



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

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

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)

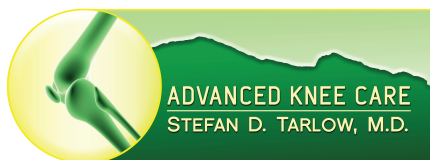
PERTINENT FAMILY HISTORY:

Favorite Activities /SPORTS/ Job Requirements:

Habits: Alcohol ☐ NO ☐ YES
Tobacco ☐ NO ☐ YES
Recreational Drugs ☐ NO ☐ YES
Additional Information:

Signed (Patient or Parent, If Minor)

Date



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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