Patient Information (please print) Date:_____

Patient Name (first/middle/last)	Social Security #	Date of Birth	Age	Marital Status	Male Female

Address	City/State	Zip Code	Home Phone #

Email address	Cell Phone #

Employer	Occupation

Employer Address	City/State	Zip Code	Business Phone #

The following information is required if insurance is listed with a spouse as the subscriber

Spouse's Name	Spouse's Social Security #	Spouse's Date of Birth

Spouse's Employer	Employer Address	Business Phone #

If patient is a minor or a student, please complete below

Mother's Name	Mother's Social Security #	Mother's Date of Birth

Mother's Employer	Employer's Address	Business Phone #

Father's Name	Father's Social Security #	Father's Date of Birth

Father's Employer	Employer's Address	Business Phone #

Address of Parent (if different from child)	Mother Father	Phone #

If injured at school – name & address of school

Patient's physician information

Name of Family Doctor	Name of Referring Doctor

Patient's Emergency Contact information

Emergency Contact 1.	Phone #	Relationship

Emergency Contact 2.	Phone #	Relationship

PLEASE COMPLETE INSURANCE INFORMATION ON THE BACK SIDE.....

When registering in our office, please present your insurance cards, photo ID, any forms to be filled out (completed and signed) and your referral if you have HMO insurance.

Health Insurance

Primary Insurance (Name and Address)		
ID #	Group #	
Subscriber's Name	Subscriber's Social Security #	Subscriber's Date of Birth
Secondary Insurance (Name and Address)		
ID #	Group #	
Subscriber's Name	Subscriber's Social Security #	Subscriber's Date of Birth

Worker's Compensation Insurance

Were you injured on the Job? Yes / No	**If yes,** Date of injury:	Body Part:
Address to send bill:		Claim #

Automobile Insurance

Was an automobile involved in your injury? Yes / No	**If yes,** Date of injury:	Body Part:
Address to send bill:	Claim #	Policy #

Legal

Is a lawyer involved in your injury? Yes / No	If yes, Name of Attorney:
Address of Attorney:	

Please Read: All charges are payable at the time of service. If hospitalization is indicated, the patient is responsible for furnishing insurance claim forms to the office prior to hospitalization.

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our Billing Department.

Insurance Authorization and Assignment:

I hereby authorize Arthritis & Joint Replacement Center of Reading, a Division of Keystone Orthopaedic Specialists LLC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to Arthritis & Joint Replacement Center of Reading, all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature of patient or responsible party Date

PATIENT QUESTIONNAIRE

The following information is very important to your health. Please take time to fully and completely fill out this important information.

Name _____ Age _____

Today's Date _____ Date of Injury _____

Who is your family physician? _____ Who referred you here? _____

Employer/Company _____ Occupation _____

Did your injury occur at work? □ yes □ no Which is your dominant hand? □ right □ left

Please briefly state your current problem

1. Where is your pain? _____ □ Right □ Left

2. Describe the incident that caused your pain_____

3. How severe is your pain? (on a scale of 0 to 10; 0 = no pain; 10 = extreme pain)
   Please circle one number : 0 1 2 3 4 5 6 7 8 9 10

4. Describe your type of pain (examples: sharp, stabbing, dull, ache, constant, intermittent, etc.)_____
_____

5. How often do you have the pain? (examples: once a week, everyday, etc.)_____
_____

6. How long does it last? (examples: 2 minutes, 2 hours, all day, etc.) _____

7. When does your pain occur? (examples: in the morning, all the time, with certain positions, etc.)
_____

8. Any other problems associated with your primary problem? (examples: swelling, stiffness, numbness, weakness, tingling, clicking, grinding, popping, etc.) _____
_____

9. What makes your pain better? _____

10. What makes your pain worse? _____

11. Have you had any of these diagnostic studies for this problem?

	Yes	No	Date
Diagnostic x-rays	☐	☐	_____
CT scan ("cat scan")	☐	☐	_____
Arthrogram (x-ray with dye injection)	☐	☐	_____
Electromyogram (EMG)	☐	☐	_____
MRI	☐	☐	_____
Injections	☐	☐	_____

12. What type of doctors or health care providers have you seen for this condition?
_____

13. Do you have any additional information that would be helpful in understanding your problem?
_____

REVIEW OF SYSTEMS

Please answer the following to the best of your ability.

