

Dear Patient,

Attached you will find an important health history questionnaire that we are asking you to complete. This information is an integral part of your examination today, and the form will be scanned into your electronic medical record. Please fill in each circle completely as shown in the following example:

Correct:

Do you smoke? Yes No

Incorrect:

Do you smoke? Yes No

Do you smoke? Yes No

Thank you for taking the time to fill this questionnaire, and for allowing us to participate in your care.

Sincerely,

Total Joint Replacement Service

TOTAL JOINT REPLACEMENT SERVICES – REVIEW OF SYSTEMS

NAME:

DATE:

Do you experience any of the following?

- | | | |
|-------------------------------------|---------------------------|--------------------------|
| Change in Body Weight? | <input type="radio"/> Yes | <input type="radio"/> No |
| Appetite Loss? | <input type="radio"/> Yes | <input type="radio"/> No |
| Fevers? | <input type="radio"/> Yes | <input type="radio"/> No |
| Weakness? | <input type="radio"/> Yes | <input type="radio"/> No |
| Night Sweats? | <input type="radio"/> Yes | <input type="radio"/> No |
| Fatigue? | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Stiffness? | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Pain? | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Swelling? | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint Redness? | <input type="radio"/> Yes | <input type="radio"/> No |
| Back Pain? | <input type="radio"/> Yes | <input type="radio"/> No |
| Dry Mouth? | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty Swallowing? | <input type="radio"/> Yes | <input type="radio"/> No |
| ringing in Ears? | <input type="radio"/> Yes | <input type="radio"/> No |
| Diminished Vision? | <input type="radio"/> Yes | <input type="radio"/> No |
| Red Eyes? | <input type="radio"/> Yes | <input type="radio"/> No |
| Seasonal Eye Symptoms? | <input type="radio"/> Yes | <input type="radio"/> No |
| Shortness of Breath? | <input type="radio"/> Yes | <input type="radio"/> No |
| Chest Pain? | <input type="radio"/> Yes | <input type="radio"/> No |
| Cough? | <input type="radio"/> Yes | <input type="radio"/> No |
| Chest Pain? | <input type="radio"/> Yes | <input type="radio"/> No |
| Palpitations? | <input type="radio"/> Yes | <input type="radio"/> No |
| Leg Swelling? | <input type="radio"/> Yes | <input type="radio"/> No |
| Heartburn? | <input type="radio"/> Yes | <input type="radio"/> No |
| Blood in Stool? | <input type="radio"/> Yes | <input type="radio"/> No |
| Diarrhea? | <input type="radio"/> Yes | <input type="radio"/> No |
| Rash? | <input type="radio"/> Yes | <input type="radio"/> No |
| Hives? | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty Healing? | <input type="radio"/> Yes | <input type="radio"/> No |
| Paralysis? | <input type="radio"/> Yes | <input type="radio"/> No |
| Tingling Numbness? | <input type="radio"/> Yes | <input type="radio"/> No |
| Difficulty Balancing While Walking? | <input type="radio"/> Yes | <input type="radio"/> No |
| Tremors? | <input type="radio"/> Yes | <input type="radio"/> No |
| Painful Urination? | <input type="radio"/> Yes | <input type="radio"/> No |
| Frequent Urination? | <input type="radio"/> Yes | <input type="radio"/> No |
| Urinary Incontinence? | <input type="radio"/> Yes | <input type="radio"/> No |
| Recurrent Urinary Tract Infections? | <input type="radio"/> Yes | <input type="radio"/> No |
| Fatigue? | <input type="radio"/> Yes | <input type="radio"/> No |
| Excessive Sweating? | <input type="radio"/> Yes | <input type="radio"/> No |
| Excessive Thirst? | <input type="radio"/> Yes | <input type="radio"/> No |
| Excessive Urination? | <input type="radio"/> Yes | <input type="radio"/> No |
| Sensitivity to the Cold? | <input type="radio"/> Yes | <input type="radio"/> No |
| Swollen Glands? | <input type="radio"/> Yes | <input type="radio"/> No |
| Depression? | <input type="radio"/> Yes | <input type="radio"/> No |
| Sleep Disturbances? | <input type="radio"/> Yes | <input type="radio"/> No |
| Panic Attacks? | <input type="radio"/> Yes | <input type="radio"/> No |
| Itchy Eyes? | <input type="radio"/> Yes | <input type="radio"/> No |
| Ear Fullness? | <input type="radio"/> Yes | <input type="radio"/> No |
| Sinus Congestion? | <input type="radio"/> Yes | <input type="radio"/> No |

