

# Alta Orthopaedics Patient Registration

Please present your insurance card(s)

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
(Last) (First) (Middle)

Sex: Male Female Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell #: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_ Phone #: \_\_\_\_\_

Marital Status: Single Married Separated Divorced Widowed

Spouse/Parent: \_\_\_\_\_  
(Last) (First) (Middle)

Social Security #: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Alta Orthopaedics does not accept HMO patients. Additionally we are not responsible for obtaining authorizations nor are we responsible to inform you of what insurance plans we are currently accepting. Please check with your insurance carrier directly for this type of information.

**Payment Policy:** Payment is due at the time services are rendered, unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. Payment is the sole responsibility of the patient, patient's spouse, or parent of a minor.

**Patient Authorization:** I hereby authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize National Heritage Ins. Co. to release information regarding Medicare claims submitted by the named provider.

**HIPPA Notice of Privacy Practices:** We are required by law to maintain the privacy of, and provide individuals with the HIPPA Regulations of our legal duties and privacy practices with respect to health information. If you have any objections to this form, please speak with our HIPPA Compliance Officer. The patient signature acknowledges they have received this notice.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

# Alta Orthopaedics General Health Evaluation

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

What is being evaluated today? \_\_\_\_\_

Date symptoms began: \_\_\_\_\_ Dominant hand: (Please circle) Left / Right

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Maximum weight: \_\_\_\_\_

Please list your current medications: \_\_\_\_\_

Do you have any allergies to medications? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Packs per day: \_\_\_\_\_ for \_\_\_\_\_ years.

Do you drink alcohol?    None    Daily    Socially    Occasionally    Rarely

Do you have any of these conditions?    (Please circle below)

Cancer, Heart Trouble, High Blood Pressure, Rheumatic Fever, Diabetes, Arthritis, Gout,  
Difficulty Breathing (asthma/emphysema), Lung Disease, Fainting Spells, Jaundice/Hepatitis,  
Anemia/Bleeding Problems, Stomach Ulcers/Intestinal Problems, Circulation Problems

Details: \_\_\_\_\_

Has any member of your family had any of these conditions?    (Please circle below)

Cancer, Heart Trouble, High Blood Pressure, Rheumatic Fever, Diabetes, Arthritis, Gout,  
Difficulty Breathing (asthma/emphysema), Lung Disease, Fainting Spells, Jaundice/Hepatitis,  
Anemia/Bleeding Problems, Stomach Ulcers/Intestinal Problems, Circulation Problems

Details: \_\_\_\_\_

Have you ever been hospitalized or had surgery?

Date: \_\_\_\_\_ Procedure/illness: \_\_\_\_\_

Have you had any of these tests? X-Ray, MRI, CT, Bone Scan, EMG NCVS, ESI

Date: \_\_\_\_\_ Where? \_\_\_\_\_

Have you seen another Dr. for this problem? Dr. \_\_\_\_\_