

Patient Registration Form – Tri-State Neurosurgical Associates - UPMC

Patient information:

Today's Date: _____

Name: _____ Birthdate: _____ - _____ - _____

SS#: _____ - _____ - _____ Age _____ Sex: M or F Martial Status: M S W D Other

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone:() _____ Work Phone:() _____ Mobile:() _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Nearest Relative: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Address: _____

Is Injury related to: ___Auto ___Work ___Other Last Day Worked: _____

How did you hear about us? _____

Person responsible for bill (Self if over age 18, legal guardian if under age 18)

Name: _____ Birthdate: _____ - _____ - _____

SS#: _____ - _____ - _____ Sex: M or F Martial Status: M S W D Other

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone:() _____ Work Phone:() _____ Mobile:() _____

Employer: _____ Occupation: _____

Relationship to patient: _____

Primary Insurance: (please present card for verification):

Insurance Name: _____ Copay Amount-PCP: \$ _____ Specialty: \$ _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Sex: M or F Birthdate: _____ - _____ - _____

Address: _____ Phone: _____

Insurance ID# _____ Group #: _____ Effective Date: _____

SS#: _____ - _____ - _____ Relationship to patient: _____ Employer: _____

Secondary Insurance (Please send card for verification):

Insurance Name: _____ Copay Amount-PCP \$ _____ Specialty \$ _____

Address: _____ City: _____ State: _____ Zip: _____

Subscriber Name: _____ Sex: M or F Birthdate: _____ - _____ - _____

Subscriber Address: _____ Phone: _____

Insurance ID #: _____ Group #: _____ Effective date: _____ - _____ - _____

SS #: _____ - _____ - _____ Relationship to patient: _____ Employer: _____

AUTO / WORKERS COMPENSATION CLAIMS

Injury Description: _____

Accident Date / Injury Date: _____ Type of Claim: WC AUTO

State of Accident (auto only) _____ Workers Comp / Auto Claim #: _____

Insurance Name: _____ Phone #: _____

Contact Person / Agent's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Employer (Worker Comp only): _____

Employer Phone #: _____

Patients under 18

Mother's Name: _____ SS #: _____

Home Phone #: _____ Work Phone #: _____

Father's Name: _____ SS#: _____

Home Phone#: _____ Work Phone #: _____

I authorize payment of medical benefits to Tri-State Neurosurgical Associates-UPMC for the services provided. I also authorize release of medical information necessary to process my claim.

Signature: _____ Date: _____

Name _____ Age _____

Date of onset/Reason for visit _____

Medications	Medications

Please list all allergies: _____

Do you have an allergy to latex? Yes or No (circle one)

Are you claustrophobic? Yes or No (circle one)

Please check and circle whether you have had or have ever been treated for the illnesses or diseases listed below:

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart attack or coronary artery disease | <input type="checkbox"/> Strokes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizures, convulsions, passing out spells |
| <input type="checkbox"/> Asthma, emphysema, shortness of breath | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Irregular heart beat, chest pain |
| <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Heart murmur or valve disease |
| <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Hepatitis or yellow jaundice | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> inflammation of the intestines or colitis | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Phlebitis/blood clot in leg |
| <input type="checkbox"/> kidney stones or problem | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Urinary tract or bladder infections | <input type="checkbox"/> Depression | <input type="checkbox"/> Chronic skin problems or disease |
| <input type="checkbox"/> Rheumatic fever/rheumatic heart disease | <input type="checkbox"/> Rheumatic diseases such as lupus, rheumatoid arthritis, fibromyalgia or chronic fatigue syndrome | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Alcohol or chemical dependency issues | | |

SURGICAL PROCEDURES

Physician Initials _____ Date _____

FAMILY HISTORY

Please list below how many living and deceased parents or siblings you have and what medical problems they have:

Relationship	Medical Problems	Living?

SOCIAL HISTORY

Have you ever smoked cigarettes, cigars or a pipe? _____ Are you currently a smoker? _____

How much do you smoke? _____ How long have you smoked? _____

If you have stopped smoking, please answer the following questions:

How much did you smoke? _____ How many years did you smoke? _____

When did you quit smoking? _____ What did you smoke? _____

Do you drink alcohol? _____ How much do you drink in an average week? _____

What type of alcoholic beverage do you drink (i.e. beer, wine, mixed drinks)? _____

Do you use recreational drugs? _____ What kind and frequency? _____

Marital status

Single _____ Married _____ Divorced _____ Widowed _____ Other _____

Do you live alone? _____

Do you have children? _____ How many and ages? _____

Highest level of education: _____ What is your occupation? _____

Last day of work _____

Was this a work related injury? _____

Was this a result of a motor vehicle accident (mva)? _____

Is there litigation pending? _____

Physican Initials _____ **Date** _____