				If yes, are you being treated by a Dr. for this?
General				
1. Any recent unexplained changes in weight	□ No	□ Yes	*	□ No □ Yes
2. Night sweats	□ No	□ Yes	*	□ No □ Yes
3. Any Weakness or fatigue	□ No	□ Yes	*	□ No □ Yes
4. Loss of appetite	□ No	□ Yes	*	□ No □ Yes
5. Any immune deficiencies	□ No	□ Yes	*	□ No □ Yes
6. Any unexplained fevers	□ No	□ Yes	*	□ No □ Yes
Musculoskeletal				
7. Any joint pain	□ No	□ Yes	*	□ No □ Yes
8. Joint swelling	□ No	□ Yes	*	□ No □ Yes
9. Muscle pain	□ No	□ Yes	*	□ No □ Yes
10. Muscle cramps	□ No	□ Yes	*	□ No □ Yes
11. History of back pain	□ No	□ Yes	*	□ No □ Yes
Skin				
12. Any rashes	□ No	□ Yes	*	□ No □ Yes
13. Changes in skin	□ No	□ Yes	*	□ No □ Yes
Head				
14. Frequent headaches	□ No	□ Yes	*	□ No □ Yes
Eyes				
15. Any eye pain (discomfort)	□ No	□ Yes	*	□ No □ Yes
16. Any double vision	□ No	□ Yes	*	□ No □ Yes
17. Any blurred vision	□ No	□ Yes	*	□ No □ Yes
Ears, Nose & Throat				
18. Anything ringing in the ears	□ No	□ Yes	*	□ No □ Yes
19. Any ear pain	□ No	□ Yes	*	□ No □ Yes
20. Any nasal discharge	□ No	□ Yes	*	□ No □ Yes
21. Any nasal bleeding	□ No	□ Yes	*	□ No □ Yes
22. Any sinus pain	□ No	□ Yes	*	□ No □ Yes
23. Any soreness	□ No	□ Yes	*	□ No □ Yes
24. Any hoarseness	□ No	□ Yes	*	□ No □ Yes
25. Any difficulty swallowing	□ No	□ Yes	*	□ No □ Yes
Respiratory				
26. Any chest pain	□ No	□ Yes	*	□ No □ Yes
27. Wheezing	□ No	□ Yes	*	□ No □ Yes
28. Coughing	□ No	□ Yes	*	□ No □ Yes
29. Do you have or have you had tuberculosis	□ No	□ Yes	*	□ No □ Yes

				If yes, are you being treated by a Dr. for this?
Neurological				
30. Have you had any fainting or black outs	□ No	□ Yes	*	□ No □ Yes
31. History of seizures	□ No	□ Yes	*	□ No □ Yes
32. Any memory loss	□ No	□ Yes	*	□ No □ Yes
33. Numbness	□ No	□ Yes	*	□ No □ Yes
34. Tingling	□ No	□ Yes	*	□ No □ Yes
Cardiovascular				
35. History of heart problems	□ No	□ Yes	*	□ No □ Yes
36. High blood pressure	□ No	□ Yes	*	□ No □ Yes
37. Low blood pressure	□ No	□ Yes	*	□ No □ Yes
38. Any chest pains or palpitations	□ No	□ Yes	*	□ No □ Yes
39. Shortness of breath with normal activities	□ No	□ Yes	*	□ No □ Yes
Gastrointestinal				
40. Abdominal pain	□ No	□ Yes	*	□ No □ Yes
41. Frequent diarrhea	□ No	□ Yes	*	□ No □ Yes
42. Constipation	□ No	□ Yes	*	□ No □ Yes
43. Heart burn	□ No	□ Yes	*	□ No □ Yes
44. Unexplained nausea or vomiting	□ No	□ Yes	*	□ No □ Yes
45. History of hepatitis	□ No	□ Yes	*	□ No □ Yes
46. Ulcers	□ No	□ Yes	*	□ No □ Yes
47. Blood in the stool	□ No	□ Yes	*	□ No □ Yes
48. Black stools	□ No	□ Yes	*	□ No □ Yes
Endocrine				
49. History of thyroid problems	□ No	□ Yes	*	□ No □ Yes
Miscellaneous				
50. Are you depressed	□ No	□ Yes	*	□ No □ Yes
51. Bruise easily	□ No	□ Yes	*	□ No □ Yes
52. Anemia	□ No	□ Yes	*	□ No □ Yes
53. Allergies	□ No	□ Yes	*	□ No □ Yes
For Women Only				
54. Do you have menstrual irregularities	□ No	□ Yes	*	□ No □ Yes

