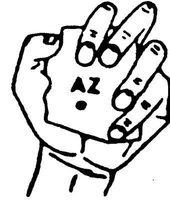
AFFILIATED ARM SHOULDER & HAND SURGEONS, LTD



PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY & COMPLETE IN FULL!

APPOINTMENT DATE: ________________________

LAST: ______________________________ FIRST: ______________________________ MIDDLE: _____

PATIENT DATE OF BIRTH: _______________________ PATIENT SEX: MALE FEMALE

PATIENT SOCIAL SECURITY #: __________________________ MARITAL STATUS: ______________

ETHNICITY / RACE: __________________________

HOME ADDRESS: ____

CITY / STATE / ZIP: ____

PATIENT PRIMARY PHONE #: HOME / CELL / OTHER: _______________________________________

PATIENT 2ND PHONE #: HOME / CELL / OTHER: ____

PATIENT WORK #: ________________________ EMAIL ADDRESS: _____________________________

EMPLOYMENT STATUS: __________________ OCCUPATION: __________________________

EMPLOYER NAME:____

PRIMARY DOCTOR NAME: ____________________________________ PHONE: ___________________

PREFERRED PHARMACY NAME: _______________________________ PHONE: _________________

(PLEASE CIRCLE) ARE YOU: RIGHT or LEFT HANDED or AMBIDEXTROUS?

ARE YOU PREGNANT? __________________________________

DATE OF INJURY OR START OF SYMPTOMS: ______________

[ ] SHOULDER (R or L) [ ] ELBOW (R or L) [ ] WRIST (R or L) [ ] HAND (R or L)

IS YOUR INJURY RELATED TO: (PLEASE CIRLCLE) WORK AUTO PERSONAL INJURY or N/A?

ARE YOU UNDER THE CARE OF A PAIN MANAGEMENT DOCTOR? ____________________________

IF YES, PLEASE LIST YOUR DOCTOR'S NAME, CLINIC, AND PHONE NUMBER:

____

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YOU MAY FAX YOUR COMPLETED PACKET TO (602) 954-6433 OR EMAIL TO FRONTDESKRUGGERI@GMAIL.COM

UP TO 24 HOURS PRIOR TO YOUR APPOINTMENT

NAME: ____________________________ DOB: __________ APPT DATE: __________

PRIMARY INSURANCE

INSURANCE NAME: ____

ID #: ______________________________ GROUP #: _______________________

GUARANTOR FULL NAME: ____

GUARANTOR DATE OF BIRTH: ____

GUARANTOR SOCIAL SECURITY #: _______________________________________

SEX OF GUANANTOR: (PLEASE CIRCLE) MALE FEMALE

GUARANTOR HOME ADDRESS: ____

CITY/STATE/ZIP: ____

GUARANTOR PRIMARY PHONE # ____

GUARANTOR SECONDARY PHONE #: _____________________________________

GUARANTOR EMPLOYER: ____

GUARANTOR WORK #: ____

SECONDARY INSURANCE

INSURANCE NAME: ____

ID #: ______________________________ GROUP #: _______________________

GUARANTOR FULL NAME: ____

GUARANTOR DATE OF BIRTH: ____

GUARANTOR SOCIAL SECURITY #: _______________________________________

SEX OF GUANANTOR: (PLEASE CIRCLE) MALE FEMALE

GUARANTOR HOME ADDRESS: ____

CITY/STATE/ZIP: ____

GUARANTOR PRIMARY PHONE # ____

GUARANTOR SECONDARY PHONE #: _____________________________________

GUARANTOR EMPLOYER: ____

GUARANTOR WORK #: ____

NAME: ______________________________ DOB: ___________ APPT DATE: ___________

INDUSTRIAL / WORK INJURY CLAIM INFORMATION

INDUSTRIAL INSURANCE NAME: ____

DATE OF INJURY: ________________________ CLAIM NUMBER: _________________________

CONTACT NAME: ________________________ PHONE NUMBER: ________________________

NURSE CASE MANAGER: ____

PHONE NUMBER: _________________________ FAX NUMBER: __________________________

INDUSTRIAL INSURANCE ADDRESS:

____

____

____

LEGAL CLAIM INFORMATION

ATTORNEY NAME: ____

DATE OF INJURY: _______________________ FILE / CLAIM NUMBER: ____________________

CONTACT NAME: ____

PHONE NUMBER: __________________________ FAX NUMBER: _________________________

NAME: ______________________________ DOB: ___________ APPT DATE: ___________

Current medications:

