

REGISTRATION FORM

(To safeguard your information, please do not e-mail this form to us)

PATIENT INFORMATION

Patient Name _____ SSN _____
Address _____
Home Tel (____) _____ Work Tel (____) _____ Other (____) _____
Temporary Address (if not local) _____
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
On what date did you first consult us for this condition? _____
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 _____
Home Tel (____) _____ Work Tel (____) _____ Other (____) _____
Emergency Contact #2 _____ Relationship _____
Address _____
Home Tel (____) _____ Work Tel (____) _____ Other (____) _____

RESPONSIBLE PARTY (FOR CHILD) –OR– SPOUSE INFORMATION

Name _____ Sex: M F
Address _____
Home Tel (____) _____ Work Tel (____) _____ Other (____) _____
Employer _____
Employer's Address _____
Occupation _____ Relationship to Patient _____
Date of Birth _____ SSN _____ CDL _____

PRIMARY INSURANCE INFORMATION

Insurance Company _____ Tel (____) _____
Billing Address _____
Subscriber's Name _____ Relationship to Patient _____
Subscriber's Address (if not listed above) _____
Subscriber's Tel (____) _____ Subscriber's Employer _____
Subscriber's Employer's Address _____ Subscriber's Employer's Tel (____) _____
Subscriber's ID Number _____ Subscriber's Group Number _____
Was authorization obtained (if required)? Y N PCP _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____ Tel (____) _____
Billing Address _____
Subscriber's Name _____ Relationship to Patient _____
Subscriber's Address (if not listed above) _____
Subscriber's Tel (____) _____ Subscriber's Employer _____
Subscriber's Employer's Address _____ Subscriber's Employer's Tel (____) _____
Subscriber's ID Number _____ Subscriber's Group Number _____
Was authorization obtained (if required)? Y N PCP _____

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

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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 _____