PATIENT REGISTRATION FORM
(Complete All Pages)

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

STREET OR BOX NO. ______________________________ Communication Preference

CITY ______________ STATE ________ ZIP CODE ___________ E-mail Text message Phone

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)

Norris, Blessinger & Woebkenberg
Orthopaedics & Spine

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 & WOEBKENGERG 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 __________________________________

Norris, Blessinger & Woebkenberg
Orthopaedics & Spine

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	

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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**
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________
______________________	_______	__________	_________________

Patient signature: ______________________________________ **Date:** ____________

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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 compete the following:

Name of Insurance Company ____

Agent's Name or Contact Person ______________________________________

Insured Party ____

Insurance Company Address ____

____

______________________________ Signature

_____________ Date Signed