REGISTRATION INFORMATION

Date: _____ (PLEASE PRINT) Home Phone: (____) _____

Patient: _____ Cell Phone: (____) _____
Last Name First Name Middle Initial

Responsible Party (if a minor): _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____

Employer/School Address: _____

Occupation: _____ Employer/School Phone: (____) _____

Spouse (or responsible party) Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: (____) _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer: _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any): _____

Contract # _____ Group # _____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your number: _____ County of: _____

I prefer to: ☐ Pay my balance in full at time of service. ☐ Pay my balance in full upon receipt of first statement.

☐ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: (____) _____

Your Drugstore Name: _____ Phone: (____) _____

How did you learn of our practice? _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

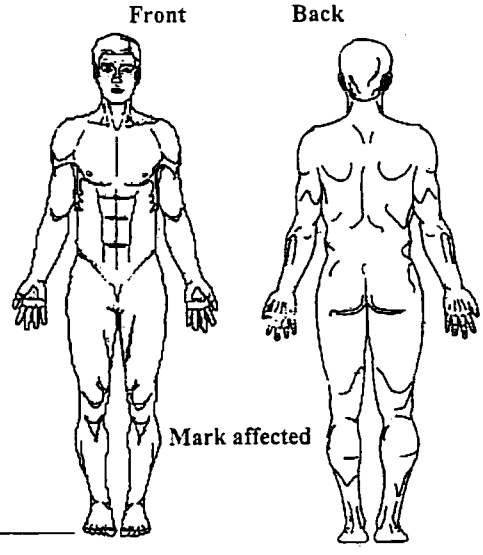
_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Name _____ Age_____
Please fill in all information which applies to you and please check appropriate box(s)

Occupation: _____ Right handed ☐ Left handed ☐
My problem began on: _____ (closet date/year)
Type of injury/problem
☐ Work related ☐ Injury at home ☐ Slip/fall
☐ Motor Vehicle ☐ Sports injury ☐ Arthritis
☐ Other: _____

Treatment for my problem/injury has included:
☐ Medication ☐ Physical Therapy ☐ Home/Gym exercise
☐ Other Physician ☐ Chiropractor ☐ Injections

Work Status:
☐ Part Time ☐ not working ☐ Light Duty
Have you been seen in the Emergency Room? ☐ Yes ☐ No
Which Hospital_____



Diagnostic tests already performed for this problem/injury:
☐ X-Rays ☐ MRI ☐ CT scan ☐ Nerve Test ☐ Bone Scan ☐ other _____

Medication Allergies ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other _____

Past Medical History: ☐ None

☐ Asthma	☐ Cancer	☐ Bleeding Disorder	☐ Diabetes
☐ Heart disease	☐ Hepatitis	☐ Thyroid Disease	☐ HIV/Aids
☐ Glaucoma	☐ Stroke	☐ Nerve Disease	☐ Lung Disease
☐ Ulcers	☐ High Cholesterol		☐ Tuberculosis
☐ Hypertension	☐ other _____		☐ Migraines
☐ Osteoporosis			

Past Surgical History: ☐ None

☐ Gastrointestinal	☐ Tonsils	☐ Gynecological
☐ Joint replacement	☐ Ear/tubes	☐ Cancer
☐ Hernia	☐ Arthroscopy	☐ Heart
☐ Cataracts'	☐ Hand	☐ Neck/back
☐ Appendectomy	☐ Gall bladder	☐ other _____

Current Medications:
_____
_____
_____

Please check the box if you have any of the following symptoms
☐ bleeding ☐ swelling ☐ Memory loss ☐ ringing in the ears
☐ Incontinence ☐ Blood in stool/urine ☐ Headaches ☐ Chest pain
☐ Palpitations ☐ Cough ☐ Dizziness ☐ Nausea/vomiting
☐ Easy Bruising ☐ Numbness/tingling ☐ Shortness of breathe

Smoker: ☐ Yes ☐ No Do you Drink Alcohol ☐ Yes ☐ No History of substance abuse ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No Date of last menstrual period _____

If you were in a Motor Vehicle Accident Please answer the following questions
☐ Driver ☐ Passenger front ☐ Passenger Back ☐ Pedestrian
Direction of impact ☐ Front end ☐ Rear end ☐ Passenger side ☐ Driver side
Did your head hit ☐ Dashboard ☐ Windshield?
Loss of conciseness ☐ Yes ☐ No Air bag deployment ☐ Yes ☐ No

Please list any previous accident(s) injuries or any pertinent medical/family history:

_____

Signature _____ Date _____

ANDREW S. ELLOWITZ, M.D.
ORTHOPAEDIC SURGERY

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the Treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered Medically necessary or advisable based on the judgment of the attending physician Or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature, even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Andrew S. Ellowitz, M.D.** may include consent at satellite offices under common ownership.

I, the undersigned, authorized **Andrew S. Ellowitz, M.D.** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorized to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Andrew S. Ellowitz, M.D.**

I acknowledge that I have been given the **Andrew S. Ellowitz, M.D.** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official. Patient Initial:_____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient (or Responsible Party) Signature *Date*

HIPPA PRIVACY

Acknowledgement Of Receipt of Notice Of Privacy Practices

I, _____(Print full legal name here; the Patient or " Patients Legal Representative") have been provided with the Notice of Privacy Policy (the Policy") of this provider and have been offered a copy of such policy to keep for my records.

_____ (Initial Here) I hereby acknowledge that I have been provided with a copy of the Policy.

_____(Initial Here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, provider may still provide treatment to me.

_____

signature of patient date

Refused to Sign Notice Of Privacy Practice

Reason:_____

_____

_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____, M.D. to furnish medical information concerning _____ (patient) to _____

_____

_____(name and address of person to receive records).

Any and all information may be released, including but not limited to mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below: _____

_____

_____

_____

The information may be used only for the following purposes:*_____

_____

_____

_____

_____

This authorization is effective now and will remain in effect until_____ (date).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

[ ] parent or guardian of minor patient (to the extent minor could not have consented to the care)
[ ] guardian or conservator of an incompetent patient
[ ] beneficiary or personal representative of deceased patient **
[ ] spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

*Signed: _____ Dated: _____
Treating Physician

** For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both patient's treating physician and the patient sign the authorization form before information may be released.*

*** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*