



ADVANCED KNEE CARE
STEFAN D. TARLOW, M.D.

Telephone: (480)483-0393 Scheduling: (480)225-2343 Fax: (480)237-9473 tarlowknee@gmail.com

Scottsdale Location
8630 E. Via De Ventura
Suite 105
Scottsdale, AZ 85258

Uptown Phoenix Location
4440 North 36th Street
Suite 100
Phoenix, AZ 85018

Today's Date ____/____/____

Patient Registration Form - PLEASE PRINT

Patient Name: _____

Address: _____

E-Mail Address: _____

Patients Social Security #: ____/____/____

Phone: Mobile (____) _____ Other (____) _____

Birth Date: ____/____/____ Age: _____ Sex: Male Female

Occupation: _____

Employer and City: _____

Pharmacy Name/Location (online Rx): _____

Alternative Contact (Name/Phone): _____ (____) _____

Responsible Party Information (if different from above)

Responsible Party: _____

Relationship to Patient: _____

Phone: Mobile _____ Other _____

Occupation: _____

Employer Address: _____

Patient Name: _____ DOB: ____/____/____

PATIENT INFORMATION

Height ____/____ Weight _____ Ideal Weight _____

Primary Care Doctor: None or _____ Referred by: _____

DESCRIBE YOUR KNEE PROBLEM (CHIEF COMPLAINT):

Date of Injury or onset of condition: ____/____/____

ANY TREATMENT THUS FAR FOR KNEE ?

Orthopedic Exam: NO YES Physical Therapy: NO YES Ice: NO YES

Knee Injections: NO YES Knee Bracing: NO YES Heat: NO YES Rest: NO YES

Medications for Knee:

Prior Knee Surgery:

MEDICAL HISTORY (YES OR NO, SPECIFICS ON YES)

Heart Disease: NO YES

Breathing Problems: NO YES

Diabetes: NO YES

Bleeding Disorder: NO YES

High Blood Pressure: NO YES

Cancer: NO YES

Blood Clots: NO YES

Stroke/Seizure: NO YES

MRSA/Hepatitis/AIDS: NO YES

MEDICATION USAGE (Name only):

MEDICATION ALLERGY: NO / YES

PREVIOUS HOSPITALIZATIONS / SURGERY (not relating to knee)

PERTINENT FAMILY HISTORY:

Favorite Activities /SPORTS/ Job Requirements:

Habits: Alcohol NO YES

Tobacco NO YES

Recreational Drugs NO YES

Additional Information:

Patient Name: _____ DOB: ____/____/____

Insurance Information

Primary Insurance: _____

Member ID#: _____ Group #: _____

Policy Holder: Same as Patient or _____

Policy Holders SS# : Same as Patient or _____

Policy Holders DOB: Same as Patient or ____/____/____ Relationship to Patient: Self or _____

Secondary Insurance: _____

Member ID#: _____ Group #: _____

Policy Holder: Same as Patient or _____

Policy Holders SS# : Same as Patient or _____

Policy Holders DOB: Same as Patient or ____/____/____ Relationship to Patient: Self or _____

Workman's Comp Carrier: complete following 4 lines

Claim #: _____ Date of Injury: ____/____/____

Adjustor: _____

Adjustor Phone/Fax _____/_____

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:

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.

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 \$50 cancellation Fee:

_____ / ____/____

Signed (Patient or Parent, If Minor)

Date