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

Advanced Knee Care, PC.

A division of Integrated Orthopedics

Stefan D. Tarlow, MD

17300 N. Perimeter Dr.
Suite 150
Scottsdale, AZ 85255

T (480) 480-0393
F (480) 237-9473
doctlow@gmail.com

Scheduling: (480)225-2343

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: ____

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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

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:

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High Blood Pressure:	☐NO	☐YES
Cancer:	☐NO	☐YES
Blood Clots:	☐NO	☐YES
Stroke/Seizure:	☐NO	☐YES

____

____

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: ______________________________________

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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