SPOUSE OR PARENT INFORMATION (If parent information, fill both name sections completely.)

(Last) (First) (MI) (Last) (First) (MI)

STREET OR BOX NO. _____ STREET OR BOX #: _____

CITY _____ STATE _____ ZIP _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUS PHONE _____ HOME PHONE _____ BUS PHONE: _____

SOC. SEC. # _____ BIRTH DATE _____ SOC. SEC. # _____ BIRTH DATE _____

EMPLOYER _____ EMPLOYER _____

ADDRESS: _____ ADDRESS: _____

PRIMARY INSURANCE:

SECONDARY INSURANCE:

NAME OF INS. _____ NAME OF INS. _____

TREATMENT AND FINANCIAL AGREEMENT: I hereby consent to treatment by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C to include x-rays, injections, casts, and such other office procedures as they deem necessary. I accept full responsibility for any charges incurred for services rendered to me. I agree to make payment at the time of my service(s) and allow the insurance to reimburse me for that amount. The office staff will file my claim with my primary insurance carrier if all information is provided by me. HOWEVER, PAYMENT IS STILL DUE AT THE TIME OF SERVICE. Exceptions to this are: Blue Cross/Anthem, Encore, Sagamore, Patoka Valley, Medicare, and Worker's Compensation. I understand that Dr. Norris is not a Medicaid provider. I also understand our providers are not mediators between my insurance company(ies) and me and that it is my responsibility to contact the insurance company for payment on my account. I UNDERSTAND THE ABOVE AND CONSENT TO TREATMENT AT THIS TIME.

SIGNATURE _____ DATE _____
(Patient/Responsible Party)



RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, or third party administrator having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents to give to the group policyholder, my employer, third party administrator, my third party carrier, or its legal representative, any and all such information.

I UNDERSTAND the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C, or as may be otherwise lawfully required, or as I may further authorize. I AGREE that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

I AUTHORIZE payment of medical benefits to be made to NORRIS & BLESSINGER ORTHOPAEDICS & SPINE on any claim submitted for any services furnished me by either Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C.

I have received a copy of the Privacy Practices of Norris, Blessinger & Woebkenberg Orthopaedics & Spine.

SIGNED _____ DATE _____

COST OF COLLECTIONS

In the event any unpaid balance is assigned for collections with any third party and/or an attorney to obtain judgment or otherwise satisfy payment of this account, I am obligated to pay the costs incurred directly or indirectly by Dr. Norris, Dr. Blessinger, Dr. Woebkenberg, Will Walker, NP, Kelsey Vonderheide, PA-C, or Jarred Lampert, PA-C to collect amounts owed such as 33 1/3% collection costs, court costs, attorney's fees, interest, late fees, sheriff's fees, and the like. In the event of a returned check, there will be a fee assessed of \$22.

SIGNED _____ DATE _____



MEDICAL HISTORY FORM
(Please use **BLACK** ink and **PRINT** name)

Name _____ **Birth Date** _____ **Today's Date** _____

Age: _____ Sex: Male Female Height: _____ Weight: _____ Dominant Hand: Left Right

Primary Care Physician: _____ Other (i.e., specialist): _____

MEDICAL ILLNESSES:

___ Diabetes ___ Osteoarthritis ___ Rheumatoid arthritis ___ Blood clots ___ Stroke ___ Gout

___ High blood pressure (hypertension) ___ Ulcer disease ___ GERD (acid reflux) ___ Sleep apnea

___ Osteoporosis ___ Elevated cholesterol (hyperlipidemia) ___ Dementia/Alzheimer's ___ Asthma

___ Liver disease/hepatitis ___ Heart disease ___ Congestive heart failure ___ COPD ___ Atrial fibrillation

___ Kidney (renal) disorder ___ Thyroid disorder ___ Cancer (type) _____

HIV POSITIVE? Yes No

HAVE YOU HAD ANY OF THESE SYMPTOMS IN LAST THREE MONTHS? (check all that apply):
If none, please check this box

- | | | | |
|----------------|------------------------|-------------------------|---|
| 1) GU | ___ painful urination | ___ blood in urine | ___ prostate problems |
| 2) HEM | ___ easy bleeding | ___ easy bruising | ___ anemia |
| 3) SKIN | ___ frequent rashes | ___ skin ulcers | ___ lumps ___ psoriasis |
| 4) NEU | ___ headaches | ___ dizziness | ___ seizures ___ motor/sensory problems |
| 5) ENDO | ___ excessive sweating | ___ excessive thirst | ___ heat/cold intolerance |
| 6) PSY | ___ depression | ___ anxiety | ___ drug/alcohol addiction |
| 7) CON | ___ weight loss/gain | ___ loss of appetite | |
| 8) EYE | ___ blurred vision | ___ double vision | ___ vision loss |
| 9) ENT | ___ hearing loss | ___ hoarseness | ___ trouble swallowing |
| 10) RS | ___ chronic cough | ___ shortness of breath | ___ chronic bronchitis |
| 11) CV | ___ chest pain | ___ irregular heartbeat | |
| 12) GI | ___ heartburn | ___ nausea/vomiting | ___ blood in stool |



SURGICAL HISTORY:

Procedure

Year

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Do you smoke? Yes ___ No ___ ___ packs/day Chew tobacco? Yes ___ No ___ ___ cans/day

Do you drink alcohol? Yes ___ No ___ ___ drinks/week

Are you in school? Yes ___ No ___ Where? _____

Do you work outside the home? Yes ___ No ___ Where? _____
(Part-time ___ Full-time ___)

FAMILY HISTORY:

Have any immediate family members had any of the following disorders? If so, list relative.

Diabetes _____ Hypertension _____ Cancer _____ Heart disease _____ Rheumatoid Arthritis _____

ALLERGIES:

Latex? Yes ___ No ___ Other: _____

CURRENT MEDICATIONS:

MG/MCG

FREQUENCY

REASON FOR TAKING

<u>CURRENT MEDICATIONS:</u>	MG/MCG	FREQUENCY	REASON FOR TAKING
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient signature: _____

Date: _____



ACCIDENT REPORT

1) Patient's Name/Address: _____

2) When (DATE and TIME) did the accident happen? _____

3) Where did the accident happen? Auto _____ Your Home _____ School _____
Work _____ Other (Describe) _____

4) What happened? Describe accident: _____

5) Is there any other insurance involved- i.e., Home Owner's, Auto, Workmen's Compensation,
School Athletics, etc? If so, please complete the following:

Name of Insurance Company _____

Agent's Name or Contact Person _____

Insured Party _____

Insurance Company Address _____

Signature

Date Signed