Drug Name	Strength (mg)	Dosage (How often?)
1. ______________________	______________	______________________
2. ______________________	______________	______________________
3. ______________________	______________	______________________
4. ______________________	______________	______________________
5. ______________________	______________	______________________
6. ______________________	______________	______________________

Drug Allergies:

Drug Name	Strength (mg)	Reaction
1. ______________________	______________	______________________
2. ______________________	______________	______________________
3. ______________________	______________	______________________

Height: __________________________ **Weight:** ________________________

Describe your symptoms and what caused them. Include duration, location and severity: (example: right hand numbness since March of 2010, worse with gripping activities and developing weakness)

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Please give a brief summary of the treatment and/or testing you've had for this condition: (example: wrist splints for 6 months, over the counter Ibuprofen with minimal benefit, NCV test last May) **Please bring in all related medical records, nerve studies, MRI/XR films including the reports**

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____

NAME: ___________________________ DOB: __________ APPT DATE: __________

Please check all that apply to your medical history:

__ No prior medical history, healthy
__ADHD combined
__Adrenal hyperplasia
__Allergic rhinitis
__ Anemia
__ Anemia pernicious
__Anorexia
__Asperger's syndrome
__Atrial fibrillation
__ Bipolar disorder
__ Blood transfusion
__ BPH
__ Breast cancer
__ Bronchiolitis RSV
__Cervical cancer
__Cholelithiasis
__CLL
__Colitis
__Colon polyps
__COPD
__CRI
__CVA
__Depression
__Diabetes type 1
__Digits accessory
__Eczema
__ESRD
__Failure to thrive
__Gastric cancer
__Gastritis
__Hernia Hiatal
__Hernia umbilical
__Hyperlipidemia
__hyperthyroidism
__Hypothyroidism
__Insomnia
__Leukemia
__Lymphoma
__MGUS
__Mononucleosis
__Nephrolithiasis
__Obesity
__Onychomycosis
__Osteopenia
__Ovarian Cancer
__Pancreatic cancer
__PDD

__Addison's disease
__ ADHD inattentive
__ AIDS
__ Alzheimer's disease
__ Anemia iron deficiency
__Anesthesia complications
__ASHD
__ Asthma
__Autism
__ Bladder cancer
__ Bone cancer
__ Brain cancer
__Bronchiolitis non RSV
__CAD
__CHF
__CKD
__Clotting disorder
__Colon cancer
__constipation
__CRF
__Crohns disease
__D (Rh) sensitized
__Diabetes
__Diabetes type 2
__Down syndrome
__Esophageal cancer
__ESRD on HD
__Fibrocystic disease
__Gastric ulcers
__GERD
__Hernia inguinal
__History of abnormal PAP
__Hypertension
__Hypospadias
__Infertility
__Laryngeal cancer
__Lung cancer
__Melanoma
__Migraine headaches
__Multiple myeloma
__NHL
__Obstructive sleep apnea
__Osteoarthritis
__Osteoporosis
__Pacemaker
__Parkinson's disease
__Peptic ulcers

NAME: ____________________________ DOB: __________ APPT DATE: __________

__Phlebitis
__Positive PPD
__Prostate cancer
__Pulmonary embolus
__PVD
__Renal Cancer
__Rheumatoid arthritis
__Sacral dimple
__Sarcoidosis
__Schizophrenia
__Seizure disorder
__Strokes
__Syncope (Fainting)
__Syncope(Fainting) near death experience
__Testicular cancer
__Thyroid cancer
__Tuberculosis
__Ulcerative colitis
__Uterine anomaly
__Uterine cancer
__Varicose Veins
__Vitamin B12 deficiency
__Waldenstoms
__Wegener's
__Whipples disease
__Wilsons disease
__WPW syndrome
__Xerostomia
__Zollinger Ellison

Other medical conditions not listed____

Please check all that apply to your surgical history:

