

REGISTRATION FORM

PATIENT INFORMATION

Patient Name _____ SSN _____
Address _____ City _____ Zip _____
Home Tel (____) _____ Work Tel (____) _____ Cell (____) _____
Which telephone numbers can we leave messages that may contain private health information on? _____
Email address _____
Sex: M F DOB _____ Age _____ Marital Status: S M D W Sep Other _____
Who is your primary care physician? _____
Who referred you to this office? _____
What is the reason for today's visit? _____
What is the date this condition began, or the date of injury? _____
Is this condition due to an automobile accident? Y N Does this concern a work-related injury? Y N
Your Employer (if you're a student, the name of your school) _____
Employer's Address (or address of school) _____
Your Occupation _____ Date Last Worked _____
If a child, patient lives with: Mother Father Guardian Other _____

EMERGENCY-CONTACT INFORMATION

Emergency Contact #1 _____ Relationship _____
Address _____ City _____ Zip _____
Home Tel (____) _____ Work Tel (____) _____ Cell (____) _____
Emergency Contact #2 _____ Relationship _____
Address _____
Home Tel (____) _____ Work Tel (____) _____ Cell (____) _____

RESPONSIBLE PARTY (FOR CHILD) –OR– SPOUSE INFORMATION

Name _____ Sex: M F
Address _____ City _____ Zip _____
Employer _____ Occupation _____ Relationship to Patient _____
Date of Birth _____ SSN _____ CDL _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Tel (____) _____
Billing Address _____ City _____ Zip _____
Subscriber's Name _____ Relationship to Patient _____
Subscriber's Tel (____) _____ Subscriber's Employer _____
Subscriber's ID Number _____ Subscriber's Group Number _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Tel (____) _____
Billing Address _____ City _____ Zip _____
Subscriber's Name _____ Relationship to Patient _____
Subscriber's Tel (____) _____ Subscriber's Employer _____
Subscriber's ID Number _____ Subscriber's Group Number _____

Patient signature _____ Date _____

ASSIGNMENT OF BENEFITS

I hereby assign medical and/or surgical payments—including major medical benefits to which I am entitled, private insurance, and proceeds from any other health plan—to Nicholas Colyvas, M.D., for services he provides. This assignment shall remain in effect until I submit a written revocation to him. I understand that I am financially responsible for all charges for the provided services, whether or not they are paid for by such insurance. I hereby authorize assignee to release any of the foregoing information to secure payment. A copy of this assignment shall be as valid as the original.

Patient signature _____

Date _____

Nicholas Colyvas M.D., Inc.

Orthopaedic Surgery and Sports Medicine

2299 Post Street, Suite 107
San Francisco CA 94115
Telephone (415) 409-1367
Fax (415) 923-1036

429 Llewellyn Avenue
Campbell CA 95008
Telephone (408) 364-1673
Fax (408) 364-1635

801 Brewster, Suite 150
Redwood City CA 94063
Telephone (415) 409-1367
Fax (415) 923-1036

Questionnaire for Patients

Please fill out this questionnaire as completely as you can. This will assist in making your orthopaedic consultation as simple and effective as possible.

Name _____

Yourself

What is your age? _____

What is your height? _____

What is your weight? _____

Are you left-handed, or right-handed? L R

Your work

Who was your employer at the time of the injury? _____

What is/was your job title at that company? _____

Are you still working there? _____

If so, how long have you worked there? _____

If not, how long did you work there? _____

When was your last day of work? _____

Your injury

On what date were you injured? _____

Which part of your body was injured? _____

Where were you first treated? _____

Have you seen any other specialists? _____

Have you had X-rays, MRIs, or other studies? _____

Has this part of your body had an injury or problem prior to this? _____

If yes, please describe the injury or problem briefly: _____

At the present time

Are you still working? _____

Are you taking medication for the injury or problem? _____

If you have had physical therapy, are you still in physical therapy? _____

Have you had surgery for the injury? _____

Are you getting better, getting worse, or staying the same? _____

Your medical history

Other medical problems: _____

Prior surgery(ies): _____

Medications: _____

Are you a smoker, or a nonsmoker? _____

Allergies, if any: _____

Patient signature _____

Date _____