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Patient Registration Form PLEASE PRINT

PATIENT NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 E-MAIL ADDRESS: \_\_\_\_\_  
 PATIENTS SOCIAL SECURITY#: \_\_\_\_\_  
 PHONE CELL/WORK/HOME \_\_\_\_\_  
 BIRTH DATE: \_\_\_\_\_  
 AGE: \_\_\_\_\_ SEX: MALE FEMALE  
 OCCUPATION: \_\_\_\_\_  
 EMPLOYER AND CITY: \_\_\_\_\_  
 SPOUSE OR ALTERNATIVE CONTACT  
 (NAME/PHONE/CITY): \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)  
 RESPONSIBLE PARTY: \_\_\_\_\_ RELATIONSHIP TO  
 PATIENT: \_\_\_\_\_  
 HOME PHONE: \_\_\_\_\_ WORK: \_\_\_\_\_ CELL: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 EMPLOYER ADDRESS: \_\_\_\_\_

**Insurance Information**  
 Primary Insurance: \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
 Insurance Co Name : \_\_\_\_\_ Insurance Co Name: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_  
 Policy Holders SS# : \_\_\_\_\_ Policy Holders SS#: \_\_\_\_\_  
 Policy Holders DOB: \_\_\_\_\_ Policy Holder DOB: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Workman's Compensation Insurance**  
 Insurance Carrier: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Adjustor: \_\_\_\_\_ Adjustor Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_

Authorization To Release Information: I hereby authorize Advanced Knee Care, P.C. to release any information required in the course of my examination or treatment to the above stated insurance companies:  
 Signed (Patient Or Parent, If Minor) : \_\_\_\_\_  
 Date: \_\_\_\_\_

Authorization To Pay: I hereby authorize payment directly to Advanced Knee Care, P.C. for the surgical and/or medical benefits, if any otherwise payable to me for services. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection cost and reasonable fees as may be required to obtain collection of this account.  
 Signed (Patient Or Parent, If Minor) : \_\_\_\_\_  
 Date: \_\_\_\_\_

Cancellation Policy: if I am unable to keep my appointment, I will notify AKC no later than 24 hours prior to my scheduled appointment. If I fail to notify AKC, I agree to pay a \$25 cancellation penalty:  
 Signed (Patient Or Parent, If Minor) : \_\_\_\_\_  
 Date: \_\_\_\_\_

MEDICAL HISTORY for Advanced Knee Care – Dr. Tarlow  
PATIENT INFORMATION

Today's Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Patient's Name \_\_\_\_\_

Patient Age: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Referred by ? (if different) \_\_\_\_\_

DESCRIBE YOUR KNEE PROBLEM (CHIEF COMPLAINT):

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Date of Injury or onset of condition: \_\_\_\_\_

Is this Worker's Compensation? NO / YES (circle one)

ANY TREATMENT THUS FAR FOR KNEE ?

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PREVIOUS KNEE SURGERY:

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MEDICAL HISTORY (YES OR NO, SPECIFICS ON YES)

Heart Disease: NO / YES \_\_\_\_\_

Breathing Problems: NO / YES \_\_\_\_\_

Diabetes: NO / YES \_\_\_\_\_

High Blood Pressure: NO / YES \_\_\_\_\_

Cancer: NO / YES \_\_\_\_\_

Blood Clots: NO / YES \_\_\_\_\_

Stroke/Seizure: NO / YES \_\_\_\_\_

Hepatitis/AIDS: NO / YES \_\_\_\_\_

MEDICATION USAGE (Name only):

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ALLERGIES: \_\_\_\_\_

PREVIOUS HOSPITALIZATIONS / SURGERY (not knee surgery)

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PERTINENT FAMILY HISTORY:

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SOCIAL HISTORY:

(please circle) Single Married Children YES / NO

SPORTS / ACTIVITIES:

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Habits: Alcohol YES / NO Tobacco NO/ YES Street Drugs NO/ YES