English

PATIENT REGISTRATION FORM
(Please print and complete in full)

DATE OF APPT: _____

AFFILIATED ARM, SHOULDER & HAND
Sebastian B. Ruggeri, M.D.
Gary North, P.A.-C.
3104 E Indian School Rd, Ste 200
Phoenix, Arizona 85016
(602) 954.9484 F: (602) 954.6433

PATIENT: (LAST) _____ (FIRST) _____ (MI) ____

SSN: _____ **DATE OF BIRTH:** _____ ☐ Male ☐ Female

MARITAL STATUS: _____ **ETHNICITY/RACE:** _____ or... ☐ *Decline to Answer*

STREET ADDRESS/P.O. BOX: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____ **EMAIL:** _____

EMPLOYER: _____ **OCCUPATION:** _____

PRIMARY DOCTOR: _____ **DOCTOR'S PHONE:** _____

Are you ☐ **LEFT** handed… ☐ **RIGHT** handed… or are you ☐ **AMBIDEXTROUS**?

DATE OF INJURY (approx): _____ or... **START OF SYMPTOMS** (approx): _____

SHOULDER *Left* ☐ / *Right* ☐ **ELBOW** *Left* ☐ / *Right* ☐ **WRIST** *Left* ☐ / *Right* ☐ **HAND** *Left* ☐ / *Right* ☐

ARE YOU PREGNANT?..... ☐ Yes ☐ No

IS THIS A WORK RELATED INJURY?..... ☐ Yes ☐ No

IS THIS AN AUTO ACCIDENT RELATED INJURY?..... ☐ Yes ☐ No

IF YES, ARE YOU OR WILL YOU BE SEEKING AN ATTORNEY?..... ☐ Yes ☐ No

IS THIS AN ATTACK RELATED INJURY, PERSON OR ANIMAL?..... ☐ Yes ☐ No

YOU MAY FAX YOUR COMPLETED PACKET TO (602).954.6433 OR EMAIL TO
FRONTDESKRUGGERI@GMAIL.COM

Name: _____ DoB: _____ Appt Date: _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

MEMBER/SUBSCRIBER ID#: _____ **GROUP #**: _____

GUARANTOR FULL NAME: (LAST) _____ (FIRST) _____ (MI) ___

GUARANTOR SSN: _____ **GUARANTOR D.O.B.**: _____

SEX OF GUARANTOR: ☐ Male ☐ Female

GUARANTOR STREET ADDRESS/P.O. BOX: _____

GUARANTOR CITY/STATE/ZIP: _____

GUARANTOR PRIMARY PHONE: _____ **ALT PHONE**: _____

GUARANTOR EMPLOYER: _____

GUARANTOR WORK PHONE: _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _____

MEMBER/SUBSCRIBER ID#: _____ **GROUP #**: _____

GUARANTOR FULL NAME: (LAST) _____ (FIRST) _____ (MI) ___

GUARANTOR SSN: _____ **GUARANTOR D.O.B.**: _____

SEX OF GUARANTOR: ☐ Male ☐ Female

GUARANTOR STREET ADDRESS/P.O. BOX: _____

GUARANTOR CITY/STATE/ZIP: _____

GUARANTOR PRIMARY PHONE: _____ **ALT PHONE**: _____

GUARANTOR EMPLOYER: _____

GUARANTOR WORK PHONE: _____

Name: _____ DoB: _____ Appt Date: _____

Current Medications

	Drug Name	Strength (mg)	Dosage (how often?)
1.			
2.			
3.			
4.			
5.			

PREFERRED PHARMACY: _____ **PHONE**: _____

Drug Allergies **Do you have a LATEX ALLERGY.....** ☐ **YES** ☐ **NO**

	Drug Name	Reaction (hives, trouble breathing, etc.)
1.		
2.		
3.		

