NEW PATIENT INTAKE FORM **RM#:** ____ **INS:** _____ **N:** __

Name: _____ Age: _____ Date: _____
Primary Care Physician: _____
Referred By: _____
Preferred Pharmacy: _____

What is your chief symptom or problem? _____
Location of Pain/Problem: _____ When did the pain/problem start (date)? _____
How was injury sustained: ❒ No Injury ❒ Sports ❒ Slip/Fall ❒ Other _____
Please describe: _____
_____
If injury, Place of Occurrence: ❒ Home ❒ School ❒ Work ❒ Other _____
Pain IMPROVES with _____ Pain WORSENS with _____

Please rate the severity or intensity of pain (circle number):

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

The pain is present: ❒ Constantly ❒ Intermittently ❒ At Night
The quality of pain is: ❒ Sharp ❒ Dull ❒ Burning ❒ Other
Have you had any Physical Therapy for this problem? ❒ No ❒ Yes, at _____ for _____ wks/mons

****

Systems Review – Please indicate "Yes" or No" if you have had any recent ailments below. If answer is "Yes," please describe the problem.

	YES	NO	TYPE		YES	NO	TYPE
Cold or flu?	____	____	_____	Respiratory Problem?	____	____	_____
Skin problem?	____	____	_____	Heart Problem?	____	____	_____
Eye/ear problem?	____	____	_____	Intestinal Problem?	____	____	_____
Nerve problem?	____	____	_____	Urinary Problem?	____	____	_____
Depression/anxiety?	____	____	_____	Bleeding Problem?	____	____	_____

ALLERGIES (please list what you are allergic to and the type of reaction): _____
_____

CURRENT MEDICATIONS

Name of Medication	Dose	Frequency
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

SUPPLEMENTS (e.g. St John's Wort, Ginseng, Creatine):
_____
_____

PAST SURGICAL HISTORY

Type of Surgery	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

For Office Use:
❒ Nap ❒ Ibu ❒Cel ❒Nor-5 ❒ _____

Genova: ❒ GI ❒ Nutr ❒ Adreno ❒ IGG/IGE ❒ Hormne

Labs: ❒ Fasting ❒ Non-Fasting

Orders: ❒ PT ❒ MRI ❒ Referral **❒ 2/2**

_____

Other: _____

Follow-up: _____

VITALS: _____

Name: _____ Date: _____

PAST MEDICAL HISTORY – Please indicate "Yes" or "No"

CONDITION	YES	NO
Coronary Artery Disease		
High Blood Pressure		
Heart Attack		
Murmur		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Hyperlipidemia		
Stroke		
Seizure		
Kidney Failure		
Diabetes		
Thyroid Disease		

CONDITION	YES	NO
Gout		
Cancer		
If yes, Type:		
Asthma		
Tuberculosis		
Emphysema		
Hepatitis		
Ulcer		
GI Bleed		
Anemia		
Bleeding Disorder		
Deep Vein Thrombosis		

PAST FAMILY HISTORY – Please indicate "Yes" or "No" if it pertains to an immediate family member only (e.g. parent, sibling, or grandparent)

CONDITION	YES	NO	RELATIONSHIP
Coronary Artery Disease			
High Blood Pressure			
Heart Attack			
Stroke			
Diabetes			
Thyroid Disease			
Cancer			
Hepatitis			
Anemia			
Bleeding Disorder			

SOCIAL HISTORY

Tobacco Use: ❒ Current Smoker ❒ Former Smoker ❒ Never Smoker
If Yes, Type: ❒ Cigarette ❒ Pipe ❒ Cigar ❒Other _____
# of Packs per day: _____ # of years smoking: _____

Alcohol Use: ❒ Yes ❒ No
If yes, # of Drinks per ❒ Day ❒ Week ❒ Month: _____

OTHER: Sports/Exercise: Type: _____ # Days/Week _____ Duration per Session: _____

If student, school attending:
High School: _____
College: _____

Occupation: _____
❒RIGHT-handed ❒LEFT-handed

IMUA Orthopedics, Sports & Health moving you forward

REGISTRATION FORM

❒ Elizabeth M. Ignacio, MD
❒ Nicole Y. Gesik, DO

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth

Address	City	State	Zip

Phone (Please ✓ Primary #)	❒ Home ❒ OK to lv msg?	❒ Work ❒ OK to lv msg?	❒ Cell Phone ❒ OK to lv msg?

