Boston Sports Medicine

Patient Registration Form

Name: _____ Date: _____

Age: _____ Sex: ☐ M ☐ F Occupation: _____

Referred by Dr _____
Referring Physician's Address: _____

Chief Complaint: _____

General Health: (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medications: ☐ None or below list medications you are taking
_____ for _____
_____ for _____
_____ for _____

Allergies: ☐ None (Reaction due to allergy)
Allergic to Penicillin _____
Allergic to sulfa drugs _____
Allergic to _____

Prior surgical procedures and hospitalizations (include dates):

_____
_____

Review of Systems (check symptoms you have) and describe:

Constitutional (☐ fever, ☐ weight loss, etc.) _____
Eyes (☐ double vision, ☐ blurring, ☐ glasses) _____
ENT, Mouth (☐ deafness, ☐ sinusitis, ☐ dizziness) _____
Heart (☐ chest pain, ☐ murmur, ☐ irregular beats) _____
Circulation (☐ high blood pressure) _____
Respiratory (☐ asthma, ☐ shortness of breath, ☐ cough) _____
GI (☐appetite, ☐ diarrhea, ☐ constipation) _____
Urinary (☐ problem urinating, ☐ incontinence) _____
GYN (☐ menstrual problems, ☐ pregnancies) _____
Musculoskeletal (☐ arthritis, ☐ stiffness) _____
Skin (☐ acne, ☐ rash) _____
Breast (☐ lump) _____
Neurological (☐ seizures, ☐ weakness, ☐ balance) _____
Psychiatric (☐ depression, ☐ mood liability, ☐ other) _____
Endocrine (☐ thyroid problems) _____
Hematologic (☐ bleeding tendency, ☐ anemia) _____
Lymphatic (☐ enlarged lymph nodes) _____
Allergy (☐ hay fever, ☐ dermatitis) _____
Weight _____ Height _____

Family History
Are there any illnesses that run in the family? _____
Diabetes? _____ Bleeding problems? _____
Anesthesia problems? _____

Social History
☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of children & ages _____
Tobacco use _____ Packs per day ____ Number of years _____
Alcohol use _____ Drug use _____ Exposure to Hepatitis or AIDS? ☐ Yes ☐ No
Living Situation: _____

Reviewed by Dr. _____

*****MUST COMPETE ENTIRE FORM INCLUDING INSURANCE, PCP, DATE OF BIRTH *****

PATIENT NAME: _____
First name Middle initial Last name

DOB: _____/_____/_____ **MGH unit #:** _____ **Social Security #:** _____

Street address: _____ Home phone: _____

City: _____ State & Zip Code: _____ Work phone: _____

E-Mail address: _____ Cell phone: _____

Parent name (if patient is a child): _____ Spouses' name: _____

In case of emergency, please notify: _____ Phone: _____

PRIMARY INSURANCE INFORMATION (if Workers Comp or MVA please speak with secretary)

Insurance carrier: _____ ID #: _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____ Member Services telephone: _____

Primary Care Physician: _____ Telephone: _____

Address: _____

Referring physician (if not PCP): _____ Telephone: _____

Address: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insurance carrier: _____ ID# _____ Group #: _____

Subscriber's name: _____ Relationship to patient: _____

RELEASE AND ASSIGNMENT FORM

To My Insurance Carriers:

1) I authorize the release of any medical information necessary to process my/my child's insurance claims.
2) I authorize and request payment of medical benefits directly to my/my child's physicians.
3) I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4) I agree that a photocopy of this form may be used in lieu of the original.
5) I understand that I am responsible for the charges that occur as result of my/my child's medical treatment.

_____ _____
Signature of patient/responsible party Date

MEDICARE LIFETIME AUTHORIZATION (<u>Medicare Patients Only</u>)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. I permit a copy of this authorization to be used in lieu of the original and request payment of medical insurance benefits whether to myself or to the party who accepts this assignment. Regulations pertaining to Medicare assignments of benefits apply.

_____ _____
Signature of patient/responsible party Date