Surgeries/ Hospitalizations:

Year	Problem	Physician

Medical History / Illness: (Please check if applicable)

□ thyroid disease	□ diabetes (use insulin)	□ diabetes (pills only)
□ heart disease	□ heart attack	□ angina
□ heart rhythm problems	□ high blood pressure	□ murmur
□ asthma	□ COPD/emphysema	□ bronchitis/pneumonia
□ anemia	□ blood clots (DVT/embolus)	□ skin problems
□ stomach ulcers or bleeding	□ colitis /diverticulitis	□ diarrhea/constipation
□ irritable bowel disease	□ hepatitis /yellow jaundice	□ cirrhosis
□ kidney failure	□ kidney stones	□ stroke
□ seizure disorder	□ Alzheimer's/ Parkinson's	□ infections
□ arthritis	□ lupus/rheumatoid arthritis	□ gout
□ cancer	□ bone disorders	□ other _____

Drug Allergies: _____

Current Medications: (Please list)

Name	Dose (mg or grams)	Frequency (per day)

Social History: (please check)

□ single □ married □ children (if yes, how many, and their ages):_____

Living situation: □ alone □ with family □ with someone who can assist you

Do you drink alcohol? □ no □ yes (if "yes", how much, what type, and how often?)

_____

Do you smoke or use tobacco? □ no □ yes (if "yes", how much, what type, and how often?)

_____

Do you use recreational drugs? □ no □ yes (if "yes", how much, what type, and how often?)

_____

Family Medical History: (please check if applicable)

□ arthritis	□ high blood pressure	□ heart disease
□ muscle disease	□ diabetes/thyroid disease	□ cancer
□ blood clots/bleeding disorders	□ stroke	□ bone disorders
□ fractured bones in elderly	□ osteoporosis	
□ other _____		

Height _____ Weight _____ BMI _____

I read and speak English well enough to communicate with a physician □ Yes □ No

The above is true and correct to the best of my belief. _____ _____

Patient Signature Date

PRIVACY AND CONFIDENTIALITY CONSENT

The Federal Government has instituted the Health Insurance Portability and Accountability Act (HIPAA), which requires us to inform you of our policies regarding the privacy of your medical records and personal information. Your signature on this form is an indication that you have been advised in writing that this policy exists. If you would like to see our dedicated confidentiality policy, it is available upon request.

This abbreviated consent covers the following areas regarding the release of your personal and medical information:

- Information given to laboratory and radiology facilities, specialists, insurance companies and any other medical facilities that require your personal information in regards to your healthcare.
- Law enforcement entities and public healthcare facilities.
- We will not disclose or use any of your information for any other purpose without your consent.
- You have the right under these regulations to inspect and/or receive a copy of your medical records and receive an accounting of any disclosures made.
- It is our responsibility and duty to you as our patient to maintain and protect your confidentiality in regards to your personal and medical information.
- If you believe your privacy has been violated, you may register a complaint with our office administrator at 610-376-5646. Our office administrator will investigate your complaint and make every effort to ensure it does not occur again.

