



12 Upper Ragsdale Road | Ryan Ranch | Monterey, CA 93940 | P 831.648.7200 | F 831.648.7204 | montereyjoint.com

**New Patient Registration Form**

Mr. / Mrs. / Ms.	First Name	Middle Initial	Last Name	Suffix (jr, MD, etc)
Address		City	State	Zip
Home Telephone		Work Telephone	Cell or other Telephone	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth	Social Security Number	Marital Status		Sex
<input type="checkbox"/> Retired <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed		Occupation & Employer's Address (if retired, occupation prior to retirement)		

Is the patient responsible for medical charges?  Yes  No If not, please complete the following Guarantor Information

Mr. / Mrs. / Ms.	First Name	Middle Initial	Last Name	Suffix (jr, MD, etc)
Address		City	State	Zip
Home Telephone		Work Telephone	Cell or other Telephone	
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth	Social Security Number	Marital Status		Sex
<input type="checkbox"/> Retired <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed		Occupation & Employer's Address (if retired, occupation prior to retirement)		

**Primary Insurance Information**

**Secondary Insurance Information**

Name of Insurance Provider			
Claims Address	City	State	Zip
Member's ID Number	Group Number		
Specialty CoPay			

Name of Insurance Provider			
Claims Address	City	State	Zip
Member's ID Number	Group Number		
Specialty CoPay			

**Who is the doctor who referred you to our clinic?**

**Who is your primary care doctor?**

Name			
Address	City	State	Zip
Telephone		Fax	

Name			
Address	City	State	Zip
Telephone		Fax	

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**Why are you seeing the doctor today?**

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**Please list any medical problems that you have, such as high blood pressure, diabetes, etc.**

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**Please list the surgeries you have had in the past**

Surgery	year	Surgery	year

**Please list the medications that you take**

Name of medication	dosage	Name of medication	dosage

**Which Pharmacy do you use (Name & Location)**

**Please list any allergies that you have**

allergy	reaction	allergy	reaction

**Social History**

Exercise Frequency     Daily     Weekly     Monthly     Rarely     Never  
 Do you have children?     No     Yes    If yes, how many? \_\_\_\_\_  
 Are you, or could you be pregnant ?     No     Yes  
 Do you live alone?     No     Yes    Do you have a lot of stairs at home?     Yes     No  
 How often do you drink alcohol? \_\_\_\_\_     I don't drink alcohol  
 If you smoke, how may packs per day do you smoke? \_\_\_\_\_ For how many years? \_\_\_\_\_     I don't smoke tobacco  
 If you quit smoking...CONGRATULATIONS!!! How long ago did you smoke your last cigarette? \_\_\_\_\_

**Personal and Family Review of Systems:    ● circle = patient    ■ box = family member**

- |  |   |  |
|--|---|--|
| <input type="radio"/> <input type="checkbox"/> arthritis                       | <input type="radio"/> <input type="checkbox"/> stomach ulcers     | <input type="radio"/> <input type="checkbox"/> psychologic problems    |
| <input type="radio"/> <input type="checkbox"/> hypertension                    | <input type="radio"/> <input type="checkbox"/> fainting           | <input type="radio"/> <input type="checkbox"/> depression              |
| <input type="radio"/> <input type="checkbox"/> cancer                          | <input type="radio"/> <input type="checkbox"/> rashes             | <input type="radio"/> <input type="checkbox"/> poor vision             |
| <input type="radio"/> <input type="checkbox"/> mental health problems          | <input type="radio"/> <input type="checkbox"/> seizures           | <input type="radio"/> <input type="checkbox"/> poor hearing            |
| <input type="radio"/> <input type="checkbox"/> blood clots, bleeding disorders | <input type="radio"/> <input type="checkbox"/> obesity            | <input type="radio"/> <input type="checkbox"/> rheumatologic illness   |
| <input type="radio"/> <input type="checkbox"/> diabetes                        | <input type="radio"/> <input type="checkbox"/> weight loss        | <input type="radio"/> <input type="checkbox"/> ADHD                    |
| <input type="radio"/> <input type="checkbox"/> bad reaction to anesthesia      | <input type="radio"/> <input type="checkbox"/> liver disease      | <input type="radio"/> <input type="checkbox"/> IV drug use             |
| <input type="radio"/> <input type="checkbox"/> cardiac disorders               | <input type="radio"/> <input type="checkbox"/> kidney stones      | <input type="radio"/> <input type="checkbox"/> alcoholism              |
| <input type="radio"/> <input type="checkbox"/> hepatitis                       | <input type="radio"/> <input type="checkbox"/> urinary difficulty | <input type="radio"/> <input type="checkbox"/> prior blood transfusion |
| <input type="radio"/> <input type="checkbox"/> HIV/AIDS                        | <input type="radio"/> <input type="checkbox"/> scoliosis          | <input type="radio"/> <input type="checkbox"/> recent travel           |



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**RELEASE OF MEDICAL INFORMATION AND FINANCIAL RESPONSIBILITY**

We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card, if a copayment or deductible is part of your plan, we require that your portion be paid at the time of service. We will make every effort to provide you with an accurate amount due at the end of your visit today.

I hereby authorize the release of any needed medical information to insurance carriers to process a claim, and request that payment be sent to Monterey Spine and Joint for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. Monterey Spine and Joint may add monthly rebilling fees for overdue balances.

\_\_\_\_\_  
Signed Date

**MEDICARE PATIENTS ONLY: RELEASE OF MEDICAL INFORMATION AND FINANCIAL RESPONSIBILITY**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Monterey Spine and Joint for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Center for Medicare and Medical Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Signed Date

**Designation of Personal Representatives & Notice of Privacy Practices**

I, \_\_\_\_\_ have have been given the opportunity to read and review this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signed Date

I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all of my protected health information

Name	Relationship to Patient	Name	Relationship to Patient
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**Consent for Treatment if Patient is a Minor**

I grant Monterey Spine and Joint and the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the above patient.

\_\_\_\_\_  
Signed Relationship to Patient Date



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## Universal Injury or Accident Statement

Patient's Full Name

Today's Date

Please complete the following statement. Most Insurance companies request accident details and this may be forwarded with your insurance claim or provided to an adjuster to complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.

Date of Injury

Place where injury occurred (work, home, parking lot, car, friend's house, etc.)

### Please Describe How the Injury or Accident Occurred

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Was injury work related?  Yes  No If yes, complete the following section

Name of Employer

Telephone Number

Employer's Address

City

State

Zip

Workman's Compensation Carrier

Policy Number

Group Number

Claims Address

City

State

Zip

Is there a possible third party liability settlement?  Yes  No  
(e.g., Auto, Homeowners, Property)

If yes, complete the following section

Name of Insurance:

Phone

Adjuster's name (if known):

Phone

I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical charges incurred.

Patient's Signature (or Responsible party if patient is a minor)

Date