



717 S State St., Suite 900
Fairmont, MN 56031
1-507-238-4949

Patient Registration Form

Today's Date _____

Last Name _____ First _____ MI _____ Home # _____

Address _____ Work # _____

City _____ State _____ Zip _____ Cell # _____

Date of Birth _____ Are you a full time student? Y N Soc. Sec. # _____

Female Male Marital Status: Single / Married / Divorced / Widowed E-mail Address _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse (Guardian) _____ Employer _____

Work Phone # _____ Date of Birth _____ Soc. Sec # _____

Emergency Contact _____ Relationship to Patient _____ Phone # _____



SECTION #1 INSURANCE INFORMATION

Primary Health Insurance Company _____

Secondary Health Insurance Company _____

Policy / ID # _____ Group # _____

Policy / ID # _____ Group # _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Name of Insured _____ Insured Date of Birth _____

Name of Insured _____ Insured Date of Birth _____

Insured Soc Sec # _____ Insured Employer _____

Insured Soc Sec # _____ Insured Employer _____



SECTION #2 WORKERS COMPENSATION INJURY /
WC Insurance Information

SECTION #3 PERSONAL INJURY :
Motor Vehicle / Liability (Circle One)

Date of Injury _____ Claim # _____

Date of Injury _____ Claim # _____

Insurance Company Name _____

Insurance Name _____

Address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Phone # _____ Attorney _____

Contact Person _____

Insurance Adjuster Name _____



Center for Specialty Care

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge the receipt of the Notice of Privacy Practices, on the date set forth below. I understand that this Notice of Privacy Practices contains important information about my health information and that I should review the Notice of Privacy Practices.

If I have any questions or complaints, I understand that I may contact the Privacy Official at 1-507-238-4949, or at the address listed below.

Dated: _____, 20__

By: _____
Patient

Account #: _____

OR

By: _____
(Patient's Legal Representative)

**Center for Specialty Care
Attn: Privacy Official
717 South State Street
Suite 900
Fairmont, MN 56031
1-507-238-4949**



**Center for Specialty Care
Patient History**

717 S State St., Suite 900

Fairmont, MN 56031

1-507-238-4949

Today's Date: _____

Primary Physician: _____

Patient Name _____
DOB _____
MR# _____

Sex
M F

Referred by: _____

Latex Allergy Yes No Nickel Allergy Yes No
Allergies: _____

Personal & Family Medical History

| Key: (please circle) Description | Yes / No | | Mother, Father Sibling, Child | | | |
|--------------------------------------|----------|---|----------------------------------|---|---|---|
| | Personal | | Family | | | |
| Arthritis or Gout | Y | N | M | F | S | C |
| Bleeding disorders / clotting | Y | N | M | F | S | C |
| Cancer: Breast | Y | N | M | F | S | C |
| Colon | Y | N | M | F | S | C |
| Prostate | Y | N | M | F | S | C |
| Other | Y | N | M | F | S | C |
| Diabetes I/II | Y | N | M | F | S | C |
| Fractures | Y | N | M | F | S | C |
| Osteoporosis | Y | N | M | F | S | C |
| Thyroid Disease | Y | N | M | F | S | C |
| <hr/> | | | | | | |
| Anemia / Blood diseases | Y | N | M | F | S | C |
| Asthma, emphysema | Y | N | M | F | S | C |
| Colonoscopy / Date of last exam: | | | | | | |
| Colon polyps | Y | N | M | F | S | C |
| Depression / nervous problem | Y | N | M | F | S | C |
| Drug / Alcohol problems | Y | N | M | F | S | C |
| Epilepsy or seizures | Y | N | M | F | S | C |
| Gallbladder | Y | N | M | F | S | C |
| Hearing Problems | Y | N | M | F | S | C |
| Heart disease / Circulatory problems | Y | N | M | F | S | C |
| Hepatitis or liver problems | Y | N | M | F | S | C |
| High blood pressure | Y | N | M | F | S | C |
| High Cholesterol | Y | N | M | F | S | C |
| HIV / AIDS / STDs | Y | N | M | F | S | C |
| Kidney stones / Cysts / Failure | Y | N | M | F | S | C |
| Migraine headaches | Y | N | M | F | S | C |
| Pneumonia, bronchitis | Y | N | M | F | S | C |
| Sleep Apnea | Y | N | M | F | S | C |
| Stroke | Y | N | M | F | S | C |
| Tuberculosis | Y | N | M | F | S | C |

Medications:
• _____
• _____
• _____
• _____
• _____
• _____
• _____
• _____

Social History
Marital Status: Single / Married / Divorced / Widowed
Occupation (past / present) _____

Drugs
Use of Recreational Drugs = Do you use Y N
Substances Used: _____

Tobacco = Do you smoke or chew Y N
• # of Packs or Cans per day _____
• For how many years _____
• Date Quit _____
• Do you live with a smoker Y N

Alcoholic Beverages = Do you consume Y N
• How many drinks per week _____

Caffeinated Beverages = Do you consume Y N
• Cups of coffee per day _____
• Pop / Tea per day _____

Are you afraid of anyone at home? Y N

Past Surgical History / Hospitalizations (include associated complications) None

Anesthesia Complications Yes No

| Surgery / Hospitalization | Approx. Date | Facility | Surgery / Hospitalization | Approx. Date | Facility |
|---------------------------|--------------|----------|---------------------------|--------------|----------|
| 1 | | | 6 | | |
| 2 | | | 7 | | |
| 3 | | | 8 | | |
| 4 | | | 9 | | |
| 5 | | | 10 | | |

Signature of Person Completing Form

Relationship to Patient

Today's Date



FINANCIAL POLICY



Thank you for choosing Center for Specialty Care for your medical needs. We are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our Financial Policy or your responsibility.