_____ _____

Signature Date

***I give permission for Arthritis and Joint Replacement Center of Reading, a Division of Keystone Orthopaedic Specialists LLC to use outcome data, with all personal information removed, for research purposes.**

_____ _____

Signature Date

*** I give permission for Arthritis and Joint Replacement Center of Reading, a Division of Keystone Orthopaedic Specialists LLC to leave messages containing medical information at the following phone number(s):**

1. _____ 2. _____ Initial:_____

Phone Number Phone Number

*** I give permission for my medical information to be shared with the following persons**
(i.e., spouse, son, daughter, caregiver, etc.)

1. _____ Date:_____ Initial:_____

Name/Relationship

2. _____ Date:_____ Initial:_____

Name/Relationship

OFFICE PAYMENT POLICY

Thank you for selecting our office for your medical care. As part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about fees. Our fees and methods of payments are comparable with other physicians in Berks County. We ask for payment at the time of service. This includes payment for the office visit and any tests that are performed. We commonly require payment at the time of check-in. **Any advanced imaging studies which require an outside facility to perform will be billed separately by that facility.** As a courtesy, we will file all applicable office and hospital charges with your insurance carrier(s). By your signature below, you authorize and request that insurance payments be made directly to the Arthritis & Joint Replacement Center of Reading, a Division of Keystone Orthopaedic Specialists LLC. **However, you are ultimately responsible for all charges**. We advise that you familiarize yourself with the benefits of your plan. Prior to any procedure, we will assist you in determining your portion of the bill. This usually includes any un-met deductible, co-payment and co-insurance which are to be paid prior to the procedure. We accept Cash, Checks, Master Card, or Visa. After you have paid for your visit, you will receive an itemized statement. You can attach this copy to your insurance claim and send it to your carrier for processing if necessary. We are providers for several HMO and PPO plans, in which case the above may not apply. However, you are responsible for your co-payment, deductible, or other non-covered services as set by your insurance carrier. Co-payments and deductibles are collected at the time of service. **If your insurance carrier requires a referral number to receive services from our office, it is your responsibility to contact your Primary Care Physician to obtain the number prior to your office visit.**

This policy is offered in an attempt to develop and sustain a continued professional and pleasant relationship. Your cooperation is greatly appreciated.

If an account balance remains unpaid for more than 90 days and you have not made payment arrangements with our office, or you have set up a repayment schedule but fail to make the payments, your account will be turned over to a collection agency. If your account is turned over to a collection agency, an additional 20% financial fee will be added to your bill for which you will be fully responsibility.

If your account is turned over to collections, you may be dismissed from the practice and you may not be entitled to any medical services except in the event of an emergency and only for thirty (30) days after you are reported to collections unless your account is paid in full or is being paid pursuant to a payment plan. A list of other physicians in the area is available upon request.

PRINT Patient's Name:_____

Patient's Signature:_____ Date:_____

PRINT Responsible Party Name:_____

Responsible Party Signature:_____ Date:_____

THANK YOU FOR YOUR COOPERATION!

CANCELLATION POLICY

We consider an appointment to be a commitment and an agreement. When an appointment is scheduled, the time is set aside for you and no one else. Consequently, unlike other doctors' offices we do not double or triple book patients. However, in order to do this we must charge a fee for all appointments not cancelled within 24 hours of the appointment. If your must cancel a Monday appointment, you may leave a message on the answering machine over the preceding weekend.

In today's hectic world, unplanned issues arise for all of us. However, we politely request that appointments which you are unable to honor are appropriately cancelled so that we may offer them to someone else on our waiting list.

Cancelled Appointments:	No charge will be made for any appointment cancelled with at least 24 hours advance notice.
Missed Appointments:	An appointment cancelled on less than 24-hour notice or an appointment missed without notice of cancellation will be billed a **cancellation fee of $40.** This fee will not be charged to your insurance and is your responsibility to pay in full.
Exception:	Same-day cancellations because of serious medical/family emergencies or dangerous road conditions (snow and ice) will not be charged as long as a telephone call is received in the office before the scheduled appointment time.

I am aware of the cancellation policy and agree to the terms.

_____ _____

Signature Date

_____

Parent signature if appropriate