

Thank you for choosing Norton Healthcare.

PATIENT REGISTRATION AND CONSENT TO TREATMENT FORM

LAST NAME		FIRST NAME		MIDDLE NAME	
MAILING ADDRESS STREET ADDRESS/P.O. BOX					APT#
CITY			STATE		ZIP
GENDER	SPOUSE		MARITAL STATUS		PATIENT ACCOUNT NO. (For Office use Only)
M	F		<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	
			<input type="checkbox"/> DIVORCED	<input type="checkbox"/> SEPARATED	
DO YOU CONSIDER YOURSELF HISPANIC OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO			WHICH CATEGORY BEST DESCRIBES YOUR RACE? SELECT ONE OR MORE. <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White		
PERSON RESPONSIBLE FOR BILL (If different from insured)			PRIMARY CARE PHYSICIAN (PCP)		
			PCP CITY		PCP STATE
DATE OF BIRTH / /			REFERRING PHYSICIAN (RP) (If applicable)		
PRIMARY LANGUAGE			RP NAME		RP STATE
TELEPHONE NUMBERS			EMERGENCY CONTACT INFORMATION		
HOME ()			NAME (Other than Spouse)		
WORK ()			STREET ADDRESS / P.O. BOX		APT #
CELL ()			CITY		STATE ZIP
OTHER()			HOME ()		WORK ()
CUSTODIAL GUARDIAN (Please provide a copy of custodial papers for chart)				PH. NO.	
IS YOUR VISIT RELATED TO:			<input type="checkbox"/> WORKER'S COMPENSATION	<input type="checkbox"/> MOTOR VEHICLE ACCIDENT	<input type="checkbox"/> NONE OF THESE
			<input type="checkbox"/> DISABILITY	<input type="checkbox"/> LIABILITY	
EMPLOYER INFORMATION					
NAME			PATIENT OCCUPATION		
STREET ADDRESS/P.O. BOX			CITY		STATE ZIP
INSURANCE INFORMATION (PRIMARY)					
SUBSCRIBERS NAME			DATE OF BIRTH		
RELATIONSHIP TO PATIENT			PHONE NUMBER ()		
INSURANCE COMPANY		ID NUMBER		GROUP NO.	
INSURANCE ADDRESS			EFFECTIVE DATE		
INSURANCE INFORMATION (SECONDARY)					
SUBSCRIBERS NAME			DATE OF BIRTH		
RELATIONSHIP TO PATIENT			PHONE NUMBER ()		
INSURANCE COMPANY		ID NUMBER		GROUP NO.	
INSURANCE ADDRESS			EFFECTIVE DATE		
HAVE YOU COMPLETED AN ADVANCE DIRECTIVE? Y / N					
We affirm our commitment to comply with federal and state requirements pertaining to the use and disclosure of your protected health information. By signing below, you acknowledge a copy of our Notice of Privacy Practices brochure has been offered to you.					
SIGNATURE			DATE		FOR OFFICE USE ONLY: [] NOTICE RECEIVED [] NOTICE DECLINED
I authorize the release of medical information necessary to process my medical claims. I authorize payment from my insurance company to be made directly to the facility. I understand that I am responsible for and agree to pay any and all expenses not covered by my insurance or any that are not paid by the insurance company in a reasonable and timely manner. I agree to obtain any referrals required by my insurance and pay in full for any charges denied by my insurance for failure to obtain a referral. My signature also serves as consent for medical treatment.					
SIGNATURE			DATE		RELATIONSHIP (if other than patient)

PRCTF - 611



**NORTON
HEALTHCARE**

Patient Name: _____

DOB: _____

Med rec #: _____

Louisville Arm & Hand Office Policies

Payments, including co-payments and co-insurance are due prior to services being rendered. If you're insurance plan requires you to pay co-insurance for an office visits you will need to pay \$50.00 if you have not yet met your yearly deductible and \$35.00 if you have met your deductible and are responsible to pay a percentage of the office charges.

If any of your information such as your address or insurance changes you are required to notify the office.

If you are filing a workers' compensation or liability claim it is your responsibility to provide our office with the billing information. Prior authorization for treatment is required.

If your insurance requires a referral it is your responsibility to obtain that referral prior to your scheduled appointment. If a referral is not obtained we will need to reschedule your appointment.

Upon late arrival the office reserves the right to reschedule your appointment to a later time and or date.

There is a \$15.00 fee every time a disability or FMLA paperwork is filled out by our office. Please allow 14 business days for forms to be completed; as well as medical record request.

Please allow 2 business days for prescription refills to be approved. Prescriptions can not be refilled on weekends or holidays. Lost or stolen prescriptions will not be refilled.

For your medical safety, you need to inform your treating physician of other medications you are taking. If you are receiving medications including narcotics from another physician we may be unable to prescribe additional medications.

Signature: _____ Date: _____

Louisville Arm & Hand 315 E. Broadway, Suite 195, Louisville KY. 40202
Phone-502-629-4263 Fax - 502-629-4282

 **NORTON HEALTHCARE**

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Do you have any medication allergies? ___Yes ___No

If yes please list: _____

Are you currently taking any medication or dietary supplements? ___Yes ___No

If yes please list: _____

Are you right or left handed? ___Right ___Left Height _____ Weight _____

Briefly explain what you are seeking treatment for: _____

Did you have an injury? ___Yes ___No

If yes when: _____ Was this injury job related? ___Yes ___No

Occupation: _____

Family Doctor: _____ Referring Doctor: _____

Have you ever smoked? ___Yes ___No ___quit (when: _____)

If yes, how much and for how long? _____

Do you drink alcohol? ___Yes ___No If yes how many drinks per week _____ Type of Alcohol _____

Do you currently have or have ever had any of the following, please circle yes or no: if yes please explain

- | | | | |
|--|-----|----|-------|
| Diabetes | Yes | No | _____ |
| Thyroid disease | Yes | No | _____ |
| Heart Disease | Yes | No | _____ |
| High blood pressure | Yes | No | _____ |
| Lung disease | Yes | No | _____ |
| Stomach problems | Yes | No | _____ |
| Liver disease | Yes | No | _____ |
| Bowel problems | Yes | No | _____ |
| Arthritis | Yes | No | _____ |
| Muscle weakness | Yes | No | _____ |
| Neurologic problems
(stroke, numbness, headaches) | Yes | No | _____ |
| Kidney problems | Yes | No | _____ |
| Skin problems | Yes | No | _____ |
| Anemia | Yes | No | _____ |
| Bleeding trouble | Yes | No | _____ |
| Trouble hearing | Yes | No | _____ |
| Ringing in ears | Yes | No | _____ |
| Cancer | Yes | No | _____ |
| Infectious disease | Yes | No | _____ |
| Organ transplant | Yes | No | _____ |
| Mental illness | Yes | No | _____ |

Do you have a family history of:

Diabetes ___Yes ___No

Heart Disease ___Yes ___No

Arthritis ___Yes ___No

Cancer ___Yes ___No

Problems with anesthesia ___Yes ___No

Other: _____

List any past surgeries: _____