Gender ❒ M ❒ F	SSN	Occupation	Employer

Marital Status	Work Status	School Status	Ethnicity	Race
❒ Single	❒ Full-Time	❒ Full-Time	❒ Hispanic/Latino	❒ American Indian or Alaska Native
❒ Married	❒ Part-Time	❒ Part-Time	❒ NON-Hispanic	❒ Asian
❒ Divorced	❒ N/A	❒ N/A	❒ Unknown/Refused	❒ Black/African American
❒ Widowed		School:	**Preferred Language**	❒ Native Hawaiian/Pacific Islander
❒ Other			❒ English	❒ White
			❒ Other	❒ Other

Please tell us how you heard about us:

❒ Doctor ❒ Friend/Relative ❒ Internet ❒ Television ❒ Other

Name of Referring Doctor or Friend/Relative	Primary Care Provider

INSURANCE INFORMATION

❒ Private Insurance ❒ Workers' Compensation ❒ No-Fault ❒ Third Party Liability

Condition we are treating you for today:	Date of Injury/Onset:	
If WC of NF Injury, Adjuster's Name:	Phone:	Fax:

Primary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Secondary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Tertiary Insurance (Please provide copy of your insurance card)

Insurance Co:	Subscriber's Name:	DOB:

Policy or Claim #:	Pt's Relationship to Subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

RESPONSIBLE PARTY INFORMATION (Complete ONLY if different from patient)

Last Name	First Name	MI	Date of Birth

Address	City	State	Zip

Phone (Please ✓ Primary #)	❒ Home Phone ❒ OK to lv msg?	❒ Work Phone ❒ OK to lv msg?	❒ Cell Phone ❒ OK to lv msg?

Gender ❒ M ❒ F	SSN	Occupation	Employer

If patient is a minor, person(s) who may authorize treatment: _____

Relationship to patient: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone (Please ✓ Primary #)	❒ Home Phone	❒ Work Phone	❒ Cell Phone

RELEASE OF INFORMATION

I authorize the release of confidential medical information to the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

APPOINTMENT REMINDERS

I'd like receive appointment reminders by: (you may select both options)

❒ Text Phone #: _____

❒ E-Mail Email Address: _____

I would like to receive the IMUA Orthopedics, Sports & Health email newsletter: ❒ Yes ❒ No, thank you

❒ To email address listed above ❒ Alternate email: _____

ACKNOWLEDGEMENTS & CONSENTS

I verify that the information provided above is correct. I understand that I am financially responsible for all charges, regardless of insuranc coverage. I request that payment of insurance benefits be made on my behalf to ***IMUA Orthopedics, Sports & Health*** *for any services furnished to me.*

I authorize IMUA Orthopedics, Sports & Health, LLC to disclose/request my health information, including copies of records as necessry, to/from:

1. *Any health insurance plan, company, or billing service that provides insurance coverage for me for the purpose of payment of charges.*
2. *Consulting and treating physicians, diagositc facilities, labs, radiology/imaging, outpatient facilities and hospitals, and other health providers for the purpose of continuity of care.*
3. *Any insurance company that provides liability insurance coverage for IMUA Orthopedics, Sports & Health to evaluate clinical performan*
4. *Any workers' compensation, no-fault, or administrative proceeding for the purpose of evaluating my medical condition.*

All medical information with no exceptions, will be disclosed/requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

Patient Financial Responsibility:

I acknowledge full financial responsibility for services rendered by IMUA Orthopedics, Sports & Health, LLC as detailed above.

Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I hereby give my consent to IMUA Orthopedics, Sports & Health to use or disclose, for purposes of carrying out treatment, payment, or healthcare operations, all protected health information contained in the health record of _____ (print patient's name). I understand that this facility may share my information electronically or on paper with other providers in the cours of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer tha this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to disclose my health information. Written revocation of consent must be sent to this facility.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I was made aware of IMUA Orthopedics, Sports & Health's Privacy Policy and a copy was available for my review.