__No prior surgeries
__AAA repair
__AAA repair endovascular
__Abdominal wall hernia repair
__Abdominoplasty
__Adenoidectomy
__Aortic valve repair
__Aortic valve replacement
__AortoFemoral bypass left
__AortoFemoral bypass right
__Appendectomy
__ASD repair
__Axilla LN dissect left
__Axilla LN dissect right
__Biopsy CT guided
__Biopsy ultrasound guided
__Breast augmentation
__Breast biopsy left
__Breast biopsy right
__Breast lift
__Breast lumpectomy left
__Breast lumpectomy right
__Breast reduction
__Bronchoscopy
__CABG 1 vessel
__CABG 2 vessel
__CABG 3 vessel
__CABG 4 vessel
__CABG 5 vessel
__Cardioversion elective
__Carotid endarterectomy left
__Carotid endarterectomy right
__Carpal tunnel surgery
__Cataract surgery
__Cerebral aneurysm clip
__Cesarean section
__Cholecystectomy (Gallbladder)
__Cleft lip revision
__Cleft palate revision
__Colectomy
__Colectomy partial
__Dilation and curettage
__Discectomy cervical
__Discectomy lumbar
__Duodenectomy
__Femoral pop bypass bilat
__Fem pop bypass left
__Fem pop bypass right
__Fistula AV left up ext
__Fistula AV right up ext
__Foam sclerotherapy
__Forehead lift
__Fusion cervical
__Fusion lumbar
__Gastrectomy
__Gastrectomy partial
__Gastric bypass
__Gastric lap banding

NAME: ____________________________ DOB: __________ APPT DATE: __________

__Hemorrhoidectomy
__Hernia repair inguinal left
__Hernia repair umbilical
__Hip replacement left
__Hysterectomy total abd
__Knee arthroscopy left
__Knee replacement left
__Laminectomy lumbar
__LASIK surgery
__Liposuction
__Lobectomy lung low left
__Lobectomy lung mid right
__Lysis peritoneal adhesion
__Mastectomy left
__Mediastinoscopy
__Mitral valve replacement
__Myringotomy bilateral
__Myringotomy right
__Nephrectomy left
__Ocular enucleation
__Oophorectomy bilateral
__Oophorectomy right
__Orchiectomy left
__ORIF hip left
__Otoplasty
__Pancreatectomy
__Pin fixation
__Pneumonectomy right
__Prostatectomy
__Renal biopsy
__Rhinoplasty
__Saphenous vein stripping
__Skin graft
__Stab avulsion var veins
__Temporal artery biopsy
__Thyroidectomy complete
__Thyroidectomy right
__Transplant heart
__Transplant kidney right
__Transplant lung right
__Tricuspid valve replace
__Tympanic membrane patch
__Urethral dilatation
__VSD repair
__Hernia incisional
__Hernia repair inguinal right
__Hiatal hernia repair
__Hip replacement right
__Hysterectomy total vag
__Knee arthroscopy right
__Knee replacement right
__laparoscopy exploratory
__Ligation varicose veins
__Lobectomy lung up left
__Lobectomy lung low right
__Lobectomy lung up right
__Mandibular advancement
__Mastectomy right
__Mitral valve repair
__Muscle biopsy
__Myringotomy left
__Nephrectomy bilateral
__Nephrectomy right
__Oculoplasty
__Oophorectomy left
__Orchiectomy bilateral
__Orchiectomy right
__ORIF hip right
__Pacemaker
__Parathyroidectomy
__Pneumonectomy left
__Prostate biopsy
__Push enteroscopy
__Retinal reattachment
__Rhytidectomy
__Sinus surgery
__Small bowel resection
__Strabismus surgery
__Thor aortic aneurysm rep
__Thyroidectomy left
__Tonsillectomy
__Transplant kidney left
__Transplant lung left
__Tricuspid valve repair
__Tubal ligation
__Tympanoplasty
__Vasectomy
__Whipple procedure

Other surgeries not listed____

NAME: ____________________________ DOB: __________ APPT DATE: __________

Do you drink coffee daily? (Please circle) Yes No

Number of cups per day: 1 2 3

Please circle which ever one applies to you:

1) Current everyday smoker 2) Current some day smoker 3) Former smoker

4) Never smoker 5) Smoker, current status unknown 6) Unknown if ever smoker

If current smoker, how long have you been smoking? ____________________

If former smoker, how long ago did you stop? _____________________

If current smoker, how many cigarettes do you smoke per day? (Please circle)

1) 20-39 2) Unknown 3) 1-9 4) 10-19 5) occasionally 6) 40+

How often do you drink alcohol? (Please circle)

1) Never 2) Daily 3) Monthly 4) Occasionally 5) Weekly

Number of drinks: 1 2 3 4 5 >6

Do you use recreational drugs? (Please circle) Yes No

If YES, what kind? ____

Please list your family medical history: (example: mother died of cancer, grandfather has Diabetes, Hypertension and Heart disease, and sister has Rheumatoid Arthritis)

____

____

Do you currently experience chest pain, unexplained weight loss, chills, fatigue, fever or sweats?

