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 Jansen, 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 Jansen, 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 Jansen, 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 Jansen, 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

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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/INJURY REPORT

1) Patient's Name/Adress: ____

____

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