DATE: ______________

PATIENT REGISTRATION

(please print)

PATIENT'S FULL NAME: ______________________________ DATE OF BIRTH: __________

SOCIAL SECURITY NO: ______________________________ PATIENT'S GENDER: M F (please circle)

STREET ADDRESS: ______________________________ HOME PHONE: ( ) ______________

CITY: ____________________ STATE: ______ ZIP CODE: ______________

MARITAL STATUS: ______________ SPOUSE'S NAME (if applicable) ______________________________

EMERGENCY CONTACT: ______________________________ PHONE: ( ) ______________

RELATIONSHIP TO PATIENT: ______________________________

PATIENT'S EMPLOYER: ______________________________ WORK PHONE: ( ) __________ EXT: ______

IF PATIENT IS UNDER 18, WHO IS RESPONSIBLE FOR BILL? ______________ RELATION __________

ADDRESS & PHONE (if different than patient) ______________________________

____

REASON FOR TODAY'S VISIT: ______________________________

IF WORKER'S COMPENSATION INJURY: DATE OF INJURY: ______________________

COMPANY NAME: ____________________ CONTACT: ______________ PHONE: ( ) __________

IF MOTOR VEHICLE ACCIDENT: DATE OF ACCIDENT: ______________________

NAME/ADDRESS INSURANCE COMPANY: ______________________________

POLICY NUMBER: ____________________ CLAIM NUMBER: ____________________

INSURANCE/BILLING INFORMATION
(PLEASE PRESENT INSURANCE CARD)

PRIMARY INSURANCE

INSURANCE COMPANY: ______________________ ID # ______________ GROUP # __________

POLICY HOLDER NAME: ______________________ RELATION TO PATIENT: ______________

POLICY HOLDER EMPLOYER: ______________________ EMPLOYER PHONE: ( ) ______________

POLICY HOLDER DATE OF BIRTH: __________ POLICY HOLDER SOCIAL SECURITY # ______________

POLICY HOLDER ADDRESS: (if different than patient) ______________________________

HOME PHONE: ( ) ______________________

AAAA ***(CONTINUED ON OTHER SIDE)*** *AAAA*

SECONDARY INSURANCE: (if applicable)

INSURANCE COMPANY: ______________________ ID # ____________ GROUP # ________

POLICY HOLDER NAME: ______________________ RELATION TO PATIENT: ____________

POLICY HOLDER DATE OF BIRTH: __________ POLICY HOLDER SOCIAL SECURITY # ______________

POLICY HOLDER ADDRESS: (if different than patient) ______________________________

HOME PHONE: ( ) ____________________

POLICY HOLDER EMPLOYER: ______________________ EMPLOYER PHONE: ( ) ____________

Full payment is expected on the date of service.
This includes any insurance co-pays,medications, or other services which are not covered under your medical insurance policy.

The following forms of payment are accepted:
Cash, personal checks, money orders, MasterCard, Visa, and MAC.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for any and all balances accrued on my account for professional services rendered. To my knowledge, all information I have provided is true and correct. In the event any of this information changes, I will notify your office staff.

______________________________ ______________

SIGNATURE OF PATIENT (or guardian if patient is a minor) DATE

THIS SECTION FOR MEDICARE/MEDIGAP PATIENTS ONLY

AUTHORIZATION OF MEDICARE AND MEDIGAP BENEFITS

______________________________ ______________________________

PATIENT'S NAME MEDICARE NUMBER AND LETTER

I request that payment of authorized Medicare and Medigap benefits be made either to me, or on my behalf, to the name of the provider of services and/or supplier for any services furnished to me by the provider and/or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________

SIGNATURE OF BENEFICIARY DATE

PATIENT NAME: **AGE:** **DATE:**

PLEASE LIST AND SUPPLY THE DATES OF:

OPERATIONS:

HOSPITALIZATIONS OTHER THAN FOR SURGERY:

IMMUNIZATION HISTORY – HAVE YOU HAD: *Pneumonia Immunization?* No Yes When?

Hepatitis B? No Yes When? *Flu Immunization?* No Yes When?

Other? No Yes When? *Tetanus Immunization?* No Yes When?

WHEN WAS YOUR LAST:

Pap Smear? *Colonoscopy?* *Mammogram?*

FAMILY HISTORY

Has any family member (including parents, grandparents, siblings) ever had the following?

Illness	*Which Family Member(s)?*	*Approximate Age When Diagnosed*
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Stroke		
Mental Disease (anxiety, depression, etc)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		

Other: ____________________

MEDICATIONS (PRESCRIPTIONS, OVER-THE-COUNTER, VITAMINS, HERBS, ETC.)

Drug Name	*Dose*	*Drug Name*	*Dose*

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES? **YES** **NO**

(If YES, please list names of medicine and type of reaction)

DR. DAVID J. SILVERSTEIN ASSOCIATES BRUCE M. SILVERSTEIN, D.O. STEPHEN F. GOLD, D.O. 2920 MARIETTA AVENUE LANCASTER, PA 17601 (717) 898-2356

