PATIENT REGISTRATION

☐ **Mark E. Pruzansky, MD** ☐ **Jason S. Pruzansky, MD**

(PLEASE PRINT)

PATIENT'S LAST NAME_____ M.I._____ FIRST NAME_____

ADDRESS_____ APT#_____

CITY_____ STATE_____ ZIP_____

SEX M F BIRTH DATE___/___/___ SS#_____ MARITAL STATUS S M D W

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

PHARMACY_____ ADDRESS_____ PHONE_____

LANGUAGE PREFERENCE _____RACE: _____/REFUSED TO REPORT

EMAIL _____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS_____PHONE NUMBER_____

REFERRED BY_____

MEDICAL DOCTOR_____

ADDRESS_____ PHONE NUMBER_____

ARE YOU IN THE OFFICE FOR A SECOND OPINION? YES NO

INSURANCE DATA WORK INJURY? YES NO AUTO ACCIDENT? YES NO LAWSUIT? YES NO

GUARANTOR/GUARDIAN INFORMATION

NAME_____ RELATIONSHIP_____

ADDRESS_____ SS# _____

HOME PHONE_____WORK PHONE_____ CELL PHONE_____

PRIMARY INSURANCE _____ POLICY NUMBER_____

EMPLOYER ISSUING INSURANCE_____GROUP NUMBER_____

RELATIONSHIP TO THE INSURED SELF SPOUSE CHILD OTHER

POLICY HOLDER'S NAME_____SS#_____ DOB_____

SECONDAY INSURANCE_____ POLICY NUMBER_____

EMPLOYER ISSUING INSURANCE_____GROUPNUMBER_____

RELATIONSHIP TO THE INSURED SELF SPOUSE CHILD OTHER

POLICY HOLDER'S NAME_____SS#_____ DOB_____

EMPLOYER INFORMATION

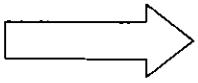
EMPLOYER_____ OCCUPATION_____

ADDRESS_____ PHONE NUMBER_____

CITY_____ STATE_____ ZIP CODE_____

PAYMENT AUTHORIZATION & ATTESTATION

I authorize payment of surgical and/or medical benefits directly to the physician and will forward to the physician any and all such benefits if they are paid directly to me. I attest to the accuracy and completeness of my answers to the above statements.



_____ _____

SIGNATURE OF PATIENT (GUARDIAN IF MINOR) DATE

☐ **Mark E. Pruzansky, M.D.** **Patient Health History** ☐ **Jason S. Pruzansky, M.D.**

PLEASE PUT AN ANSWER IN EACH SPACE. DO NOT LEAVE ANYTHING BLANK.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL ___ AGE ___ SEX M ☐ F ☐

REVIEW OF SYMPTOMS: PLEASE CIRCLE ANY YOU HAVE CURRENTLY

Constitutional:	Fever	Chills	Night Sweats	Weight Loss	Malaise	
Eyes:	Blurry	Double Vision	Glaucoma	Itch	Glasses	
Ear, Nose, Throat, Mouth:	Deafness	Pressure Sores	Dry	Discharge		
	Hoarse	Tinnitus	Sinusitis	Vertigo		
Cardiovascular:	Chest Pain	Arrhythmia	High Blood Pressure	Fainting	Cold Extremity	Claudication
Respiratory:	Asthma	Cough	Sputum	Blood	Shortness of Breath	
Gastrointestinal:	Ulcer	Nausea	Vomiting	Gas	Stool Change	Blood
Genitourinary:	Frequency	Incontinence	Dribble	Pregnant	Impotence	
Musculoskeletal:	Arthritis	Swelling	Weakness	Stiffness		
Skin:	Rash	Lesion	Mole	Lump	Sore	
Neurological:	Weak	Numb	Speech	Coordination	Seizure	Balance
Psychiatric:	Depression	Anxiety	Sleep Problems			
Endocrine:	Diabetes	Thirst	Overeating	Tired	Hair Growth Problem	
Hematologic/ Lymphatic:	Anemia	Nodules	Bruising/ Bleeding			
Allergic/ Immunologic:	Dermatitis	Eczema	Cancer	Infection	HIV/AIDS	TB/Polio

THIS BOX IS FOR MD USE – Reviewed and Annotated – All other symptoms are negative/ no interval change ☐

DO NOT LEAVE ANYTHING BLANK. ENTER 'NONE' IF YOUR RESPONSE IS NEGATIVE.