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AFFILIATED ARM, SHOULDER & HAND SURGEONS, LTD.
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY OF AFFILIATED ARM, SHOULDER & HAND SURGEONS, LTD

Affiliated Arm, shoulder & Hand Surgeons is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Affiliated Arm, Shoulder & Hand Surgeons uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluation of quality of care that we provide. For example, Affiliated Arm, Shoulder & Hand Surgeons may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Affiliated Arm, Shoulder & Hand Surgeons may also use or disclose your personal health information with prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law. We will consider all requests on a case by case basis, but the practice is not legally required to accept them.

In any other situation, Affiliated Arm, Shoulder & Hand Surgeon's policy is to obtain your written authorization before disclosing your personal health information if you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You may have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

CONCERNS AND COMPLAINTS

If you are concerned that Affiliated Arm, Shoulder & Hand Surgeons may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Affiliated Arm, Shoulder & Hand Surgeon's health information practices or if you have a complaint, please contact the following person:

AFFILIATED ARM, SHOULDER & HAND SURGEONS, LTD.
OFFICE ADMINISTRATOR
3104 E. Indian School Road, Suite 200
Phoenix, AZ 85016
Telephone: (602) 954-9484

AFFILIATED ARM, SHOULDER & HAND SURGEONS
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Affiliated Arm, Shoulder & Hand Surgeon's Notice of Information Practices. I understand that Affiliated Arm, Shoulder & Hand Surgeons may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to use and disclosure of my personal health information as noted in Affiliated Arm, Shoulder & Hand's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name (print) ______________________________ Signature______________________________________

If under 18:

Parent Name (print) ______________________________ Signature _______________________________________

Today's Date _________________________

Emergency Contact _______________________________________ Phone _________________________

Please list any persons you authorize our office to speak with regarding your care and treatment?

____

____

____

____

Do you authorize our office to leave voice messages for you on your given phone numbers? (Please circle)

YES NO

Sebastian B. Ruggeri, M.D. and Affiliated Arm, Shoulder & Hand Surgeons, LTD.
3104 E. Indian School Road, Suite 200 Phoenix, AZ 85016

FINANCIAL POLICY & DISCLOSURE STATEMENT

This office files Insurance as a courtesy to all patients. It is the responsibility of the patient to ensure the doctor gets paid.

If you are here for an industrial injury, your claim has been accepted, and your visits are pre-approved, we do require your signature below to authorize resale of any information to the Industrial Insurance carrier.

If you have a pre-determined co-payment amount with your particular plan, it is due and payable at the time of each and every visit.

If you insurance plan is a **PPO, EPO, POS** or **HMO** and your plan has a deductible and/or co-insurance policy (90/10, 80/20, 70/30 …etc.) your portion will be paid at the end of your visit. If you have an outstanding amount to meet towards your annual deductible, that amount will be reflected on your statement. If you are on **AHCCCS**, it is your responsibility to inform us of any insurance plan changes prior to your next appointment. Should any other financial arrangements need to be made, they must be made prior to your next appointment.

If for any reason your insurance does not pay the submitted claims or you fail to keep your financial arrangements made with this office, a finance charge of 1.5% (18% APR) will be added to your account each month you have an outstanding balance. This amount will be calculated from the date of the last payment received to the date the account is either paid if full or assigned to our collection agency. You are also responsible for any collection and/or attorney fees necessary to resolve the delinquent account.

If for any reason you need to cancel your appointment, we ask that you call at least 24 hours in advance of your appointment. If a phone call is not received at least 24 hours prior to your appointment, a NO SHOW FEE will be billed to you, the patient, and not your insurance company.

I hereby authorize Sebastian B. Ruggeri, M.D. to release any information acquired in the course of my examination or treatment to aid in the payment of medical and/or surgical bills submitted on my behalf. I also authorize Sebastian B. Ruggeri, M.D. to obtain, on my behalf, any insurance information covered by the "Privacy Act" from my insurance carrier files.

I hereby authorize payment directly to Sebastian B. Ruggeri M.D. and Affiliated Arm, Shoulder & Hand Surgeons, LTD. for medical and surgical benefits. Should my insurance carrier prohibit direct payment, I then hereby instruct said insurance carrier to make the check payable to myself and mail it as follows:

C/O Sebastian B. Ruggeri, M.D.
3104 E. Indian School Road, Suite 200
Phoenix, AZ 85016

I acknowledge that I have read the above information and acknowledge full responsibility for all charges incurred regardless of any possible insurance coverage and reimbursement. A photocopy or facsimile of this authorization shall be considered as valid as the original.

Patient Name (print) ________________________ Signature___________________________ Date _______________
If under 18:
Parent Name (print) _________________________ Signature___________________________ Date _______________