Patient Registration Form – Tri-State Neurosurgical Associates - UPMC

Patient information: Today's Date: _____

Name: _____ Birthdate: ____-____-____ Age: _____

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: _____

Emergency Contact:_____ Relationship: _____ Phone: _____

Primary Care Physician:_____ Phone: _____

Address: _____

How did you hear about us? **Circle One:**

Self Friend Previous Patient Newspaper Ad Magazine Internet UPMC Referral Hotline Physical Therapist

Specify _____

Physician Name _____ Specialty_____

Physician Address _____

Is Injury related to: ____Auto _____Work _____Other Last Day Worked: _____

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 present 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: _____

MEDICAL HISTORY

Name: _____ **Age:** _____

Reason for visit: _____

Medications	Medications

Please list all allergies: _____

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

Are you claustrophobic? Yes No (Circle one)

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

Cardiovascular:
___Heart attack
___High blood pressure
___Coronary artery disease
___Irregular heart beat
___Chest pain
___High Cholesterol
___Rheumatic fever/rheumatic heart disease
___Heart murmur

Respiratory:
___Asthma/cough/wheezing
___Shortness of breath
___Emphysema/COPD
___Sleep Apnea
___Pneumonia

Neurological:
___Strokes
___Seizures
___Fainting spells

Endocrine:
___Diabetes
___Thyroid Disease

Genitourinary:
___Urinary tract infections
___Urinary incontinence
___Prostate problems
___Kidney stones/problems
___Sexually transmitted disease

Gastrointestinal:
___Inflammation of the intestines
___Stomach ulcer
___Heartburn/reflux

Psychiatric:
___Depression
___Anxiety
___Bipolar
___Alcohol or chemical dependency

Rheumatic:
___Fibromyalgia
___Lupus
___Arthritis
___Gout

Blood/Lymphatic:
___Anemia
___Blood transfusions
___Cancer
___Blood clots

Hepatic:
___Liver disease
___Hepatitis
___Type A
___Type B
___Type C

Integumentary:
___Rashes
___Eczema
___Psoriasis

Other: _____

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?**
Mother	_____	Yes No
Father	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No

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 Initals _____ Date _____