PAST MEDICAL HISTORY:

Height: ____ Ft ____ In Weight (approx): ____ Lbs Dominant Hand: R ____ L ____ Both ____

List all Current and Past Medical Problems: _____

List all Medications, Pills, Herbs, Vitamins: _____

List all Medication Allergies: _____

Sensitive to Aspirin/ NSAIDS: ☐ Yes ☐ No

List all Surgeries with Dates: _____

List All Orthopedic Injuries with Dates (Sprains/ Fractures): _____

FAMILY HISTORY:

List family members with Bone/Joint/ Nerve/ Tendon/Cancer Problems: _____

SOCIAL HISTORY: ENTER OR CHECK MARK YOUR ANSWERS

☐ S ☐ M ☐ W ☐ D ☐ Live Alone ☐ With Someone Private House: ☐ Elevator ☐ Stairs, #Floors: ____

Substance: Tobacco (Packs ____ Years ____) Quit Smoking ? ☐ < 1 year ☐ > 1 year ☐ > 5 years ☐ > 10 years

Alcohol (Type & Quantity): _____ Drugs? : _____

Exercise: ☐ Yes ☐ No Type: _____ Frequency: _____

Sports Frequency: _____ Currently Working? ☐ Yes ☐ No

What type of work do you do? _____ Full-time ☐ Part-time ☐

Please sign: I attest to the accuracy and completeness of my answers to the above statements.

_____/_____

Signature **Date**

For office use only: ck-in_____ rvw_____

□ **Mark E. Pruzansky, MD** □ **Jason S. Pruzansky, MD**

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____

I, _____(guarantor/patient), hereby authorize Mark E. Pruzansky, MD, PC and/or Jason S. Pruzansky, MD to charge my credit card account(s) as designated below for any amounts paid directly to _____ (patient) by a third party payor for services provided by Mark E. Pruzansky, MD. PC. and/or Jason S. Pruzansky, MD if payment has not been received by Mark E. Pruzansky, MD. PC. and/or Jason S. Pruzansky, MD within ten days of notification of such payment by the third party payor. I further authorize Mark E. Pruzansky, MD. PC. and/or Jason S. Pruzansky, MD to charge the designated account(s) for any services provided by Mark E. Pruzansky, MD. PC. and/or Jason S. Pruzansky, MD if the insurance company (s) or other third payor (s) _____ (patient) has designated as responsible for payment fails to make payment as a result of ineligibility, unused deductible, patient portion responsibility, or where the service was not covered. In the event that my credit card company for any reason does not accept the charge, I will immediately make payment directly to Mark E. Pruzansky, MD. PC. and/or Jason S. Pruzansky, MD for all monies owed.

Signature of Guarantor/Patient Cardholder:_____

Credit Card Type: (circle one) VISA MASTERCARD AMEX

Cardholder's Name:_____

Account Number:_____

Expiration Date:_____

Card Security Code:_____

Charge Amount:_____

For office use only: ck-in_____ rvw_____

Mark E. Pruzansky, MD, PC **Jason S. Pruzansky, MD**

Welcome to Our Office

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance, or payments, please speak with one of our Billing Representatives.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. If you have a health plan that requires its own insurance claim form, please provide us with a signed and completed claim form.
3. Your referral or authorization for services when applicable.

Payment Policy: Payment in full is expected at the time service is rendered. For your convenience, we accept cash, check, or credit cards. We will bill those insurance companies with which we have an agreement. Please note that in the event of non-payment, the account may be placed with an outside collection agency and the expenses will be added to your account balance. Balances that exceed 90 days from the date of service will be charged an additional fee of $100.00 plus a finance fee of 1.5% per month. If you have any questions, please feel free to ask one of our representatives or our Billing Service.

Self-pay Accounts: If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

Insurance Plans: If you are the insured, we will bill those insurance plans with which we have an agreement. However, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. If you have PPO or HMO insurance plan, we will collect the required co-payment, co-insurance, and any deductible that is due at the time of the visit. In the event that your health plan determines a service to be "non-covered," we will bill you and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement or you are not using insurance, payment is expected, in full, at the time of service. As a courtesy, we may submit a claim to your insurance company on your behalf.

Medicare: We will bill your Medicare insurance and secondary carrier, if you have one.

Notice of Privacy Practices: I have received the Mark E. Pruzansky, MD PC and/or Jason S. Pruzansky, MD Notice of Privacy Practices, and I have been provided an opportunity to review its contents.

It is understood and agreed that my purpose of requesting examination and treatment is for medical purposes only and is not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical records and X-rays in the possession and control of this office pursuant to an authorization by the undersigned and upon payment of the usual copying charges.

Other fees: copy of records, copy of x-rays, form completion.

I understand that Mark E. Pruzansky, MD PC and/or Jason S. Pruzansky, MD may agree to bill my insurance as a courtesy and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.

_____ _____ _____

Name of Patient (please print) Signature of Patient or Responsible Party Date

_____ _____ _____

Interpreter/Representative Name Interpreter/Representative Signature Date

For office use only: ck-in_____ rvw_____