Acknowledgement of Receipt of Office and Financial Policies:

I acknowledge that I have reviewed and received a copy of the Office and Financial Policies of IMUA Orthopedics, Sports, & Health, LLC

My signature below indicates my full understanding and consent to the above-described policies

_____ _____

Signature **Date**

_____ _____

Print Name **Relationship to Patient**

Welcome to IMUA Orthopedics, Sports & Health! We are glad that you have chosen us to take care of your health care needs, and we look forward to partnering with you to realize your health care goals. In order to keep you informed of our Office and Financial Policies, we ask that you read and sign our acknowledgement prior to any treatment. Please speak with us if you have any questions.

OFFICE POLICIES

APPOINTMENTS – The office hours for each physician will vary, but every effort will be made to accommodate the date and time desired. Office visits are by appointment only. While every effort will be made to keep your wait time to a minimum, emergencies do occur and will be given priority. We will attempt to contact you as soon as possible to provide the option of rescheduling your appointment

CANCELLED APPOINTMENTS / NO SHOWS - If it is necessary to cancel your appointment, we kindly ask that you give us at least 24 hours notice so that we may accommodate other patients in need of our services. Please note that a $30.00 Cancellation/No Show fee will be billed to you (which is not payable by your insurance) for any missed appointments if proper notification has not been received by our office. Patients arriving more than 15 minutes after their scheduled appointment will be considered a "No Show." Patients with three "No Shows" may face dismissal from our practice.

AFTER HOURS EMERGENCIES – If you are having a medical emergency, please call 911 immediately and go to your nearest emergency room. Our physicians can also be reached after hours through the Physicians Exchange at 524-2575.

PRESCRIPTION REFILLS – Please call our office during normal business hours to obtain medication refills. This will allow your physician to consult your medical record and make the best decision regarding your care. Prescriptions will be called in within 48 hours of request. Refills will not be handled after hours.

MEDICAL FORMS COMPLETION - A $10.00 - $25.00 fee will be charged for completion of insurance forms such as TDI, Life Insurance, or Flexible Spending forms (the charge is based upon the number of pages and complexity of the information requested). Payment is required at the time the forms are picked up.

REQUEST FOR COPIES OF MEDICAL RECORDS - If you are requesting a copy of your medical records for yourself or a third party, we require a signed authorization by the patient or their Legal Representative. This form may be faxed in to (808) 521-8127. Please allow ten (10) days' notice. There may be a fee charged for this, and payment in full is required before the records can be released.

FINANCIAL POLICIES

IMUA Orthopedics, Sports & Health participates with most insurance plans. We will gladly file claims on your behalf, however, payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party as the insurance contract is between you and your insurance company. It is your responsibility to understand the benefits and coverage of your plan, including those for physical examinations and laboratory tests that may be ordered on your behalf. The benefits paid by your plan are negotiated by your employer, and thus not all services are automatically covered. We encourage you to be familiar with your plan benefits and contact your insurance carrier if you have any questions. You will be required to complete an Injury/Illness form stating that your injury is NOT the result of a third party's liability.

HMO / MANAGED CARE PLAN REFERRALS - Some insurance plans require that you obtain a referral from your primary care provider in order for your visit to be covered. Failure to obtain the necessary referrals may lead to your visit being denied, and as a result, your having to be responsible for the entire balance. If you arrive for your appointment without a referral, we reserve the right to reschedule your appointment.

WORKERS' COMPENSATION – If your injury is a result of a work-related injury, we must have approval from your adjuster prior to your visit. Failure to properly report the injury to your employer/insurance carrier may result in your claim being denied and the balance being your responsibility.

PAYMENT AT TIME OF SERVICE - We ask that you remit payment for any applicable co-payments, deductibles, or co-insurance amounts at the time of service. Once your insurance carrier has processed your claim, any outstanding balance not collected at the time of service will be billed to you.

If you do not have any insurance coverage, we do not participate with your insurance carrier, or if there is a question of whether or not your insurance carrier will cover your visit, we require payment in full at the time of service. In the event that your insurance carrier does make payment, you will be refunded your payment less any balance due.

If you do have an outstanding balance due, we would appreciate your prompt payment in full. In the event that you are unable to make payment in full, please call our business office at (808) 521-8170 and we will be happy to arrange a payment plan for you.

DELINQUENT ACCOUNTS - If multiple attempts to collect payment from you are unsuccessful, we reserve the right to turn your balance over to a collection agency. In addition to the balance due, you will also be responsible for any legal or collection agency fees due.

RETURNED CHECKS – A $20.00 fee will be assessed for each check returned for insufficient funds.