REGARDING INSURANCE

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are NOT a party to this contract. We will file insurance claims to your Primary Insurance carrier if all necessary information is made available. It is your responsibility to provide our office with the most current insurance information at every visit. For new patients, we require a picture identification card for identity theft purposes. We WILL NOT become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than supply factual information as necessary. You are responsible for the items above as well as any services considered "not medically necessary" by your insurance company. The remaining balance determined as patient responsibility will be paid immediately upon notice from insurance company. If payment cannot be **made in full** after insurance has processed, the Billing Department will assist you in making other payment arrangements.

A PAYMENT IS DUE AT THE TIME OF SERVICE

You will be responsible for any co-payments, deductibles, and/or coinsurance amounts. (There is no co-pay for Medicare.) If payment cannot be made at each visit, notify the Billing Department to make other arrangements. We accept payment by check, cash, Visa, and Mastercard.. We also offer CareCredit payment plans for qualifying individuals.

PATIENTS WITHOUT INSURANCE (PRIVATE PAY)

Full payment is due at the time of service. We offer a 15% prompt pay discount if payment is made at time of service for clinic visits. For surgeries scheduled at South Central Surgical Center, the prompt pay discount will be given if payment is received prior to surgery. If payment cannot be made at each visit, the Billing Department will assist you in making other payment arrangements.

WORKER'S COMPENSATION

All necessary information must be provided to file your claim or you will be responsible for PAYMENT IN FULL. If your claim is denied by Worker's Compensation, YOU are responsible for PAYMENT IN FULL.

LIABILITY, MVA & PERSONAL INJURY

If you are a personal injury patient, you must provide our office with the appropriate billing information to send claims. If we are unable to obtain payment, the charges for the services rendered will be YOUR responsibility. Our office WILL NOT become involved in disputes arising from personal injury, MVA or liability claims. All bills will be sent directly to you. It is your responsibility to forward them to your attorney if you wish. Financial responsibility ALWAYS rests with the patient.

MINORS

The adult who signs as the "Financially Responsible Party" is responsible for payment of services rendered. Our office WILL NOT become involved in disputes between divorced parents.

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to Fairmont Orthopedics & Sports Medicine, P.A. for medical/professional services rendered. I further authorize the release of any medical information necessary for billing, treatment or healthcare operations. I agree to pay, in current manner, any balance of said professional service charges over and above this insurance payment. We require a minimum monthly payment on patient balances.

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Fairmont Orthopedics & Sports Medicine, P.A., for any services furnished by that physician/provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits or the benefits payable for related services.

For services performed, you may receive separate billing statements for anesthesia services, physician charges, x-ray and facility services.

If you have questions on your account, you may contact our billing department at 888-974-6636.

Financially Responsible Party _____ Date _____



Center for Specialty Care Review of Systems

717 S State St., Suite 900
Fairmont, MN 56031

Name _____

MR# _____

DOB _____

KEY: Place an **X** in the box if it **applies** to You

CONSTITUTIONAL

- Fatigue
- Fever / Chills
- Night sweats
- Abnormal weight gain or loss
- Other: _____

MUSCULOSKELETAL

- Joint pains / stiffness
- Joint swelling
- Back pain
- Disc disease
- Deformities
- Problems walking
- Other: _____

SKIN

- Skin lesions
- Change in moles
- Skin rash
- Nail problems
- Other: _____

NEUROLOGIC

- Seizure disorder
- Fainting / blackouts
- Paralysis
- History of stroke (CVA)
- Headaches
- Memory problems
- Weakness
- Numbness/ tingling
- Speech difficulties
- Other: _____

CARDIOVASCULAR

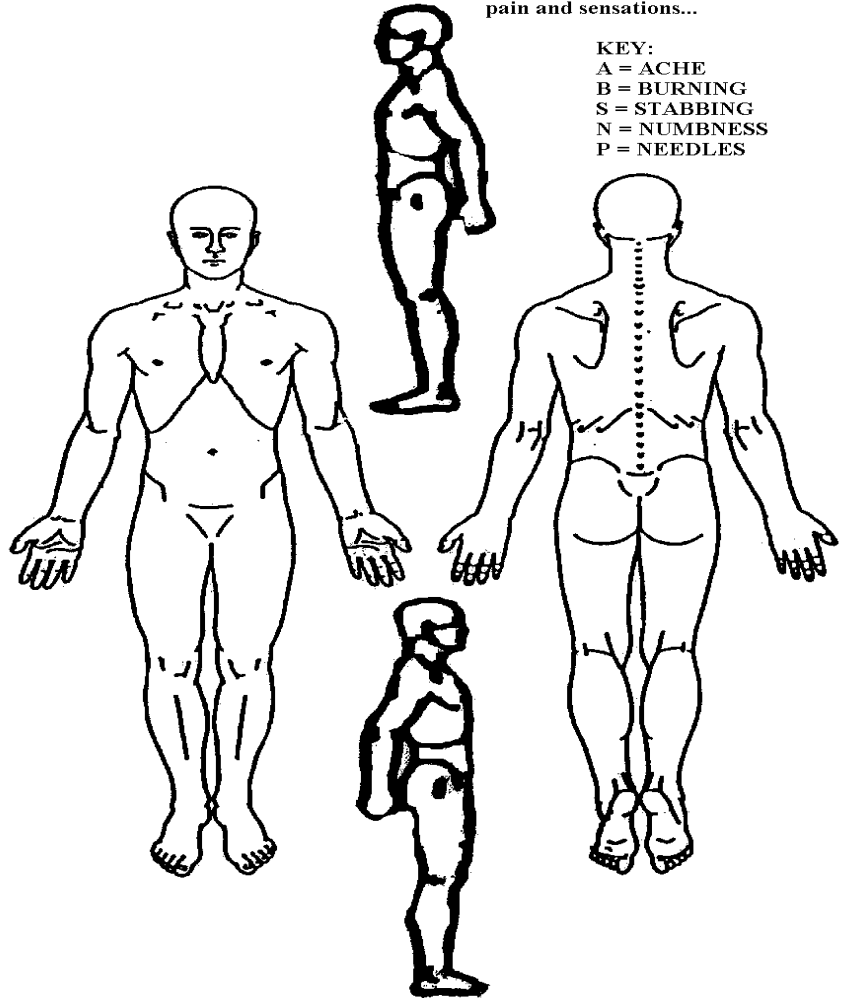
- Chest tightness, pressure or pain
- Swelling in your feet or legs
- Sleep on more than one pillow
- Awaken at night unable to get your breath
- Palpitations
- Rapid or irregular heartbeat
- Light headedness
- History of a heart murmur
- Leg cramps when walking
- Other: _____

ENDOCRINE

- Difficulty tolerating heat or cold
- Recent change in skin or hair
- Goiter
- Excessive Thirst
- Excessive Appetite
- Excessive Urination
- Other: _____

Use the letters listed below to indicate the TYPE and LOCATION of your pain and sensations...

KEY:
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = NEEDLES





Center for Specialty Care

Review of Systems

717 S State St., Suite 900
Fairmont, MN 56031

RESPIRATORY

- Frequent / chronic cough
- Cough up sputum or phlegm
- Cough up blood
- Shortness of breath
- Wheezing
- Excessive snoring
- Pain

Other: _____

EYES

- Glaucoma
- Cataracts
- Corrective lenses / Contacts
- Itchy / watery eyes
- Blurred or double vision
- Eye pain
- Excessive tearing
- Redness / Swelling
- Discharge

Other: _____

ENT

- Earache
- Draining ears
- Loss of hearing
- Vertigo
- Ringing in your ears
- Hearing aids
- Runny nose
- Nose Bleeds
- Change in sense of smell
- Sinus infections
- Sore throat
- Dentures
- Sores in mouth
- Swallowing difficulties
- Hoarseness / Voice change
- Altered taste

Other: _____

Patient Signature

Today's Date

Review of Systems 81106cr

GASTROINTESTINAL

- Loss of appetite
- Food intolerance
- Rectal Bleeding
- Heartburn or indigestion
- Nausea
- Vomiting
- Describe color of Vomit

- Diarrhea
- Constipation
- Hemorrhoids
- Black & tarry stools
- Difficulty swallowing
- Use of laxatives

Other: _____

HEMATOLOGIC / LYMPHATIC

- Easy bruising
- Anemia
- Blood transfusion
- Swollen lymph glands
- Bleeding tendencies

Other: _____

ALLERGIC / IMMUNOLOGICAL

- Hives
- Removal of spleen
- Use of Prednisone or steroids

Other: _____

PSYCHIATRIC

- Depression
- Anxiety
- Mood changes
- Suicidal thoughts
- Difficulty sleeping

Other: _____

GENITOURINARY

- Blood in urine
- Pain / Burning with urination
- Frequent urination at night
- Incontinence / Bladder control
- Urinary tract infections
- Enuresis (bed wetting)

Other: _____

MEN ONLY

- Difficulty with erection
- Dribbling of urine
- Decreased urine stream size
- Difficulty starting urination
- Prostate disease

Other: _____

WOMEN ONLY

- Change in periods
- Hot flashes
- Vaginal itching / discharge
- Pregnant

Method of birth control

Other: _____

BREAST

- Nipple discharge
- Pain
- Lumps or swelling
- Monthly Self Breast Exam

Other: _____