PREVENTION

Do you wear seatbelts?	Yes	No	If not, why not? ________________
Do you smoke?	Yes	No	If yes, how many packs per day? ___
Do you drink alcohol beverages?	Yes	No	If yes, how much per week? ______
Do you drink coffee?	Yes	No	If yes, how many cups per day? ___
Any personal history of substance abuse?	Yes	No	Rx Meds? Illicit Drugs?
If there is a gun in your home, do you keep it unloaded and out of children's reach?	Yes	No	N/A
Have you ever engaged in any activity which has put you at risk of getting AIDS?	Yes	No	If yes, explain: ______________
Do you wish to be tested for AIDS?	Yes	No	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	Yes	No	If yes, explain: ______________
Are you in a relationship in which you have been physically hurt (slapped,kicked,punched, bruised) by your partner?	Yes	No	
Do you ever feel afraid of your partner?	Yes	No	N/A
Do you have a "Living Will"?	Yes	No	
Do you have a Donor Card?	Yes	No	
Do you use birth control?	Yes	No	If yes, which method? __________

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS

Please circle if **YOU** have had problems with, or are presently complaining of any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids.
29. Gallbladder disease
30. Colitis
31. Hepatitis or Jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin Diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. Achieve erection
50. Maintain erection

OTHER: ______________

GYNECOLOGIC AND OBSTETRIC HISTORY

Age of onset of periods:	Frequency:	Length of periods:
Pregnancies:	Births:	Miscarriages:

Prolonged or abnormal bleeding?	Yes	No	(please describe)________________________
Leakage of urine?	Yes	No	(please describe)________________________
Pelvic pain?	Yes	No	(please describe)________________________
Abnormal discharge?	Yes	No	(please describe)________________________
History of abnormal Pap smear?	Yes	No	(type of treatment?)____________________

PATIENT NAME:____ **DATE:**____________________

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DR. DAVID J. SILVERSTEIN ASSOCIATES
PATIENT FINANCIAL AGREEMENT

______________________________	______________________________
PATIENT NAME (PLEASE PRINT)	**ACCOUNT # OR DATE OF BIRTH**

As a patient of this practice, I understand and agree that:

- Payment for medical services is expected when services are rendered. I may pay with cash, credit card (Visa, Mastercard) or personal check. There is a $20 administrative fee added for all returned checks drawn on accounts with insufficient funds or closed accounts.

- Our office participates with a number of health plans. If we participate with your health insurance carrier, we will file a claim on your behalf. We are not obligated to submit claims to carriers with whom we do not participate; however, we may do so as a courtesy in certain situations. Please be aware that we do not accept assignment on any claims submitted to a non-participating insurance carrier.

- All CO-PAYS will be collected at the time of service as well as any BALANCE due on your account. A $5 administrative charge may be added for co-payments not received on date of service and each billing cycle (monthly) thereafter until paid in full.

- BALANCE due on your account may be from yearly deductibles, co-insurance, or non-covered services as determined by your chosen health plan. Balance due is moved to patient responsibility when incorrect or insufficient insurance information is provided to our office.

- Any changes to your insurance coverage, name, address, or phone number needs to be communicated to our office staff on check-in to assure correct billing and contact information is maintained in our records. Please be prepared to present your insurance card to our staff at every visit.

- I am financially responsible for NON-COVERED services as determined by my health plan or insurance company. My physician or I may request procedures or treatments that are not covered benefits of my insurance coverage, i.e. Physical Exams, Therapy, etc. It is my responsibility as a patient to understand my benefits and coverage of my chosen insurance plan and will contact my insurer for coverage questions.

- When a consultation, test, or procedure is scheduled by the staff at our office, it is ultimately your responsibility to contact your insurance company to verify that the consult, test, or procedure being scheduled is a covered service AND the specialist or facility you are being referred to is in-network. Our office is not responsible for any bills you may incur for having services performed at an out-of-network specialist and/or facility.

- If I am determined to be ineligible for insurance coverage by my health plan or insurance company on the date of service, the bill becomes my full and immediate responsibility.

PATIENT NAME (PLEASE PRINT) ACCOUNT # <u>OR</u> DATE OF BIRTH

- Outstanding balances that are my responsibility are to be paid at the time of service unless payment arrangements have been made with our billing office. I understand that an additional $30 charge may be incurred on any balances sent to a collection agency.

- If my insurance carrier requires a Primary Care Physician assignment, I am responsible for arranging this with my health plan. I agree that Dr. David J. Silverstein Associates must be able to be confirmed on my insurance card, enrollment papers, or insurance eligibility list for my insurance to accept responsibility for services provided by my chosen PCP. If this cannot be confirmed, I will have the option to reschedule my appointment or be seen and responsible for payment of all services rendered on date of service.

- If you are a medical assistance patient, please be aware that our office participates with AmeriHealth Mercy, UPMC and Access only. If we are not listed as your Primary Care Physician on the date of service, or if it is confirmed that you are part of another medical assistance program with whom we do not participate, <u>we will not be able to see you in our office until it is confirmed that we are your Primary Care Physician</u>. It is your responsibility to contact your medical assistance carrier to make these changes.

- If I am a Medicare patient, I will be asked to sign waivers for any procedure or test that in the opinion of the physician, Medicare is likely to deny as unnecessary or non-covered. This may include tests and/or routine medical exams. Medicare recipients are responsible for payment for Medicare waived services.

- I will be responsible for giving a 24-hour notice to cancel appointments for which I cannot show. I understand that if I do not show for my appointment, I will be charged a $25 fee. This fee is my personal responsibility and cannot be billed to my insurance company. Repeated No-Show patients will be asked to seek care elsewhere.

- I will be responsible for payment of fees associated with the completion of FMLA papers, disability forms, work excuses or paperwork required from my employer, or re-issue of lost prescriptions. These services are not billable to my insurance company and are my personal responsibility.

Signature______________________________ Date________________