



Center for Specialty Care
Patient Registration Form

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

Todays 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
Policy / ID # Group #
Address
City State Zip
Name of Insured Insured Date of Birth
Insured Soc Sec # Insured Employer

Secondary Health Insurance Company
Policy / ID # Group #
Address
City State Zip
Name of Insured Insured Date of Birth
Insured Soc Sec # Insured Employer

SECTION #2 WORKERS COMPENSATION INJURY / WC Insurance Information

Date of Injury Claim #
Insurance Company Name
Address
City State Zip
Phone # Fax #
Contact Person

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

Date of Injury Claim #
Insurance Name
Address
City State Zip
Phone # Attorney
Insurance Adjuster Name
Phone # Fax #



Center for Specialty Care Patient History

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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



Center for Specialty Care Review of Systems

717 S State St., Suite 900
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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

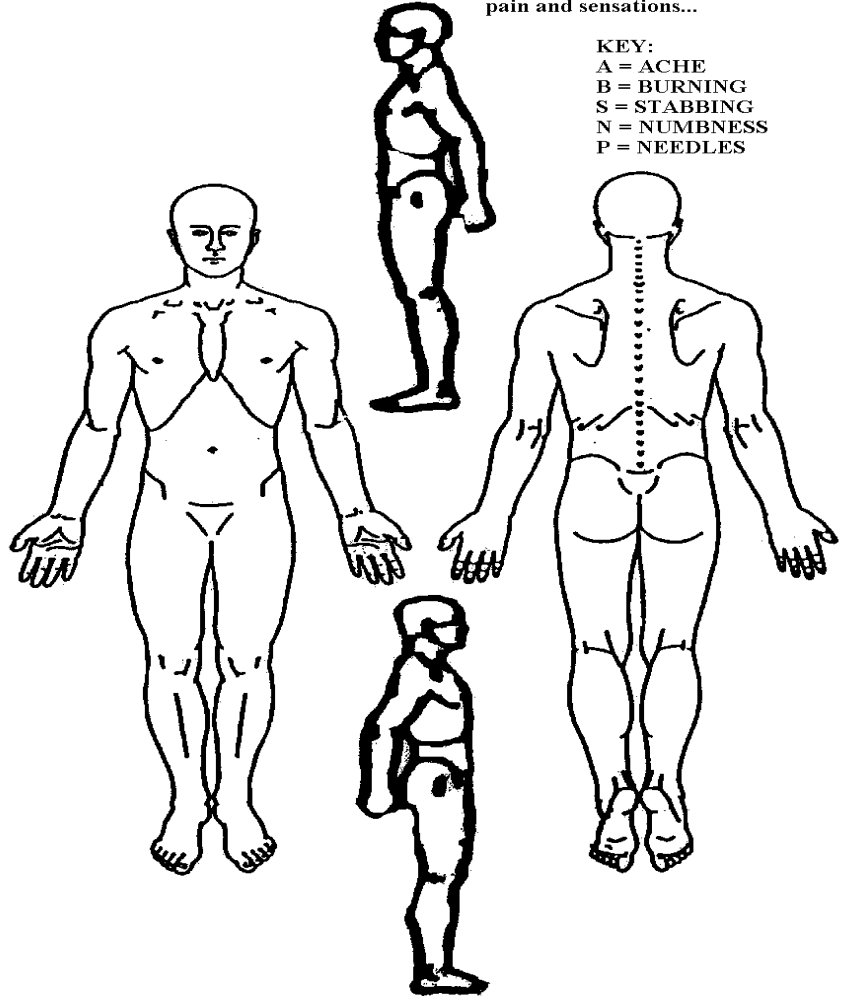
- Chest tightness, pressure or pain
- Swelling in your feet or legs
- Sleep on more than one pillow
- Awaken at night unable to get your breath
- Palpitations
- Rapid or irregular heartbeat
- Light headedness
- History of a heart murmur
- Leg cramps when walking
- Other: _____

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

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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: _____

GASTROINTESTINAL

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

Other: _____

- 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: _____

Patient Signature _____

Today's Date _____



FINANCIAL POLICY



Patient Name: _____ **DOB:** _____

Thank you for choosing Center for Specialty Care for your orthopedic care! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship.

We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to speak to a Patient Service Representative in our Billing Office at 507-238-4949, Option 4.

Payment is Due At the Time of Service

- We accept payment by cash, check, Visa, Mastercard and Discover. We also offer CareCredit financing for qualifying individuals.
- _____ • All deductibles and non-covered services are due at the time of service.
- _____ • Co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of \$25.00 for co-payments not paid at the time of check in.
- _____ • If you have an outstanding Patient Due Balance, this amount is due when you check in for your appointment.
- _____ • In the event you need surgery and you do not have health insurance coverage, we must receive a payment of no less than 50% of the estimated doctor's fees before we will schedule the surgery. In addition, if you are scheduled to have surgery at South Central Surgical Center, we must receive a payment of no less than 50% of the estimated fees by the day of the surgery.
- _____ • We request that at least **24 hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. All cancellations with less than 24 hours notice and "no-shows" will be billed a \$25.00 administrative fee. Patients who repeatedly "no show" for appointments may be discharged from the practice.
- _____ • Patients with no verifiable insurance coverage are required to pay \$100.00 at the time of service.

Proof of Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party - auto insurance, liability insurance company, worker's compensation – instead of your regular health insurance carrier. You are responsible to provide the office with all information required to bill the third party when you check in for your appointment.
- We will bill benefit-assigned claims to both the third party and your health insurance carrier for all services provided by our office at the same time. However, you are ultimately responsible for payment for any charges incurred.
- _____ • It is your responsibility to notify the practice of changes in your health insurance.

Self-Pay Accounts

- _____ • We designate accounts, **Self-Pay**, under the following circumstances: (1) patient is covered by an insurance plan that our physicians do not participate in, (2) patient does not have a current, valid insurance card on file, (3) patient does not have a valid insurance referral on file, or (4) patient does not have health insurance coverage, (5) patient does not provide information for motor vehicle accident, liability claims, or worker's compensation at time of service

FINANCIAL POLICY

Referrals

- _____ • If you have an HMO plan we are contracted with, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled or asked to pay for the visit in advance.

Our Responsibility to Report Non-Compliance

- _____ • It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments/deductibles at time of service, or who repeatedly “no show” for appointments.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient’s services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is self-pay, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (*e.g., percentage of financial responsibility*).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Billing and Payments

- _____ • All balances are due in full within 30 days of the statement date.
- _____ • If you cannot pay the balance in full within 30 days, please contact Billing at 507-238-4949 Option 4. Failure to contact us within the 30 day period will result in further collection efforts including submission of the claim(s) to a collection agency.
- _____ • It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.

We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

_____ I have read, understand, and agree to the above Financial Policy.

_____ I authorize my insurance benefits be paid directly to Fairmont Orthopedics & Sports Medicine and/or South Central Surgical Center LLC.

_____ I authorize Center for Specialty Care, through its appropriate personnel, to perform or have performed upon me appropriate assessment and treatment procedures.

_____ I authorize Center for Specialty Care to release to appropriate agencies, any information acquired in the course of my or the above named patient’s examination and treatment.

X Patient/ _____ Date _____
Guarantor Signature

Acknowledgement of Center for Specialty Care Notice of Privacy Practices

I hereby acknowledge that I have reviewed or received or have been given the opportunity to receive a copy of Center for Specialty Care Notice of Privacy Practices.

X Patient Signature _____ Date _____