Patient Registration Form 2010

Please PRINT

Total Joint Replacement Services



Today's Date:

PATIENT INFORMATION

Last Name		First Name		Middle Initial	
Date of Birth		Social Security Number		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Life Partner <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other		Language other than English			
Race (optional) <input type="checkbox"/> Black - Non Hispanic <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian / Pacific Islander <input type="checkbox"/> White - Non Hispanic <input type="checkbox"/> Other					
Home Address		Apt #	City	State	Zip Code
Home Phone		Work Phone		Other Phone	<input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Fax
Email Address		Employment <input type="checkbox"/> Active Military <input type="checkbox"/> Full-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Child/Dependant <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other			
Employer		Address		Phone	

REFERRAL INFORMATION

Primary Care Physician		Referring Physician			
How did you hear about us?		<input type="checkbox"/> Newsday <input type="checkbox"/> LI Advance <input type="checkbox"/> Suffolk Life <input type="checkbox"/> Other Print Ad	<input type="checkbox"/> Radio - WALK <input type="checkbox"/> Radio - B103 <input type="checkbox"/> Radio - KJOY <input type="checkbox"/> Radio - 94.3	<input type="checkbox"/> Radio - AM1100 <input type="checkbox"/> Friend/Relative <input type="checkbox"/> Other	

INSURANCE INFORMATION

Primary Insurance Plan Name		Secondary Insurance Name			
Address		Address			
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
Insured Name		Insured Name			
Insured Date of Birth		Insured Date of Birth			
Identification Number		Identification Number			
Group Name / Number		Group Name / Number			
Effective Date		Specialist Co-Pay	Effective Date		Specialist Co-Pay
Is Your Condition Related To		<input type="checkbox"/> Employment	<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Other Accident	<input type="checkbox"/> Accident Date
Workers Comp / No Fault Carrier Information					

EMERGENCY CONTACT INFORMATION

Last Name		First Name		Relationship to Patient	
Address		Home Phone		Other Phone <input type="checkbox"/> Cell <input type="checkbox"/> Pager	

SIGNATURE:

DATE:

FINANCIAL POLICY

Although we participate in most insurance plans, your insurance company may not cover every service provided by this office. In addition, it is impossible for the physicians and office staff at Total Joint Replacement Services, PC to know the individual rules and regulations of each plan.

It is the **PATIENT'S RESPONSIBILITY** to know the limits and requirements of their individual health insurance plan. (Eg. Referral requirements, copay obligations, coinsurance obligations, etc.) Please contact your insurance carrier directly if you have any questions regarding your coverage.

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN, IT IS YOUR RESPONSIBILITY TO PRESENT TO YOUR APPOINTMENT WITH TOTAL JOINT REPLACEMENT SERVICES, PC WITH A VALID, UNEXPIRED REFERRAL. IF YOU ARE RETURNING FOR A FOLLOW-UP OR POST OPERATIVE EXAMINATION PLEASE CHECK WITH THE FRONT DESK TO SEE IF YOU WILL NEED A REFERRAL. YOU WILL BE RESPONSIBLE FOR ALL SERVICES NOT COVERED BY YOUR INSURANCE.

All copayments are expected at the time of service, unless advance arrangements have been made with the office manager. Any coinsurance or deductible responsibility will be billed after your insurance carrier processes our claim. *A \$25 fee will be charged for all returned checks.*

I have read and agree to the preceding information.

SIGNATURE:

DATE

SIGNATURE ON FILE

Signature of patient or authorized person.

I authorize the release of medical information necessary to report claim(s) to my insurance plan(s).

A copy of this signature is valid as the original.

SIGNATURE:

DATE

Signature of insured or authorized person to ASSIGN BENEFITS OTHERWISE PAYABLE TO THE INSURED DIRECTLY TO THE PROVIDER INDICATED ON THE CLAIM(S).

A copy of this signature is valid as the original.

SIGNATURE:

DATE:

TO BE COMPLETED BY PATIENTS COVERED BY MEDICARE and/or those with a Medigap

Name of Beneficiary:

I request that payment of authorized Medicare benefits be made on my behalf to Total Joint Replacement Services, PC for any services furnished to me by the providers therein. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents, to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named provider(s) any information regarding my Medicare claims under Title XVIII of the Social Security Act.

SIGNATURE:

DATE:

I request that payment of authorized Medigap benefits be made on my behalf to Total Joint Replacement Services, PC for any services furnished to me by the providers therein. I authorize any holder of medical information about me to release to my Medigap plan any information needed to determine these benefits or the benefits payable for related services

SIGNATURE:

DATE: