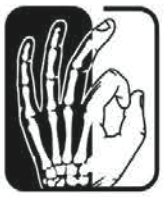

Lisa R. Reznick, M.D., P.A.

BOARD CERTIFIED ORTHOPAEDIC & HAND SURGEON

SPECIALIZING IN GENERAL ORTHOPAEDICS & HAND SURGERY

Welcome to our practice! We truly appreciate your trust and confidence. Our goal is to make each of your visits informative and constructive. We strive to provide you with the highest quality of care for all of your Orthopedic and surgical needs. Thank you for choosing our practice!

By following the general instructions below and providing us with all of the necessary information on your Orthopedic issue, we can better facilitate your office visit.

Please bring a copy or CD of any x-rays, MRIs, CT scans or electrodiagnostic studies (EMG/NCV) that have been previously performed to evaluate your current condition.

Please fill out a "Release of Medical Records" form (found on the website) for EACH of the physicians, surgeons, ERs, Urgent Cares, and/or hospitals where you have been previously treated for this condition.

You will also find a copy of our "**Notice of Privacy Practices**" on our website. It is **NOT** necessary to print this out and is for your information only. Upon your request, copies are also available in our office.

Please fill out your paperwork completely including your health and surgical history, family history, medications and allergies to medications. This information is pertinent to your care.

If you have printer issues or issues opening your new patient paperwork, please call our office at (972) 395-9000 or come in 20 minutes early for your appointment in order to complete this paperwork.

We look forward to meeting you!

Lisa R. Reznick, M.D., P.A.
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REGISTRATION FORM

PATIENT INFORMATION				
Name				**DOB:**
Address				
	Street		City	State Zip
SSN		**Email:**		**Marital Status:**
Contact #s				
	Cell	Home	Work	Other
Emergency Contact			**Contact #:**	

RESPONSIBLE PARTY INFORMATION				
Name				**DOB:**
Relationship	*(Check relationship to patient)*	Spouse ☐	Parent ☐	Other ☐
SSN		**Email:**		
Contact #s				
	Cell	Home	Work	Other

HEALTH INSURANCE INFORMATION				
Primary Insurance				
Insurance Name				
Policy Holder Name				**DOB:**
Policy #				**Group #:**
Relationship to Policy Holder	*(Check)*	Self ☐	Spouse ☐	Child ☐ Other ☐
Secondary Insurance (if applicable)				
Insurance Name				
Policy Holder Name				**DOB:**
Policy #				**Group #:**
Relationship to Policy Holder	*(Check)*	Self ☐	Spouse ☐	Child ☐ Other ☐
WORKER'S COMPENSATION (IF APPLICABLE)	*If worker's comp injury, please provide following info.*			
Employer				**Contact #:**
Employer Address				
	Street		City	State Zip
Adjuster Name				**Contact #:**

Patient/Parent/Guardian Signature: _____ Date: _____

PATIENT HISTORY FORM

Patient Name: _____ **Today's Date:** _____

Birthdate: _____ **Age:** _____ **Handedness (check one):** Right ☐ Left ☐ Ambidextrous ☐

Date of Last Physical Exam: _____

Reason for Today's visit? _____

PAST MEDICAL HISTORY: (Please check **ALL** conditions that you currently have or have had in the past)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ MRSA
- ☐ Mumps
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Suicide Attempt
- ☐ Stroke
- ☐ Thyroid (Hyper /Hypo)
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers

REVIEW OF SYMPTOMS: (Please only check **CURRENT** problems)

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Rapid heartbeat
- ☐ Swelling of ankles
- ☐ Varicose veins

Ear, Eye, Nose, Throat
- ☐ Bleeding Gums
- ☐ Blurred/Double Vision
- ☐ Difficulty Swallowing
- ☐ Earache/Drainage
- ☐ Hearing Loss/Ringing
- ☐ Nosebleeds
- ☐ Sinus Problems

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Hemorrhoids
- ☐ Indigestion

General
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache
- ☐ Numbness
- ☐ Sleep Loss/Gain
- ☐ Sweats
- ☐ Weight Loss/Gain

Genito-Urinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Muscle/Joint/Bone

Pain, Weakness, Numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Fingers
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ Wrist

Skin
- ☐ Bruise easily
- ☐ Change in moles
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars

MEN only
- ☐ Breast lump
- ☐ Erection dysfunction
- ☐ Lump in testicles
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Other

1. Date of last menstrual period: _____
2. Date of last Pap Smear: _____
3. Have you had a mammogram? ☐ Y / N ☐
4. Are you pregnant? ☐ Y / N ☐

_____ _____

Patient/Parent/Guardian Signature **Date**

FAMILY HISTORY

Relation	Age	State of Health	Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Check if your blood relatives had any of the following:

	Disease	Relationship		Disease	Relationship
☐	Arthritis		☐	Hay Fever	
☐	Asthma		☐	Heart Disease	
☐	Cancer		☐	Kidney Disease	
☐	Diabetes		☐	Stroke	
☐	Epilepsy		☐	Tuberculosis	
☐	Gout		☐	Other	

SURGICAL HISTORY

Year	Hospital	Reason for Hospitalization and Outcome

CHILDREN

Year of Birth	Sex	Complications, if any

Have you ever had a blood transfusion? **Y / N** If yes, please give approximate dates: _____

Have you ever had a prior **MRSA** infection? **Y / N**

SOCIAL HISTORY

Tobacco Use: Y / N Packs/day: _____ Year Started: _____ Year Stopped: _____

Alcohol Use: Y / N Quantity: _____ Type: _____

Drug Use: Y / N Quantity: _____ Type: _____ Last Time Used: _____

Occupation: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any errors or omission that I may have made in the completion of this form.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Reviewed By (STAFF USE ONLY) **Date**

MEDICATIONS

PRESCRIPTIONS

Medication Name	Dosage	Frequency	Route of Administration

OVER-THE-COUNTERS

Medication Name	Dosage	Frequency	Route of Administration

HERBALS/VITAMIN/MINERAL/DIETARY (NUTRITIONAL) SUPPLEMENTS

Medication Name	Dosage	Frequency	Route of Administration

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS:

_____
_____
_____
_____

Pharmacy Name: _____
Address: _____
_____
Phone: _____

_____ _____

Patient/Parent/Guardian Signature **Date**

Lisa R. Reznick, M.D., P.A.
BOARD CERTIFIED ORTHOPAEDIC & HAND SURGEON
SPECIALIZING IN GENERAL ORTHOPAEDICS & HAND SURGERY

FINANCIAL AND OFFICE POLICIES

Please **initial** below for each applicable statement to acknowledge your understanding of our policies:

_____ 1. **Assignment of Insurance Benefits:** I hereby authorize direct payment of my insurance benefits to **Lisa R. Reznick, M.D., P.A.** I understand that I am financially responsible for any balance not covered by my insurance including labs, X-rays or other diagnostic services or procedures.

_____ 2. **Authorization to Release Information:** I hereby authorize **Lisa R. Reznick, M.D., P.A.** to release any medical or incidental information that may be necessary for either medical care or for processing insurance or financial benefits.

_____ 3. **Medicare/Medicaid:** I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made to **Lisa R. Reznick, M.D., P.A**.

_____ 4. **Returned Check Fee:** I understand that if a check written on my behalf is returned for insufficient funds, I will be responsible for the original amount of the check plus a **$25 fee**, paid immediately by cash, money order, cashier's check or credit card.

_____ 5. **No Show Fee:** I understand that if I am unable to attend a scheduled appointment, I must call (972) 395-9000 and cancel the appointment 24 hours in advance. Failure to cancel my appointment will result in a charge to my account of a "no show" appointment fee of **$25.00 / incidence**. I understand that if I arrive to an appointment more than 20 minutes late without notifying the office of my tardiness, then my appointment might need to be cancelled and rescheduled.

_____ 6. **Collection Agency:** I understand that if my account is 90 days overdue and has to be sent to a collection agency, I will be responsible for any unpaid balances plus any additional fees incurred from the collection agency, lawyers or court proceedings. I also understand that **Lisa R. Reznick, MD, PA** has the right to disclose all relevant personal and account information necessary to the agency to collect payment.

_____ 7. **Notice of Privacy Practice:** I acknowledge that **Lisa R. Reznick, MD, PA** provided me with a written copy of the "Notice of Privacy Practices". I also acknowledge that I have been afforded the opportunity to read the "Notice of Privacy Practices" and ask questions.

_____ 8. **Authorization/Referrals:** I understand that if my insurance plan requires me to obtain a formal referral from my PCP (Primary Care Physician) prior to my office visit, that I am responsible to obtain this referral as well as to insure that any previous referral hasn't expired prior to my appointment at **Lisa R Reznick, MD, PA.**

_____ 9. **FMLA/Disability Forms/Medical Records Fees:** I understand that I will be charged a **$25.00** for any administrative paperwork, disability forms, FMLA, or requested copies of medical records (up to 20 pages with $0.50/page thereafter). I also understand that there is an **$8.00 fee** for requested CD of my X-rays.

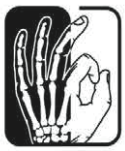
_____ 10. **Self-Pay Patients:** Patients who are self-pay/uninsured will be required to pay 100% of charges at time of service.

_____ 11. **Motor Vehicle Accident Patients**: If your health insurance has a clause that covers motor vehicle accidents, then we can see you under your health insurance plan. If NOT, we cannot bill your health insurance plan. You will be then classified as a self-pay patient and will be expected to pay 100% at the time of service and at every visit. We do NOT accept automobile insurances nor do we accept Letters of Protection (LOP) from lawyers to cover these cases.

By signing below, I acknowledge that I have read and understood all of the above statements.

_____ _____

Patient/Parent/Guardian Signature **Date**



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BOARD CERTIFIED ORTHOPAEDIC & HAND SURGEON
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Consent to Leave Phone/Email/Fax Messages

At times, we may need to contact your about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be able to serve you better in this regard. In an effort to protect your privacy and follow HIPAA guidelines, we have developed the following policy on leaving messages containing medical information. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave detailed messages on voice mail or answering machines
- We will NOT send emails/faxes

How would you prefer to be contacted regarding test results, appointment reminders, billing and insurance questions or other relevant medical information? Please indicate **ALL** of your approved methods below:

☐ Phone
☐ Cell phone: _____
☐ Home phone: _____
☐ Work phone: _____
☐ Email: _____
☐ Fax: _____

Please identify those individuals below with whom we may share and discuss your medical and account information on your behalf?

Spouse/Partner: ☐ Yes ☐ No If yes, name: _____
Son/Daughter: ☐ Yes ☐ No If yes, name(s):_____
Other: ☐ Yes ☐ No If yes, name(s): _____

Special Instructions, if any: _____
_____

I, _____, give **Lisa R. Reznick, M.D., P.A.** permission to leave phone messages and/or email/fax messages regarding my medical care/account information as indicated above. I also give **Lisa R. Reznick, M.D., P.A.** permission to speak to the specific individuals indicated above on my behalf regarding any relevant medical or accounting/insurance issues. I fully understand that this consent will remain valid until revoked by me in writing:

_____ _____
Patient/Guardian Signature Date