Virtua

Medical Group

PATIENT REGISTRATION FORM

Date: _____

Name: _____ SS#: _____ Date of Birth: _____
Last Name First Name MI

Marital Status: S M W D Phone #: _____ H C W Other Phone #: _____ H C W

[If we need to leave a message with medical/personal information, what number may we use?] H C W

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Preferred language: _____ Ethnicity: Hispanic Non-Hispanic Decline Race:

Caucasian Hispanic Bi racial African/American Asian Other Decline

Emergency Contact: _____ Relationship: _____ Phone #: ( ) _____

Employer/Address: _____ Work Phone: ( ) _____

Referring Physician: (if applicable): _____ Phone: ( ) _____

Pharmacy/Address/Phone: _____ ( ) _____

INSURANCE INFORMATION

Primary Insurance: _____ Group #: _____ ID #: _____

Subscriber: _____ Relationship to Subscriber: _____ Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

Secondary Insurance: _____ Group #: _____ ID #: _____

Subscriber: _____ Relationship to Subscriber: _____ Effective Date: _____

Subscriber's Date of Birth: _____ Subscriber's Social Security Number: _____

GUARANTOR INFORMATION

Guarantor/Responsible Party: _____ Relationship to Patient: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip Code: _____

SS#: _____ Date of Birth: _____ Phone ( ) _____

Guarantor's Employer: _____ Work Phone: ( ) _____

IF RELATED TO WORK OR INJURY

Type: Worker's Comp Auto Accident Legal /Employer Personal Injury Other

Claim #: _____ Date of Injury or Accident: _____ State of Injury or Accident: _____

Worker's Comp/Auto Accident Insurance Carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Case Contact Person: _____ Phone ( ) _____

Attorney Practice Name: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip Code: _____

ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct y insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Virtua Medical Group medical service rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Virtua Medical Group to 1) release any information necessary to insurance carriers regarding my illness and treatments, 2) process insurance claims generated in the course of examination or treatment, and 3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Virtua Medical Group on behalf of myself and/or my dependents, and understand that by marking this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible party Date

_____ _____

Witness Date

Virtua Hand Surgery Health Survey

Date: _____

Name: _____ DOB: _____

Reasons for Today's Visit:

_____

Dominant Hand: R or L Injured Hand: R or L

Height: _____ Weight: _____

Allergies to Medications, latex, tape or other substances. Please list reactions

Current Medications:

Drug name and Dose	Frequency	Drug name and Dose	Frequency
1		5	
2		6	
3		7	
4		8	

Past Medical History

Please put a check in the box if you have had problems with any of the following:

AIDS/HIV		Diabetes		Osteoporosis/osteopenia	
Anemia		Gout		Pacemaker/defibrillator	
Anesthesia Difficulties		Heart Arrhythmia		Peripheral vascular disease	
Anxiety/Depression		Heart Attack		Prior treatment to hands	
Arthritis		Heart problems		Reflux	
Asthma		Heart valve/murmur		Rheumatoid arthritis	
Bleeding disorder		Hepatitis		Seizures	
Blood clot		High Blood Pressure		Sleep Apnea	
Bronchitis		High Cholesterol		Stomach ulcer	
Cancer		Kidney Disease		Stroke	
Cardiac Stents		Liver Disease		Thyroid problems	
COPD		Lyme Disease			

Other Medical Conditions:

_____

_____

Family Hand Issues: -

_____

Social History: Describe tobacco and alcohol use

_____

Hobbies that include repetitive hand usage:

_____

Do you Work? Yes No If so, occupation:

_____

Past Surgical History

Date	Procedure	Date	Procedure	Date	Procedure	Date	Procedure

Review of Systems

Please circle only current symptoms that apply to you.

General	Fevers	Chills	Excessive Weight Gain	Excessive Weight Loss	
ENT	Hearing Loss	Congestion	Sore Throat	Mouth Lesions	Cataracts
CV	Chest Pain	Rapid heart Rate			
Respiratory	Cough	Wheezing	Chest tightness	Snoring	Difficulty Breathing
GI	Abdominal Pain	Nausea	Vomiting	Diarrhea	Constipation
	Heartburn				
Musculoskeletal	Swelling	Limited motion	Muscle pain	Joint Pain	Neck pain
Skin	Rash	Prior MRSA	Skin lesions	Bruising	Nail Abnormalities
Neurology	Numbness	Weakness	Tingling	Burning	Headaches
Hematology	Blood clot	Prolonged bleeding	Low blood count	Swollen glands	

I certify the above information is correct to the best of my knowledge. I will not hold my physician or any members of the staff responsible for any omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____

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ACKNOWLEDGEMENT OF RECEIPT FORM

Health Insurance Portability and Accountability Act, [HIPAA]

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____Date of Birth: _____
(Please Print)

By signing below, I acknowledge receipt of or the opportunity to review the Notice of Privacy Practices of Virtua Medical Group. In addition, by signing below, I authorize Virtua Medical Group to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature:_____Date: _____

Phone Authorization

_____Yes, you have my permission to leave medical information on my answering machine. Please let us know which daytime telephone number is best to do so.

( )_____

_____No, you do not have my permission to leave medical information on my answering machine.

To whom, other than yourself, may we speak regarding your medical condition?

Name_____Relationship _____

Phone# _____

Name_____Relationship _____

Phone# _____

I have the right to withdraw or revise my permission at any time in writing.

Signature:_____Date: _____

For Office Use Only:

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____Individual refused to sign.

_____An emergency situation prevented us from obtaining the acknowledgement.

Signature of Virtua Representative: _____