Steven R. Allsing, M.D., Inc.
PATIENT REGISTRATION

Email Address:_____

Date_____ **What pharmacy do you use?** _____

Patient's Last Name _____ **First** _____

*Birth Date*_____Age_____ Sex: M F Marital Status M S D W

Street Address _____Apt # _____

City_____State_____Zip_____

Home Phone _____ Cell Phone_____

Parent/Guardian (if under 18) _____ Phone _____

Social Security # _____ Driver's License #_____

Patient's Employer_____Occupation_____

Employer's Address_____Work Phone_____

Please fill out your spouse's information (if applicable). This is important for both health and billing purposes. Thank you.

Spouse's Name_____Social Security #_____

Spouse's Date of Birth_____ Employer_____Occupation_____

Emergency Contact Name _____ Phone: _____

Referring Physician _____Your Primary Doctor/Family Physician _____

THE LAW SAYS WE MUST RECORD YOUR ETHNIC GROUP AND LANGUAGE, THIS WILL NOT AFFECT YOUR TREATMENT

☐ ASIAN ☐ AMERICAN INDIAN ☐ ARAB ☐ IRAQI ☐CAMBODIAN ☐ CHINESE
☐ FILIPINO ☐ PACIFIC ISLANDER ☐ HISPANIC ☐ JAPANESE ☐ KOREAN ☐ AFRICAN AMERICAN
☐CAUCASIAN ☐ VIETNAMESE ☐ OTHER (SPECIFY) _____

PRIMARY LANGUAGE

☐ ENGLISH ☐SPANISH ☐ARABIC ☐ TAGALOG ☐ RUSSIAN ☐ MANDARIN ☐OTHER _____

Is this a **work related injury**? Yes No Date of Injury_____

Worker's Comp Insurance Name_____Claim #_____

Worker's Comp Address_____Adjuster's Name_____

INSURANCE INFORMATION Circle all methods of payment that apply. Worker's Comp Insurance (see above)

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name_____	Name_____
Policy_____	Policy_____
Group#_____	Group#_____
Address_____	Address_____
Name of Insured_____	Name of Insured_____

ASSIGNMENT AND MEDICAL RECORDS RELEASE

I hereby assign directly to Steven R. Allsing, M.D., Inc. all medical benefits, if any, otherwise payable to me for services rendered by them. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Steven R. Allsing, M.D., Inc. to release all medical and billing information necessary to secure the payment of benefits to my insurer(s) and to my other treating physician(s). I authorize the use of this signature on all my insurance forms.

Signature of Patient/Insured_____Date_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Steven R. Allsing, M.D., Inc. for any services furnished to me by them. I authorize any holder of medical information about me to release to the Steven R. Allsing, M.D., Inc. and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made to Steven R. Allsing, M.D., Inc. and authorize release of medical information necessary to pay for my services. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on any other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Steven R. Allsing, M.D., Inc agrees to accept the charge determination of the Medicare carrier as the full charge, and I will be responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient/Insured_____Date_____

New Patient Information
Steven R. Allsing, M.D.

Please complete the following so that the physician and staff will be more informed and able to assist you.

Print Full Name: _____

Date of Birth: _____ Age: _____ Sex: Male / Female

Height: _____ Weight: _____ Dexterity: Right-Handed / Left-Handed

Occupation: _____

Who may we thank for referring you to our office? _____

To better assess your medical condition, please provide the following information below:

Cardiovascular	Yes	No
High Blood Pressure		
Heart Failure		
Heart Attack/MI		
Atrial Fibrillation		
High Cholesterol		
Blood Clots		

Respiratory		
Oral Steroid Use		
Chronic Bronchitis		
Emphysema/COPD		
Pulmonary Embolism		
Sleep Apnea		
Pneumonia		
Tuberculosis		

Gastrointestinal		
Liver Disorder		
Hepatitis / type?		
GERD/ Acid Reflux		
Stomach Ulcer		
Ulcerative Colitis		
Crohn's Disease		
Kidney Stones		
Kidney Failure		

