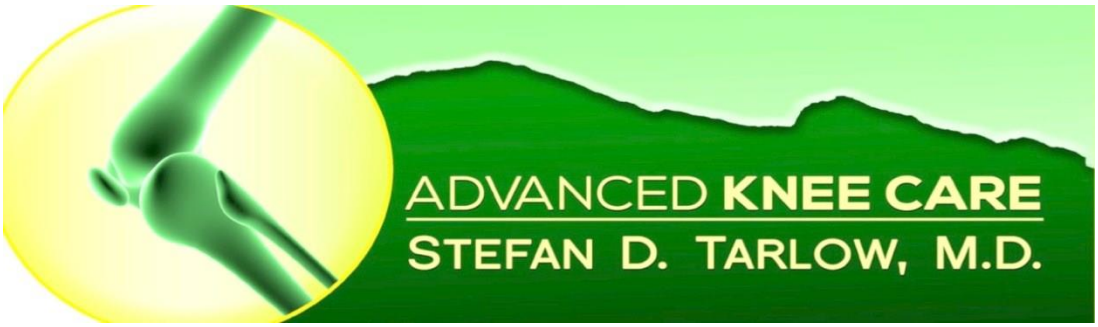

Telephone: (480)483-0393 Scheduling: (480)225-2343 Fax: (480)237-9473 tarlowknee@gmail.com

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

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