HEIGHT: _____ **WEIGHT**: _____

Describe your symptoms and what caused them. Include **duration**, **location** and **severity**. (example: right hand numbness since March 2014, worse when making a fist)

_____

_____

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

_____

_____

_____

Name: _____ DoB: _____ Appt Date: _____

Please check all that apply to your **MEDICAL HISTORY** or… ☐ *NO PRIOR MEDICAL HISTORY*

Cancer ☐ No ☐ Yes... **Which type**?: _____

❑ AIDS	❑ Alzheimer's disease	❑ Asthma
❑ Bipolar disorder	❑ COPD	❑ Depression
❑ Diabetes type 1	❑ Diabetes type 2	❑ Gastritis
❑ Heart disease	❑ Hernia	❑ Hypertension
❑ Insomnia	❑ Melanoma	❑ Obesity
❑ Onychomycosis	❑ Osteoarthritis	❑ Osteopenia
❑ Pacemaker	❑ Parkinson's disease	❑ Sleep Apnea
❑ Schizophrenia	❑ Seizure disorder	❑ Strokes
❑ Tuberculosis	❑ Vitamin B-12 deficiency	

Other medical conditions not listed: _____

Please check all that apply to your **SURGICAL HISTORY** or... ☐ *NO PRIOR SURGICAL HISTORY*

❑ AortoFemoral bypass	❑ Aortic valve repair	❑ Cardioversion elective
❑ Carpal tunnel surgery	❑ Hernia repair	❑ Hysterectomy
❑ Kidney transplant	❑ Laminectomy	❑ Pacemaker
❑ Skin graft	❑ Thyroidectomy	

Other surgeries not listed: _____

Please list your family medical history (example: mother has cancer, grandfather had diabetes, hypertension, heart disease, etc.)

_____

_____

_____

Name: _____ DoB: _____ Appt Date: _____

DO YOU DRINK COFFEE DAILY? ☐ Yes ☐ No

Number of cups per day: ☐ 1 ☐ 2 ☐ 3 ☐ basically the whole pot

DO YOU SMOKE? ☐ Yes ☐ No

☐ Everyday ☐ Some days ☐ Former smoker

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

If current smoker, how many cigarettes do you smoke per day?

☐ 1–9 ☐ 10–20 ☐ 20–30 (about a pack) ☐ 40+ (two or more packs)

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

DO YOU DRINK ALCOHOL? ☐ Yes ☐ No

How often do you drink alcohol? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally

Number of drinks: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+

DO YOU USE RECREATIONAL DRUGS? ☐ Yes ☐ No

If "**Yes**," what kind?: _____

Do you currently experience **chest pain, unexplained weight loss, chills, fatigue**, **fever** or **sweats**? If so, describe them below:

_____

_____

_____

ADVANCED DIRECTIVES

Do you have a **MEDICAL POWER OF ATTORNEY**?..... ☐ Yes ☐ No

If "**Yes**," do you have a copy?..... ☐ Yes ☐ No

Do you have a **LIVING WILL**?..... ☐ Yes ☐ No

If "**Yes**," do you have a copy?..... ☐ Yes ☐ No

Name: _____ DoB: _____ Appt Date: _____

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, Ltd. (hereby referred to as **AAS&H**) 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

AAS&H 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, AAS&H 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.

AAS&H 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, AAS&H'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 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 AAS&H may have violated your privacy rights 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 AAS&H's health information practices or if you have a complaint, please contact the following persons:

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

Name: _____ DoB: _____ Appt Date: _____

AFFILIATED ARM, SHOULDER & HAND SURGEONS, LTD.
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Affiliated Arm, Shoulder & Hand Surgeon's *Notice of Information Practices*. I understand that AAS&H 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 AAS&H'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): _____

Patient Signature …… **Date: _____**

IF UNDER 18 YEARS OLD:

Parent or Guardian Name (PRINT) _____

Parent or Guardian Signature ……..……..... **Date: _____**

Emergency Contact (PRINT): _____ **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?

☐ Yes ☐ No

Name: _____ DoB: _____ Appt Date: _____

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 industry 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 predetermined co-payment amount with your particular plan, it is due and payable at the time of each and every visit.

If your insurance plan is a **PPO**, **EPO**, **POS** or **HMO** and you 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 if you fail to keep your financial arrangement 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 AAS&H 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 _____

Guardian Name (PRINT) _____ Signature ……..……..
Date _____