Neurologic	Yes	No
Polio		
Neuropathy		
Charcot-Marie-Tooth		
Seizure Disorder		
Stroke/TIA/CVA		
Depression		
Anxiety		

Endocrine		
Thyroid Disorder		
Diabetes		

Musculoskeletal		
Gout		
Lupus/SLE		
Osteoarthritis		
Osteoporosis		
Rheumatoid Arthritis		
Fibromyalgia		
Psoriasis		
Lyme Disease		

Other		
Cataracts		
Glaucoma		
AIDS/HIV		
Cancer		

Past Surgical History: (Please list **ALL** surgeries and dates, including appendectomy, tonsillectomy, etc.)

_____

_____

_____

Are you/could you be pregnant? Yes No

Do you smoke? Yes No Quit (When?_____) Yes: Packs per day:_____

Alcohol Consumption (# of drinks per week): _____

Recreational Drug Use: Current user? Yes No Past User? Yes No

What type? _____

Family History	Yes	No
Blood Diseases in relatives		
Cancer or leukemia in relatives		
Diabetes in relatives		

Family History	Yes	No
Heart disease in relatives		
High blood pressure in relatives		
Strokes in relatives		
Mental Illness in relatives		

Review of Systems	Yes	No
Anemia		
Bleeding Tendency		
Easy Bruising		
Chest Pain		
Palpitations		
Heart Murmur		
Swollen Legs		
Leg Cramps		
Chronic Cough		
Wheezing		
Shortness of Breath		
Nausea/Vomiting		
Constipation		
Chronic Diarrhea		
Blood in Stool		

Review of Systems	Yes	No
Incontinence		
Problems Urinating		
Intolerance to Heat		
Intolerance to Cold		
Menstrual Problems		
Breast Masses		
Double Vision		
Blindness		
Use of Eyeglasses		
Use of Hearing Aid		
Deafness		
Sinus Problems		

Review of Systems	Yes	No
Frequent Headaches		
Dizziness		
Balance Problems		
Numbness/Tingling		
Weakness		
Acne		
Rash		
Swollen Glands		
Hayfever		
Allergies		
Anxiety		
Depression		

Activities of Daily Living (ADL's)

Are you able to:	Yes	No	If NO please explain
Dress yourself including shoes			
Wash and dry yourself			
Take a bath			
Get on and off the toilet			
Cut your food			
Lift a full cup to your mouth			
Make a meal			
Write a note			
Type a message on a computer			
Use a telephone			
Work outdoors on flat ground			
Climb up 1 flight of stairs (10 steps)			
Stand			
Sit			
Recline			
Rise from a chair			
Run errands			
Light housework			
Feel what you touch			
Open car doors			
Turn faucets on and off			
Get in and out of the car			
Sleep			
Engage in sexual activity			

Patient Signature: _____ Date: _____

Medication List

Patient _____ Date_____

Allergies _____

_____

Name of Medicine	Milligrams	Dose

Over the counter medications, herbal remedies, vitamins		

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS.

I consent to the use or disclosure of my health information by Dr. Steven Allsing for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Steven R. AllsingM.D. I understand that diagnosis or treatment of me by Dr. Allsing may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Dr. Allsing is not required to agree to the restrictions that may request. However, if Dr. Allsing agrees to a restriction that I request the restriction is binding on Dr. Allsing and his staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Allsing or his staff has taken action in reliance on this consent.

My "protected health information" means health information, including my demographics information, collected from me and created or received by physician, another healthcare provider, a health plan, my employer or health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Dr. Allsing's Notice of Privacy Practices when I sign this document. By signature of consent for treatment on this document, I also attest that The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses the disclosure of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations by Dr. Allsing.

Steven R. Allsing, M.D. reserves the right to change the privacy practices that are described in the Notice of privacy Practices. I may obtain a reviewed notice by calling the office or asking for a copy at the time of my next appointment.

_____ **Signature of Patient or Personal Representative**

_____ **Name of Patient of Personal Representative**

_____ **Date**